Vermont

UNIFORM APPLICATION
FY 2024/2025 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 10/19/2023 9.38.53 AM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID YLQARK22FMQ1

I. State Agency to be the Grantee for the Block Grant

Agency Name Agency of Human Services

Organizational Unit State of Vermont

Mailing Address 280 State Drive - Center Building

City Waterbury

Zip Code 05671-1000

II. Contact Person for the Grantee of the Block Grant

First Name Emily

Last Name Hawes

Agency Name Agency of Human Services, Department of Mental Health

Mailing Address 280 State Drive, NOB-2 North

City Waterbury

Zip Code 05671-2010

Telephone (802) 241-0122

Fax (802) 241-0100

Email Address emily.hawes@vermont.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/1/2023 5:25:23 PM

Revision Date 9/1/2023 5:25:50 PM

VI. Contact Person Responsible for Application Submission

First Name Stephen

Last Name DeVoe

Telephone 802-241-0090

Fax 802-241-0100

Email Address stephen.devoe@vermont.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 USC § 300x-9
Section 1920	Crisis Services	42 USC § 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Todd Daloz

Signature of CEO or Designee[1]: ______________________

Title: Deputy Secretary, Vermont Agency of Human Services

Date Signed: ______________________

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

PHILIP B. SCOTT
GOVERNOR

State of Vermont
OFFICE OF THE GOVERNOR

April 1, 2023

Xavier Becerra, Secretary
Department of Health and Human Services
Hubert H. Humphrey Bldg.
200 Independence Ave., S.W.
Washington, DC 20201

Dear Secretary Becerra:

This letter is to advise that Todd Daloz, Deputy Secretary of the Agency of Human Services, is my formal designee for all transactions required to administer the Vermont Human Services Plan Budget for FFY 2024, including each related block grant as listed below. The Agency of Human Services of the State of Vermont is designated to administer the grants or supervise their administration.

Application for Social Services Block Grant
Social Security Act, Sec. 2005 (42 U.S.C. 1397d). Regulations: 45 CFR Parts 96.70 - 96.74

Application for Preventative Health and Health Services Block Grant
U.S.C. 42 Chapter 6A Subchapter XVII Part A. Regulations: 45 CFR Part 75

Application for Maternal and Child Health Services Block Grant
Social Security Act, Sec. 501-513 (42 U.S.C. 701-713). Regulations: 45 CFR, Parts 96.1 - 96.112

Application for Substance Abuse Prevention and Treatment Block Grant
Title XIX, Part B of the Public Health Services Act (42 U.S.C. 300x). Regulations: 45 CFR Part 96

Community Mental Health Block Grant
P.L. 102-321 - Amendment to Title V created by ADAMHA Reorganization Act

Application for Low Income Home Energy Assistance Block Grant
P.L. 97-35. Regulations: 45 CFR, Parts 96.1 - 96.112

Applications for Community Services Block Grant
P.L. 970-35, the Omnibus Budget Reconciliation Act of 1981 Regulations: 45 CFR, parts 96.1 - 96.112

Sincerely,

Philip B. Scott
Governor

PBS/kp

CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(b) Have not within a three-year period preceding this proposal been convicted of or had a criminal judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) Are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

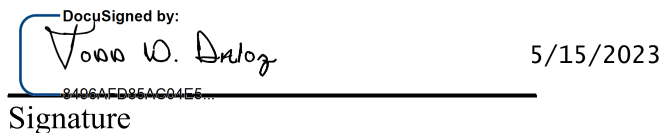
(d) Have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transaction" (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with sub grantees and/or contractors) and in all solicitations for lower tier covered transactions.

Vertmont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative



5/15/2023

Signature

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The grantee certifies that it will provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing a drug-free awareness program to inform employees about— (1) The dangers of drug abuse in the workplace; (2) The grantee's policy of maintaining a drug-free workplace; (3) Any available drug counseling, rehabilitation and employee assistance programs, and (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will— (1) Abide by the terms of the statement; and (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after each conviction;

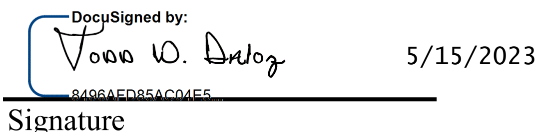
(e) Notifying the agency within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted— (1) Taking appropriate personnel action against such an employee, up to and including termination; or (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e) and (f).

Vermont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative



5/15/2023

Signature

CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of the Congress in connection with the making of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal grant or cooperative agreement.

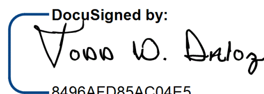
(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub grants, and contracts under grants, loans and cooperative agreements), and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. "Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure."

Vermont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative

DocuSigned by:

8496AFD85AC04E5...
5/15/2023

Signature

CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the statements herein are true, accurate and complete, and agrees to comply with the Public Health Service terms and conditions if an award is issued as a result of this application. Willful provision of false information is a criminal offense (Title 18, U.S. Code, Section 1001). Any person making any false, fictitious or fraudulent statement may, in addition to other remedies available to the Government, be subject to civil penalties under the Program Fraud Civil Remedies Act of 1986 (45 CFR Part 79).

Vermont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative

5/15/2023

Signature

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

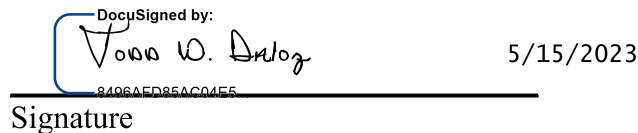
Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age ofl8, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offertory/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub awards which contain provisions for children's services and that all sub recipients shall certify accordingly.

Vermont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative



5/15/2023

Signature

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

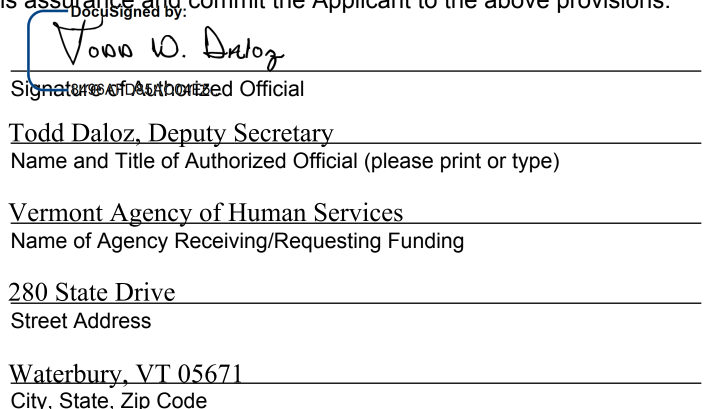
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property,any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

5/15/2023

Date



Please mail form to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Ave., S.W. Room 509F
Washington, D.C. 20201

State Information

Chief Executive Officer's Funding Agreement – Certifications and Assurances / Letter Designating Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grant to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Section 1920	Early Serious Mental Illness	42 U.S.C. 300x-9
Section 1920	Crisis Services	42 U.S.C. 300x-9
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

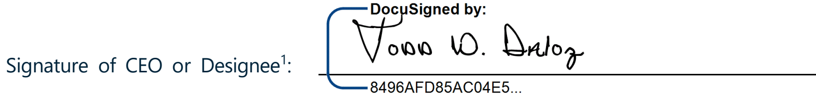
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Todd Daloz, Vermont Agency of Human Services

Signature of CEO or Designee[1]: 

Title: Deputy Secretary

Date Signed: 6/30/2023

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

GENERAL ASSURANCES

The Agency of Human Services agrees to maintain documentation to substantiate all the following assurance items. Such documentation is available for federal review to determine adequacy and completeness.

Each assurance item is followed by an indication of the categorical grant programs to which it applies. A specific reference to the comparable planning requirements of each program is included for the convenience of state and federal reviewers.

1. SINGLE STATE AGENCY

The Agency of Human Services is the single State Agency responsible for the administration or supervision of the administration of this plan.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

2. COMPLIANCE WITH REQUIREMENTS

The Agency of Human Services agrees to administer the program in accordance with the applicable Act, the State Plan and all applicable regulations, policies and procedures established by the Commissioner or the Deputy Secretary, including the requirements at 34CFR Part 85 Subpart F, Drug free Workplace Act of 1988 and debarment and suspension, 34 CFR Part 85, Section 85.510 and certification regarding lobbying as required by Section 1352, Title 31 of the U.S. Code.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

3. COMPLIANCE BY LOCAL AGENCIES

Where the Agency of Human Services supervises the administration of the State Plan, there are adequate methods for assuring compliance with the requirements of the plan by local agencies and/or services contractors.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

4. EFFICIENT ADMINISTRATION

The Agency of Human Services utilizes such methods of administration as are necessary for the proper and efficient administration of the plan.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

5. GENERAL ADMINISTRATION AND FISCAL REQUIREMENTS

The Agency of Human Services' uniform administrative requirements and cost principles are in compliance with the relevant provisions of 45 CFR Part 74, except where these provisions are superseded by statute or program regulations.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

6. TRAINING OF STAFF

The Agency of Human Services provides a program of appropriate training for all classes of positions and volunteers, if applicable.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

7. MANAGEMENT OF FUNDS

The Agency of Human Services maintains sufficient fiscal control and accounting procedures to assure proper disbursement of and accounting for federal funds paid under this plan.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

8. SAFEGUARDING INFORMATION

The Agency of Human Services has implemented such regulations, standards, and procedures as are necessary to meet the requirements on safeguarding confidential information under relevant program regulations.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)

- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

9. REPORTING REQUIREMENTS

The Agency of Human Services agrees to furnish such reports and evaluations to the Deputy Secretary or the Commissioner as may be specified.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

10. STANDARDS FOR SERVICE PROVIDERS

All providers of service under this plan operate fully in conformance with all applicable federal, state and local fire, health, safety and sanitation and other standards prescribed in law or regulations. The Agency of Human Services provides that where the state or local public jurisdictions require licensure for the provision of services, agencies providing such services shall be licensed.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

11. AMENDMENTS TO STATE PLAN

The State Plan provides for amendment whenever there is any material change in any applicable phase of State law, organization, policy, agency operations or other major conditions which affect the administration of this plan. Such amendments will be made in conformance with applicable regulations and submitted to the federal government before they are put into effect or at a reasonable time thereafter.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)

- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

12. EQUAL EMPLOYMENT OPPORTUNITY

The Agency of Human Services has an equal employment opportunity policy, implemented through an affirmative action plan for all aspects of personnel administration as specified in 45 CFR Part 86.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

13. NON-DISCRIMINATION ON THE BASIS OF HANDICAP

All recipients of funds from the Agency of Human Services are required to operate each program or activity so that, when viewed in its entirety, the program or activity is readily accessible to and usable by a handicapped person. Where structural changes are required, these changes shall be made as quickly as possible in keeping with 45 CFR 84 and P.L. 97-45.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

14. CIVIL RIGHTS COMPLIANCE

The Agency of Human Services has developed a system to ensure that benefits and services available under the State Plan are provided in a non-discriminatory manner as required by Title VI of the Civil Rights Act of 1964 as amended.

- Social Services Block Grant
- Preventative Health and Health Services Block Grant
- Maternal and Child Health Service Block Grant
- Substance Abuse Prevention and Treatment Block Grant
- Community Mental Health Services Block Grant
- Low Income Home Energy Assistance Block Grant
- Community Services Block Grant
- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)
- Community Food and Nutrition Program

15. WRITTEN POLICIES AND PROCEDURES

With regards to the provision of any services included in this plan to individuals or groups of individuals, the Agency of Human Services has established in writing and will maintain policies and procedures for the provision of such services. These policies shall include a description of the scope and nature of each service and the procedures and conditions under which each such services are to be provided, including criteria for establishment of fee schedule or contributions, if applicable.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

16. NEEDS ASSESSMENT

The Agency of Human Services has a reasonable and objective method for determining the needs of all eligible residents of all geographic areas in the State and for allocating resources to meet those needs.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

17. PRIORITIES

The Agency of Human Services has a reasonable and objective method for establishing priorities for service and such methods are in compliance with applicable statutes.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

18. ELIGIBILITY

The activities covered by this State Plan serve only those individuals and groups eligible under the provisions of the applicable statute.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

19. RESIDENCY

No requirements as to duration of residence or citizenship will be imposed as a condition of participation in Vermont's program for the provision of services.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

20. COORDINATION AND MAXIMUM UTILIZATION OF SERVICES

The Agency of Human Services has entered into cooperative arrangements with, and utilizes the services and facilities of, other appropriate public and private agencies whose activities further the purposes of the program covered by this plan or which are specifically referenced in the applicable statute. Such coordination shall maximize utilization of public and private resources.

- State Plan on Aging (Title III of the Older Americans Act)
- State Plan on Child Abuse and Neglect (45 CFR § 1340)
- State Plan on Child Welfare Services (Title IV-B of the Social Security Act)
- State Plan on Developmental Disabilities Services and Facilities Construction (45 CFR § 1386)

Vermont Agency of Human Services
Organization Name

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative

5/15/2023

Signature

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Public Hearing on AHS Block Grants
taken on Thursday, June 15, 2023, by
videoconference, beginning at 2 p.m.

APPEARANCES:
Todd Daloz, Deputy Secretary VT AHS
Emily Trutor, VDH
Ilisa Stalberg, VDH
Katie Stetler, VDH
Susan Kamp, VDH
Katherine Richardson, VDH
Kimberly Swartz, VDH
Megan Hoke, VDH
Steve DeVoe, DMH
Cara McSherry, DMH
Jim Euber, DAIL
Lily Sojourner, DCF
Heather McLain, DCF
Karolyn Long, DCF
Richard Giddings, DCF
Megan Smeaton, DCF
Ed Dwinell, DCF
Judy Morse, Central Office
Celine Edson, Central Office
Sarena Boland, Central Office
Alison Blaney, Central Office
Candace Elmquist, Central Office
Joe Wiah, ECDC
Elise Fuerstman, VDH
Courtney Smalt, VDH

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1 MR. DALOZ: Good afternoon, everyone.
2 Welcome to the AHS Block Grant and State Plan
3 hearing. My name's Todd Daloz, and I'm the Deputy
4 Secretary with the Agency of Human Services in
5 Vermont. I just want to make sure for folks who are
6 joining us online, which is almost everyone, can you
7 just let me know if you can hear me all right? Just
8 a thumbs up.
9 (Thumbs up and nodding).
10 MR. DALOZ: Thank you. Just nod.
11 Great. So I want to begin -- I'm going to hand
12 things over to Candace who is off camera but able to
13 actually see the faces and names to lead us through
14 introductions of the attendees by department so we
15 are sure we have got everyone here from each of the
16 areas of the Federal Block Grants and State Plans
17 administered by AHS.
18 So Candace, if I could just ask you to
19 name folks, and if you're here today, just introduce
20 yourself and let us know who you're here representing
21 even though we know most of you.
22 MS. ELMQUIST: All right. Instead of
23 naming folks, can I call by department? So if you're
24 from VDH, please take turns introducing yourself with
25 your title and division.

1 MS. TRUTOR: Hi, everybody. My name is
2 Emily Trutor. I am Deputy Director for the Division
3 of Substance Use Programs at the Health Department.
4 MR. DALOZ: Thanks, Emily.
5 MS. STALBERG: Hi, everyone. I'm Ilisa
6 Stalberg. I'm the Director for our Family and Child
7 Health Department, and I oversee the Title 5 Block
8 Grant.
9 MR. DALOZ: Nice to see you, Ilisa.
10 MS. STETLER: Hi, everybody. I'm Katie
11 Stetler. I'm Director of Planning at VDH here
12 representing the Preventive Health and Health
13 Services Block Grant.
14 MR. DALOZ: Hi, Katie.
15 MS. KAMP: Hi, everyone. Sorry. I'm
16 Sue Kamp from the Health Department, Health Promotion
17 and Disease Prevention Unit. We are connected to the
18 Preventive Services and Public Health Block Grant.
19 MR. DALOZ: Hi, Sue.
20 MS. RICHARDSON: Hi, everyone. My
21 name's Katherine Richardson. I'm the Health Division
22 Admin for the Planning Unit and also the Block Grant
23 Coordinator representing the Preventative Health and
24 Health Services Block Grant.
25 MS. SWARTZ: I'm Kim Swartz. I'm the

1 Director of Adolescent and Reproductive Health at the
2 Health Department, and I'm here with the Preventative
3 Health Services Block Grant.
4 MR. DALOZ: Thanks, Kim.
5 MS. HOKE: Hi, everyone. Megan Hoke,
6 Financial Director in the VDH Business Office
7 overseeing all of our Block Grants.
8 MR. DALOZ: Thanks, Meg.
9 MS. ELMQUIST: All right. That's
10 everyone from VDH. I'll ask DMH to go next.
11 MR. DeVOE: Good afternoon, everybody.
12 I'm Steve DeVoe. I use he/him pronouns. I'm the
13 Director of Quality and Accountability at the Vermont
14 Department of Mental Health. I'm also the State
15 Planner for the Community Mental Health Services
16 Block Grant.
17 MS. McSHERRY: Hi, everybody.
18 MR. DALOZ: Hi.
19 MS. McSHERRY: Hi, Cara McSherry. I
20 work in the Business Office at DMH. I'm a Financial
21 Manager.
22 MR. DALOZ: Hi, Cara.
23 MS. ELMQUIST: All right. And how
24 about DAIL.
25 MR. EUBER: Good afternoon. Jim Euber.

1 I'm the Financial Director here at DAIL. I'm here
2 representing the Social Services Block Grant.
3 MR. DALOZ: Hey, Jim.
4 MS. ELMQUIST: And DCF next.
5 MS. SOJOURNER: I'm Lily Sojourner with
6 the Office of Economic Opportunity, and I'm
7 representing the Community Services Block Grant.
8 MR. DALOZ: Hi, Lily.
9 MS. McLAIN: Hi, everybody. I'm
10 Heather McLain. I'm the Revenue Enhancement Director
11 for Family Services with the Social Services Block
12 Grant.
13 MR. DALOZ: Hello.
14 MS. LONG: I am Karolyn Long. I'm the
15 Director of the Child Operations for the Child
16 Development Divisions along with I'm representing the
17 Social Services Block Grant as well.
18 MR. DALOZ: Nice to see you, Karolyn.
19 MR. GIDDINGS: My name is Richard
20 Giddings. I'm the Program Director for the Low
21 Income Home Energy Assistance Program for Economic
22 Services.
23 MR. DALOZ: Hi, Rich.
24 MS. SMEATON: Megan Smeaton, Financial
25 Director, DCF Business Office, here for all of our

1 Block Grants.
2 MR. DALOZ: Hi.
3 MS. ELMQUIST: All right. And AHS
4 Central Office -- sorry. Go ahead.
5 MR. DWINELL: Ed Dwinell, Financial
6 Director on the cost allocation side. And we are
7 involved with all the Block Grants for DCF.
8 MS. ELMQUIST: All right. Central
9 Office. Let's start with folks on the call, and then
10 we will do in the room.
11 MS. MORSE: Hi. I'm Judy Morse. I
12 work with the Social Services Block Grant, and I'm a
13 Financial Manager in the Central Office.
14 MR. DALOZ: Hey, Judy.
15 MS. EDSON: I am Celine Edson. I'm the
16 Financial Manager for the Central Office.
17 MS. BOLAND: I'm Sarena Boland. I'm a
18 Financial Manager in the AHS Fiscal Business
19 department.
20 MS. BLANEY: I'm Alison Blaney. I'm a
21 Financial Manager at the Central Office.
22 MS. ELMQUIST: Candace Elmquist, the
23 person behind the screen. Financial Director in
24 Central Office.
25 Anyone else who did not introduce

1 themselves please go ahead now.
2 MR. DALOZ: Anyone else in the
3 introductions -- and maybe I'll ask the person who
4 just joined by phone, the 240 number.
5 MR. WIAH: Say again.
6 MR. DALOZ: Just offer introductions if
7 you just joined us.
8 MR. WIAH: Yes, this is Joe Wiah at
9 240. I'm director of ECDC, a resettlement agency
10 here in Brattleboro.
11 My last is W as in William, I as in
12 India, A as in Apple, H as in Harris. W-I-A-H.
13 MR. DALOZ: Thank you.
14 MR. WIAH: Sorry. You're breaking up.
15 MS. FUERSTMAN: I'm Elise Fuerstman.
16 I'm the Infrastructure Analyst and Health Statistics
17 and Informatics at VDH.
18 MR. DALOZ: Thanks, Lise. Any other
19 introductions?
20 MS. SMALT: My name is Courtney Smalt.
21 I am with VDH in the SVH Division and I'm the Title 5
22 Block Grant Coordinator.
23 MR. DALOZ: Thank you, Courtney.
24 Anyone else? Okay. Just for folks who joined a
25 little bit late, I'm going to go back to the top. We

1 have now done introductions. Now I'll walk us
2 through kind of this set program for this hearing.
3 I appreciate everyone taking a moment
4 to join us. And I'm going to take leave with some of
5 the colleagues here.
6 Good afternoon. Welcome to the Agency
7 of Human Services Block Grant and State Plan hearing.
8 I am Todd Daloz. I respond to he/him pronouns. I am
9 Deputy Secretary of the Agency of Human Services.
10 Under federal regulation we must prior
11 to the beginning of a new federal fiscal year conduct
12 a public hearing for the following federal Block
13 Grants and State Plans administered by AHS. Those
14 are the Social Services Block Grant, the Preventative
15 Health and Health Services Block Grant, the Maternal
16 and Child Health Services Block Grant, the Substance
17 Abuse Prevention and Treatment Block Grant, the
18 Community Mental Health Services Block Grant, the Low
19 Income Home Energy Assistance Block Grant, and
20 Community Services Block Grant.
21 Under State of Vermont statute we must
22 announce the public hearing as community members have
23 the right to attend meetings of public agencies.
24 Advertisements of the public hearing were placed in
25 the Burlington Free Press, Bennington Banner, Times

1 Argus, Brattleboro Reformer, and Rutland Herald on
2 Friday, June 2, of this year. 2023. An electronic
3 notice was also posted on the public libraries'
4 website. Additionally, legislative leaders of the
5 Joint Fiscal Committee were notified via email of
6 this public hearing.
7 Electronic summary documents as well as
8 full draft grant applications are available on the
9 AHS intranet. Internet, right?
10 MS. ELMQUIST: Internet.
11 MR. DALOZ: So they are publicly
12 available. I should note that these Block Grants and
13 State Plans and the respective programs and amounts
14 are for the most part included in the state fiscal
15 year 2024 budget which is yet to be enacted. Until
16 the federal fiscal year '24 budget is enacted into
17 law, we will submit our plans using the estimated
18 allocations based on FFY 2023 funding levels.
19 At this point we will take questions
20 from the public. As you heard in the introduction,
21 the individuals present today are members of each
22 department who will address any specific concerns or
23 questions regarding these grants and plans. We will
24 record your questions and provide a formal written
25 response as soon as possible to those questions.

1 In addition, we will post all questions
2 and answers on the Agency of Human Services' website.
3 I'm going to leave this open now for any questions
4 from any members of the public who have joined.
5 (No response)
6 MR. DALOZ: Folks can feel free to
7 raise hands or speak out as questions arise. In the
8 interest of providing sufficient opportunities for
9 the public to weigh in, if they haven't arrived at
10 the meeting at this moment, we will leave the line
11 open for an additional 20 minutes in the event that a
12 member of the public has a question.
13 So folks should feel free to mute
14 themselves, but please be ready to answer any
15 questions should a member of the public arrive within
16 the next 20 minutes, by my clock if we haven't heard
17 from a member of the public by 2:33, we will close
18 the meeting.
19 (Recess was taken.)
20 MR. DALOZ: Hi, folks. We have waited
21 10 minutes. And if anyone has joined us in the last
22 few minutes, as a reminder this is the AHS Block
23 Grant and State Plan hearing. We are leaving this
24 line open for another 10 minutes in case any members
25 of the public have joined us and have any questions.

1 As I -- maybe if you didn't hear, but individuals on
2 this call are available to answer any specific
3 questions or concerns regarding the Block Grants that
4 are the subject of today's hearing. We will record
5 any questions asked and provide formal written
6 responses to the question afterwards as soon as
7 possible. And we will also post all questions and
8 answers to the Agency of Human Services' website.
9 So at the end if there are any
10 questions from the members of the public, feel free
11 to ask them or put them in the chat. We are happy to
12 take them that way. We will leave this line open for
13 another 10 minutes. Thanks.
14 (Recess was taken.)
15 MR. DALOZ: All right, folks. Having
16 heard no inquiries from the public, and having waited
17 an additional almost 20 minutes, drag it out just a
18 little bit until the clock in the corner of the
19 screen turns to 2:33, we will conclude the AHS Block
20 Grants and State Plans hearing.
21 I appreciate everyone taking the time
22 to be available. Even though we don't have any
23 questions, I thank you all for being here and all the
24 work you do administering these tremendous programs.
25 Thank you all.

1 (Whereupon, the proceeding was
2 adjourned at 2:33 p.m.)
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1 C E R T I F I C A T I O N

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4 I certify that the foregoing is a correct

5 transcript from the record of proceedings in the

6 above-entitled matter.

7

8 ______________________________ /s/ Kim U. Sears

9 Date Kim U. Sears

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Jenney Samuleson, *Secretary*
Todd Daloz, *Deputy Secretary*

Lauren Christopher
Director of the Division of Energy Assistance
Office of Community Services
Administration for Children and Families
U.S. Department of Health & Human Services
330 C Street S.W.
Washington, D.C. 20201

I certify that the Vermont Low-Income Home Energy Assistance Program (LIHEAP) Block Grant Plan complies with the sixteen assurances required by 2605 (b) of the Low-Income Home Energy Assistance Act of 1981, as amended.

A letter from Governor Phil Scott delegating authority to the Deputy Secretary of the Agency of Human Services as his designee for all documents pertaining to the LIHEAP program is enclosed.

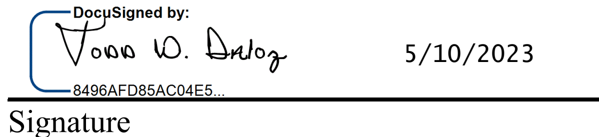
If you have any questions, please contact Richard Giddings at Richard.Giddings@vermont.gov or (802) 786-5986.

Miranda Gray, Deputy Commissioner ESD
Name and Title of Authorized Representative

5/9/2023

Signature

Todd Daloz, Deputy Secretary
Name and Title of Authorized Representative



5/10/2023

Signature

Vermont: BSCA Funding Plan 2024

Vermont Overview

The Vermont Department of Mental Health (DMH) operates under the Vermont Agency of Human Services (AHS), the Single State Agency. DMH executes grants and contracts with community mental health centers to provide mental health services to adults with serious mental illness (SMI) and children and adolescents experiencing serious emotional disturbance (SED) and their families. The community mental health system has ten (10) state-designated agencies (DAs) that serve the entire state across ten (10) catchment areas. Vermont also has two specialized services agencies (SSAs); one offering statewide intensive services for children and adolescents with SED and supports for their families; and another SSA serving adults with SMI who also require housing supports, using the Housing First model. Many agencies have more than one office to serve their respective catchment areas.

Vermont Demographics

According to 2021 American Community Survey 1-year estimate data profiles[1], Vermont has an estimated population of 645,570 with 20.6% of residents aged 65 years or older compared to the United States percentage of 16.8% for this same age range. Additionally, Vermont is less racially diverse with 91.1% of residents identifying as White compared to the United States with 61.2%. According to the United States Census, the 2021 Vermont median household income was $67,674 compared to the United States median income of $70,784, and the Vermont's overall poverty rate was 10.3% compared to the national poverty rate of 12.8%. Although, the poverty rate of Vermont's children (under age 18) was 16.9% in 2021 and the poverty rate for Vermonters ages 65 years and older was 10.3%.[2]

Demographics	Vermont	National
% Female	50.4%	50.5%
% Age 65 or older	20.6%	16.8%
% Younger than Age 18	18.1%	22.1%
Median age	42.9	38.8
Median Household income	$67,674	$70,784
% Living in poverty	10.3%	12.8%
% Children (under 18) living in poverty	16.9%	17%
% Seniors (65 and older) living in poverty	10.3%	9%
% of Adults with High School graduate or higher	93.9%	89.4%
% of Adults with bachelor's degree or higher	40.9%	35.0%
% White	91.1%	61.2%

[1] https://data.census.gov/table?q=United+States&g=010XX00US_040XX00US50&tid=ACSDP1Y2021.DP05
[2] https://vermontbiz.com/news/2022/october/04/vermont-childhood-poverty-rate-among-lowest-us#:~:text=Vermont%27s%20overall%20poverty%20rate%20is,over%20poverty%20rate%20was%209.1%25.

% Black	1.1%	12.1%
% Asian	1.8%	5.8%
% 2 or more races	5.1%	12.6%
% Hispanic or Latino	2.0%	18.8%
% Persons with language other than English spoken at home	5.8%	21.6%
% Foreign Born	4.7%	13.7%
% Population with veteran status	6.9%	6.9%

BSCA Background

The Bipartisan Safer Communities Act (BSCA) (P.L. 117-159) provides $250 million in supplemental funding for the Community Mental Health Services Block grant (MHBG). Starting October 17, 2022, SAMHSA distributed approximately $59.4 million per year through Fiscal Year 2025 to states and territories based on the congressionally mandated MHBG formula. The performance period for the 2024 funds will be two years from September 30, 2023, to September 29, 2025. Vermont's second allocation is $138,656. The award includes mandatory minimum set asides: 10% set-aside for Early-SMI (ESMI) and First Episode Psychosis (FEP) and 5% set-aside for Crisis Services. The Substance Abuse and Mental Health Services Administration (SAMHSA) is advising states to examine and address the need for mental health services in the aftermath of mass shootings and other traumatic events in communities.

Current Ongoing Activities

There has been a continuation of an expanded awareness of mental health being a key component of public health and healthcare systems, especially within emergent and crisis-related situations, as evidenced by individuals accessing mental health care through emergency departments and crisis services.

DMH continues to sustain Vermont's in-state 9-8-8 Lifeline Centers through two partner DAs: Northeast Kingdom Human Services and Northwestern Counseling and Support Services. These agencies have an average in-state answer rate of 80.9% over the past state fiscal year 2023. Vermont is tracking data on chats and texting to 9-8-8 to ensure that the state can meet client and family needs in a comprehensive manner through the full range of options to improve access to those disproportionately impacted by health inequities. Also, DMH will be launching its statewide mobile crisis initiative on January 1, 2024, in partnership with the state's 10 DAs, which will provide a comprehensive array of services to meet the needs of Vermonters.

Finally, Vermont's BSCA Funding Plan 2023 work continues to move forward in collaboration with the state's emergency preparedness and management partners. The primary focus of this plan is updating emergency preparedness and response plans to prominently include disaster mental health. These plans will better match the current landscape of the public mental health system of care, especially the continued effects of the Covid-19 pandemic on mental health, to

effectively address DMH's role and capabilities to support statewide efforts during disaster and crisis situations. The state is finalizing an RFP to be released in the coming months to enlist a contractor with experience in emergency preparedness to conduct a comprehensive review of the State Emergency Management Plan (SEMP), as well as other state plans such as the Vermont School Crisis Guide, to update these documents accordingly and to support efforts to implement other components of the BSCA Funding Plan 2023.

Plan and Proposal

1. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health emergency related resources.**

   The State of Vermont currently does not have a Coordinated Specialty Care (CSC) program to serve individuals who are experiencing early serious mental illness, in particular first episode psychosis. DMH is proposing to use the majority of the allotted 2024 BSCA funds to support the establishment of a CSC program in Vermont, in addition to the 10% set asides from other MHBG awards. It will be a significant amount of work and funding to plan, develop, and implement a CSC program. The BSCA-funded portion of this initiative will explicitly focus on disaster and crisis response for adults with SMI and children with SED who receive services from DAs and SSAs. This proposal will involve the identification and role of a CSC program in the state's mental health emergency preparedness and response plan to ensure that individuals diagnosed with SMI and SED are prioritized effectively and this program has resources needed for continuity of operations in disaster-related situations. Additionally, a portion of the 2024 BSCA funds will go to providing training and education on the state's emergency preparedness plans and ways to access resources to support adults with SMI and children with SED to broader sectors of Vermont's health care system (e.g., hospitals; primary and subspecialty care providers), local offices of public health (e.g., Vermont Department of Health Office of Local Health), emergency medical service providers, educational partners (e.g., Agency of Education; Vermont School Counselor Association), and support and community social service organizations (e.g., Vermont Association of Area Agencies on Aging; Vermont Family Network). Finally, the 5% set aside will be utilized to support the state's implementation of mobile crisis teams located in each of the 10 DAs on both this CSC program and its role in these types of situations to leverage disaster mental health-related resources on local, regional, and statewide levels, as well as to provide guidance and direction to these team members. This proposal will be in coordination with state partners (e.g., Agency of Human Services, Vermont Emergency Management), community mental health centers and their network organization (e.g., Health Care and Rehabilitation Services of Southeastern Vermont; Northeast Kingdom Human Services; Vermont Care Partners), and other health care sector

organizations (e.g., Vermont Association of Hospitals and Health Systems; Bi-State Primary Care Association).

2. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.**

   As previously noted, Vermont will be launching its statewide mobile crisis initiative on January 1, 2024, which will provide a comprehensive array of emergency services to Vermonters experiencing crises. DMH is proposing to utilize its 5% Crisis Set Aside from the 2024 BSCA award to support mobile crisis teams in being able to better assist adults with SMI and children with SED and their families to access the appropriate levels of care through improved coordination and communication. DMH will expand the awareness of available resources for these populations to ensure the mobilization of resources and to improve adherence to the scalable protocol for a localized event that was referenced in Vermont's BSCA Funding Plan 2023.

3. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.**

   Please see documentation referenced above.

4. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having SED/serious mental illness (SMI).**

   As aforementioned, Vermont does not currently have a CSC program. SAMHSA has provided explicit guidance on the need for this program in the State of Vermont, therefore efforts are currently underway to establish a program in the state that will serve youth, young adults, and families who are experiencing issues related to early serious mental illness. Given the need to mobilize as many resources as possible and Vermont's current limited capacity, the proposed BSCA funding plan for 2024 would utilize the majority of funds to assist in efforts to establish a CSC program and utilize these funds to specifically focus on any disaster-related mental health components and identify a CSC program's role in the state's emergency preparedness planning.

5. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.**

   DMH, in partnership with DAs, SSAs, Vermont Agency of Education, and local supervisory unions and school districts, intends to provide education and training on ESMI/FEP to support plans identified in the state's 2023 BSCA funding plan regarding the Vermont School Safety Center and its accompanying Vermont School Crisis Guide, which includes

several guidance documents to be used during preparedness, response, and recovery phases of critical incidents impacting schools.

6. **Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.**

   For the current 2024 BSCA proposal, DMH does not intend at present to utilize any funds towards development/enhancement of culturally and linguistically tailored messaging. Vermont has utilized funding from other MHBG awards it has received to create educational videos for Vermont New American communities regarding mental health, specifically coping with stress and sadness, in collaboration with the Vermont Language Justice Project. This video has been translated into 15 different languages.

FFY 2024 Budget for Proposed Activities ($138,656)

Program Costs

Activity	Budgeted Costs
ESMI/FEP 10% Set Aside	$80,000
Crisis 5% Set Aside	$25,000
Training and Education	$30,000
Administrative	$3,656
TOTAL	**$138,656**

Direct Costs – ESMI/FEP

- The primary focus of this award will be to support the implementation of a CSC program in Vermont. DMH anticipates the need for significant stakeholder engagement during the planning phase of this project. In addition to the 10% Set Asides from other MHGB awards, DMH has allocated $80,000 toward work supporting the establishment of this program with a focus on emergency preparedness and disaster-related response for this program.

Direct Costs – Crisis

- The Crisis Set Aside of this proposal will be used to support the state's implementation of mobile crisis teams on the CSC program and its role in disaster-related situations to leverage any necessary resources on local, regional, and statewide levels. Additionally, the proposed allocation of $25,000 will be utilized to gather stakeholder input from mobile crisis teams on ways to best support individuals experiencing FEP/ESMI and their families during disasters.

- Direct Costs – Training
    - As previously noted, there is not a CSC program in Vermont, and it will take a significant amount of resources to establish and sustain a program to effectively meet the needs of individuals experiencing ESMI/FEP. DMH has allocated $30,000 towards training and education on the state's emergency preparedness plans and ways to access resources to support this population, in addition to Vermont adults with SMI and children with SED, to Vermont health care systems and providers, community mental health partners, education systems, and other social service organizations.

Indirect Costs

- The indirect costs outlined above ($3,656) fall within the allowable 5% margin for administrative expenses to support MHBG activities. This funding will be pulled into the DMH Cost Allocation Plan to support general operating expenses and a fraction of some salaries for staff involved in MHBG-related work.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Todd Daloz

Title

Deputy Secretary

Organization

Vermont Agency of Human Services

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

The Vermont Department of Mental Health (DMH) operates under the Vermont Agency of Human Services (AHS), the Single State Agency. DMH contracts with community mental health centers to provide mental health services to adults with serious mental illness (SMI) and children and adolescents experiencing a serious emotional disturbance (SED) and their families. The community mental health system has ten state-designated agencies (DAs) that serve Vermont's twelve Agency of Human Services catchment areas. Vermont also has two specialized services agencies (SSAs); one offering statewide intensive services for children and youth with SED and supports for their families; and another SSA serving adults with SMI who also require housing supports, using the Housing First model. Many agencies have more than one office to serve their respective catchment areas.

Each DA and SSA must go through a state re-designation process as outlined in Vermont's Administrative Rules on Agency Designation every four years. If appropriate, the Commissioner of Mental Health re-designates programs at each of Vermont's ten community mental health centers and its two SSAs as meeting state and federal laws, regulations, administrative rules, and quality standards for the provision of mental health services in Vermont. In addition to the Community Rehabilitation and Treatment (CRT) programs for adults with SMI and Children's Services for children and adolescents with SED, each DA also operates Emergency Services for any Vermonter experiencing a mental health crisis, and Adult Outpatient Program (AOP) to provide counseling for adults with mental health needs who are not eligible for CRT services.

Eight of the state's ten DAs offer outpatient substance use disorder services, in addition to mental health services. The DAs' substance use disorder services are monitored and regulated by the Vermont Department of Health (VDH), Division of Substance Use Programs (DSU). VDH also operates under the Single State Agency and works collaboratively with DMH to provide oversight and safeguards the coordination of care for individuals with co-occurring needs.

DMH Central Office staff provide oversight and direction for the community mental health system of care to assure adherence to state and federal regulations and monitor the quality of services and supports delivered by DAs. In August 2011, the closure of the Vermont State Hospital (VSH), the only public psychiatric hospital in the state, due to Tropical Storm Irene brought several changes to Vermont's inpatient system of care. On July 1, 2014, the 25-bed Vermont Psychiatric Care Hospital (VPCH) was opened as the successor to the former State Hospital. DMH also contracts with two designated hospitals (DHs) in other parts of the state to provide services to adults who would previously have gone to VSH for inpatient psychiatric care (i.e., "Level 1"). Three other DHs accept involuntary adult patients for inpatient care.

Adult Mental Health Services

In 2007, Act 15: An act relating to the restoration of a Department of Mental Health and a Commissioner of Mental Health, [1] was enacted that broadened DMH's mandate to require the

department to serve adults with SMI and "…provide a flexible comprehensive service to all citizens of the state in mental health and related problems." The statute assigned the Commissioner responsibilities to coordinate mental health services with other services, programs, and both public and private entities. Vermont's community-based mental health services were strengthened under Act 79, signed into law in April 2012, which "…moved to strengthen a well- respected community mental health system, bolstering supports and filling gaps to assist people living and receiving treatment in their communities." [2] Act 79 allowed the State to strengthen community options and supported more intensive services within the inpatient system of care. It focused on improving response to acute needs for mental health services, investing in crisis beds, Intensive Recovery Residences, and improved emergency response including community outreach and coordination with police and other community emergency response agencies.

Community Rehabilitation and Treatment

The Community Rehabilitation and Treatment (CRT) program provides comprehensive services, using a multi-disciplinary treatment team approach, for adults with SMI. CRT offers a wide range of support options to help people remain integrated in their local communities in social, housing, school, and work settings based on their preferences while building strategies to live more interdependent and satisfying lives.

Adults who are eligible for Community Rehabilitation and Treatment (CRT) are defined as Individuals 18 or over, diagnosed with schizophrenia, other psychotic disorders and seriously debilitating mood disorders who meet each of the following three criteria:

1. A primary DSM-V diagnosis of at least one of the following:

- Schizophrenia
- Schizophreniform Disorder
- Schizoaffective Disorder
- Delusional Disorder
- Unspecified Schizophrenia Spectrum and other psychotic disorders
- Major Depressive Disorder
- Bipolar I Disorder
- Bipolar II Disorder, and other specified bipolar and related disorders
- Panic Disorder
- Agoraphobia
- Obsessive-Compulsive Disorder, including hoarding disorder, other specified obsessive-compulsive and related disorders, and unspecified obsessive-compulsive and related disorders.
- Borderline Personality Disorder.

2. Treatment History, including at least one of the following:

- Continuous inpatient psychiatric treatment with a duration of at least sixty days
- Three or more episodes of inpatient psychiatric treatment and/or a community-based crisis bed program during the last twelve months
- Six months of continuous residence or three or more episodes of residence in one or more of the following during the last twelve months:
    - Residential Program
    - Community Care Home
    - Living situation with paid-person providing primary supervision and care
- Participation in a mental health program or treatment modality with no evidence of improvement
- The individual is on a court Order of Non-Hospitalization.

3. Functional Impairment in social, occupational or self-care skills as a result of the DSM-V diagnosis, including demonstrated evidence of two of the following during the last twelve months, with a duration of at least six months:

- Receives public financial assistance because of a mental illness
- Displays maladaptive, dangerous, and impulsive behaviors
- Lacks supportive social systems in the community
- Requires assistance in basic life and survival skills.

Community-based CRT programs around the state served 2,228 adults in state fiscal year 2022.

Adult Outpatient Programs

Adult Outpatient Programs (AOP) serve adults experiencing mental health needs significantly enough to disrupt their lives. AOPs offer a range of mental health services that vary somewhat from agency to agency. The AOPs in community mental health system served 7,164 adults in state fiscal year 2022.

Emergency Services

Emergency Services (ES) are for anyone, irrespective of age, experiencing a mental health crisis and are available 24 hours a day, seven days a week, in Vermont's ten catchment areas. ES programs serve individuals in crisis and communities or the staff of organizations who have experienced a traumatic event. These programs have been greatly enhanced since 2011's Tropical Storm Irene and the Covid-19 pandemic with mobile crisis outreach in all catchment areas when staffing capacity allows. There are a total of 58 crisis beds (Children/youth: 18; Adults: 38; Peer service-operated for adults: 2) throughout the state covering all catchment areas, with a daily average cost 50-75% lower than hospitalization. ES programs served 10,648 individuals in state fiscal year 2022.

Inpatient Hospitalization for Adults

In addition to the state-operated VPCH, Vermont contracts with two designated hospitals to provide inpatient intensive psychiatric care to adults who experience higher acuity, greater complexity of illness, dangerousness to self or others, or more refractory illness. The patients needing "Level 1" services generally require significantly more staff time and hospital resources to meet their unique clinical needs. These two DHs that serve "Level 1" patients are the Brattleboro Retreat, in Brattleboro, and Rutland Regional Medical Center, in Rutland. Four other DHs have units for involuntary psychiatric inpatient treatment other than "Level 1": Central Vermont Medical Center, in Berlin; University of Vermont Medical Center, in Burlington; Veterans Affairs Hospital, in White River Junction; Windham Center at Springfield Hospital, in Bellows Falls. All DHs, except VPCH, have units that treat voluntary psychiatric inpatients as well.

Child, Adolescent, and Family Services

Together, DMH and the DAs are dedicated to improving the core capacity services offered throughout Vermont, achieving outcomes that improve the quality of life for consumers and families, and broadening our approach to include public health model strategies around prevention. A team of professionals, paraprofessionals, and community volunteers provides or arranges mental health services for clients, with the intensity and duration determined by each individual's and family's needs. Vermont's DAs served 10,742 clients assigned to Children's Services in state fiscal year 2022.

Each DA is required to provide comprehensive mental health services in their catchment area of the state. Core community-based services and supports for children, adolescents, and their families include:

- Immediate Response: Direct consultation and clinical evaluation of individuals who are experiencing a psychological, behavioral, or emotional crisis and/or short-term intervention for children and adolescents who are experiencing a mental health crisis. These services are intensive and time-limited.
- Outreach and Clinic-Based Treatment: These services employ best practices in clinical service delivery and are available in the DA, home, school, and general community settings. The intensity of the service is based on the clinical needs of the child and family and the family's request for specific services.
- Support Services: These services can be instrumental in reducing family stress and providing parents and caregivers with the guidance, support, and skills to nurture a child who has complex and/or intense needs. Each DA provides and/or has direct community connections to an array of support services for families and youth. These services are offered in partnership with parents and consumer advocates and are provided as the family needs and desires.
- Prevention, Screening, Referral, and Community Consultation: Each DA provides and/or has direct involvement in creating and/or maintaining community agreements that promote psychological health and resilience for families and youth.

- Primary prevention efforts focus on promoting healthy lifestyles and healthy communities for all youth and families.
- Secondary prevention efforts focus on reducing the effects of risk factors, minimizing trauma potential, and maximizing resiliency potential.
- Tertiary prevention (i.e., treatment) efforts focus on reducing any trauma that may be created by a difficult event or situation.

In addition to core-capacity services provided by DAs for each region in Vermont, there are three types of services available to the entire state that complete the continuum of care for children, adolescents, and families: intensive residential services, emergency/hospital diversion beds, and hospital inpatient services.

- Intensive residential services: Vermont has residential treatment programs that offer twenty-four hours a day, seven days a week staffing, medical/psychiatric backup services, and an in-house array of psychological assessment and treatment services.
- Emergency or hospital-diversion beds: Community-based programs that provide a high level of care and have the ability to divert youth from inpatient hospitalization.
- Inpatient Services: Brattleboro Retreat, in Southeastern Vermont, is the only inpatient facility that serves children and adolescents who are in need of inpatient psychiatric hospitalization.

Act 264

Act 264, [3] passed in 1988, requires human services and public education to work together, involve parents, and coordinate services for better outcomes for children with SED and their families. In 2005, an Interagency Agreement between the Vermont Agency of Education (AOE) and AHS expanded the target population to include children and adolescents with disabilities who are eligible for special education and disability-related services. This agreement required AHS and AOE to ensure coordination of all services provided to this population. The areas covered by this agreement include:

- coordination of services,
- agency financial responsibility,
- conditions and terms of reimbursement, and
- resolution of interagency disputes.

All students who meet eligibility requirements for special education and disability-related service delivery and coordination by AHS are entitled to coordination of services. AOE, the local education agencies (LEAs), and AHS work together to ensure that children and youth with disabilities, from ages 3 to 22, receive services for which they are eligible in a timely and coordinated manner.

Integrating Family Services

Integrating Family Services (IFS) [4] seeks to bring state government and local communities together to ensure holistic and accountable planning, support, and service delivery to meet the needs of Vermont's children, youth, and families. The project seeks to demonstrate that providing early support, education, and intervention to children, youth, and families will produce more favorable health outcomes at a lower cost. The current practice of 'waiting until circumstances are bad enough' to access funding often results in treatment programs that are out of home or out of state. Several efforts are underway, including performance-based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services. Integration is an ongoing process that is evolving in a very positive direction for children and families.

The IFS project chose Addison County as the first pilot site and began implementation on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots consolidated over 30 state and federal fee-for-service funding streams delivered as a single per-member-per-month payment under an annual aggregated spending cap for all IFS providers. This has created a more seamless system of care to ensure greater access to care, including early intervention and outreach, and no duplication of services for children and families.

Services Provided by Local School Systems

Success Beyond Six (SB6) [5] is a flexible program model for providing mental health services in schools via the following core services: assessment; individual, group, and family therapy; case management (service planning and coordination); team consultation; and specialized rehabilitation services (including social support). SB6 has been shown to work well for children, adolescents, and families needing coordination between school and home, including those requiring intensive behavioral management both at school and at home. This program also increases access to care by addressing transportation barriers and is especially helpful for families in more rural areas with limited public transportation.

Participating schools and DAs establish a local contract for DA staff to serve as clinicians, social workers, home-school coordinators, clinical/behavioral consultants, or behavioral interventionists for children and adolescents with emotional or behavioral needs. These mental health staff work in partnership with the schools to provide students and their families with an array of mental health and other home- and community-based services.

Vermont AOE promotes the implementation of Multi-Tiered Systems of Support (MTSS), including Positive Behavioral Interventions and Supports (PBIS), and DMH shares AOE's commitment to this educational evidence-based practice to support students' social, emotional, and behavioral needs. As the number of schools implementing PBIS continues to grow and the numbers of school-based strategies and supports increase for all students and staff, DMH continues to refine the use of resources and the focus of current SB6 programs. For example, DMH and AOE are jointly working with pilot sites to implement the Interconnected Systems

Framework. This framework fuses mental health and social-emotional learning within an MTSS, thereby strengthening the schools' and DAs' capacity to provide earlier interventions and support more students.

Vermont Demographics

According to 2021 American Community Survey 1-year estimate data profiles, Vermont has an estimated population of 645,570 [6] with 20.6% of residents aged 65 years or older compared to the United States percentage of 16.8% for this same age range. Additionally, Vermont is less racially diverse with 91.1% of residents identifying as White compared to the United States with 61.2%. According to the United States Census, the 2021 Vermont median household income was $67,674 compared to the United States median income of $70,784, and the Vermont's overall poverty rate was 10.3% compared to the national poverty rate of 12.8%. Although, the poverty rate of Vermont's children (under age 18) was 16.9% in 2021 and the poverty rate for Vermonters ages 65 years and older was 10.3%. [7]

Demographics	Vermont	National
% Female	50.4%	50.5%
% Age 65 or older	20.6%	16.8%
% Younger than Age 18	18.1%	22.1%
Median age	42.9	38.8
Median Household income	$67,674	$70,784
% Living in poverty	10.3%	12.8%
% Children (under 18) living in poverty	16.9%	17%
% Seniors (65 and older) living in poverty	10.3%	9%
% of Adults with High School graduate or higher	93.9%	89.4%
% of Adults with bachelor's degree or higher	40.9%	35.0%
% White	91.1%	61.2%
% Black	1.1%	12.1%
% Asian	1.8%	5.8%
% 2 or more races	5.1%	12.6%
% Hispanic or Latino	2.0%	18.8%
% Persons with language other than English spoken at home	5.8%	21.6%
% Foreign Born	4.7%	13.7%
% Population with veteran status	6.9%	6.9%

Strengths of the Vermont Mental Health System of Care

Vermont Mental Health Services

Vermont's community mental health system provides mental health services and supports for all populations mandated by Public Law 99-660, passed on November 14, 1986. Those populations are:

- Adults with diagnoses of SMI;
- Children and adolescents experiencing SED and their families,
- Rural populations;
- Homeless populations;
- Elderly individuals with mental health needs

Strengths of Adult Mental Health Services

- Adults with Diagnoses of SMI: CRT programs serve adults diagnosed with SMI, based on assessments of individual needs, through the following core services:
    - Service Planning and Coordination: assistance to individuals and their families in planning, developing, choosing, gaining access to, coordinating, and monitoring the needed services and supports, which include discharge planning, monitoring the well- being of individuals (and their families), and supporting them to make and assess their own decisions.
    - Individual Community Supports: Specific, individualized, and goal-oriented services that assist individuals (and families) to develop skills and foster social supports necessary to promote positive growth. These services may include assistance in daily living, supportive counseling, support to participate in community activities, collateral contacts, and building and sustaining healthy personal, family, and community relationships.
    - Group Community Supports: Provided in a group (four maximum) in a community environment (as opposed to a clinical facility).
    - Employment Services: Employment assessment, employer and job development, job training/education supports, and ongoing support to maintain employment.
    - Clinical Interventions: Clinical assessment and individual, family, and group therapy.
    - Medication and Medical Support and Consultation: Evaluation of the need for prescriptions, monitoring of medication, and providing medical observation, support, and consultation for an individual's health care.
    - Crisis Services: Time-limited, intensive supports provided for individuals and families in a mental health crisis, twenty-four hours a day, seven days a week. Services include emergency/crisis assessment, support and referral, and emergency/crisis beds.
    - Housing and Home Supports: For individuals in and around their residences up to twenty-four hours a day that includes supervised/assisted living, group treatment/living, unlicensed home providers, and foster families.
    - Transportation: Limited transportation necessary for individuals covered by Medicaid to and from an agency facility to receive Medicaid-reimbursable services.

- Peer Support Services: Group recovery-oriented activities in a facility milieu to promote wellness, empowerment, and a sense of community, personal responsibility, self- esteem, and hope. These activities are client-centered. This service provides socialization, skills development, and crisis support; it also promotes self-advocacy.

In addition to these core services, the following evidence-based practices are generally available in Vermont for adults and clients who meet CRT-eligibility criteria:

- Housing First for individuals with significant mental illness experiencing homelessness
- Evidence-Based Supported Employment, Individual Placement and Support
- Pharmacological Treatment
- Family Psychoeducation and Support
- Recovery Education including Wellness Recovery Action Plan (WRAP) and peer support services using Intentional Peer Support
- Dialectical Behavioral Therapy
- Integrated Mental Health and Substance Abuse Treatment
- Recovery-Oriented Cognitive Therapy
- Collaborative Network Approach (Open Dialogue)
- Shared Decision Making
- Six Core Strategies for the Reduction of Seclusion and Restraint (in inpatient psychiatric units at Designated Hospitals)
- Collaborative Documentation

Adults with SMI Living in Rural Areas

Vermont is one of the most rural states in New England. It has one Metropolitan Statistical Area (MSA) anchored by Burlington and South Burlington in Chittenden County and including Franklin and Grand Isle counties in Northwestern Vermont along the shores of Lake Champlain. The estimated population of the Burlington-South Burlington MSA in 2021 was 226,715. [8]

Mental health services provided in Vermont reach sparsely-populated, remote areas around the state to meet clients where they are. The majority of Vermont Designated Agencies have more than one office in their catchment area and historically transportation for covered services is one of the core services that a DA provides.

Outreach-oriented case management and mobile emergency services enhance mental health services in all areas of the state. Agency staff may be mobile, so that services can be provided in community settings based on clients' needs. Vermont's mental health system is committed to remaining accessible to citizens regardless of whether they live in rural or urban settings.

Homeless Adults with SMI

DMH supports efforts to end chronic homelessness and to ensure that all episodes of homelessness for individuals with SMI are as brief as possible. These efforts include:

- A full-time position Housing Program Administrator for the Adult Mental Health Services Unit;
- Administration of the state-funded CRT Housing Support fund through DAs that includes subsidies and housing assistance;
- Administration of the state-funded Housing Subsidy and Care program for homeless persons who are in the hospital and awaiting discharge without housing or prospects of a federal subsidy: subsidies and housing assistance;
- Monthly participation in Housing and Urban Development (HUD) Continuums of Care to assure preservation of the federal Shelter-Plus-Care subsidy;
- Data collection and outcome reporting to the Vermont General Assembly and SAMHSA on the Projects for Assistance in Transition from Homelessness (PATH) and other programs;
- Participation on the Governor's Homeless Council;
- Support of community collaborative projects with DMH-funded partners for uniform and consistent evidenced-based approaches;
- Sustained state-funded support for the SAMHSA Grants for the Benefit of Homeless Individuals (GBHI)-/Cooperative Agreements to Benefit Homeless Individuals (CABHI)-funded demonstration of the rural Housing First approach for the most-at-risk adults with SMI.

Older Adults with Mental Health Needs

Vermont's Elder Care Clinician Program (Elder Care) supports older adults (ages 60 years and older) who experience mental health needs such as depression, anxiety, and/or substance use disorder. This program is intended to serve this population whose mental health challenges interfere with their daily lives. The program is a joint initiative of DMH and the Vermont Department of Disabilities, Aging, and Independent Living (DAIL)'s State Unit on Aging. This initiative targets older Vermonters who are homebound and not otherwise able to access services at Designated Agencies.

Elder Care clinicians include social workers, mental health clinicians, and mental health outreach workers, as well as psychiatrists or advanced practice providers who may be part of the treatment team for consultation. Clinicians collaborate with clients to develop a treatment plan and provide services in their homes or other community settings based on preference. Elder Care staff are located either at DAs or one of Vermont's Area Agencies on Aging. These services can vary in frequency and duration based on individual needs and may include:

- Community mental health outreach
- Mental health and substance use screening and clinical assessment
- Clinical treatment, including supportive counseling

In state fiscal year 2022, 242 clients were served with 3,833 services provided that included individual/family therapy, treatment planning and coordination, and community support.

Act 79 and Act 140

Signed into law in 2012, Act 79 [2] provides a statutory framework for a system of care offering strong community support for people with mental health needs in the most integrated and least restrictive settings available. Additionally, Act 140: An act relating to miscellaneous health care provisions, [9] signed into law in 2020, called for the creation of the "Mental Health Integration Council", whose "…purpose of helping to ensure that all sectors of the health care system actively participate in the State's principles for mental health integration established pursuant to 18 V.S.A. § 7251(4) and (8) and as envisioned in the Department of Mental Health's 2020 report "Vision 2030: A 10-Year Plan for an Integrated and Holistic System of Care." This council has completed a draft report that provides recommends to meet this charge, in order to address integration on a systems level that includes addressing issues such as the lack of focus on the promotion of mental health and prevention of mental health conditions as well as provision of holistic, integrated care. [10]

Expanded and Enhanced Peer-Support Programs

Vermont's peer-support programs expanded under Act 79 to include a statewide (24/7 availability only occurred after the COVID-19 pandemic) support line, outreach services, community support, peer-run employment services, and recovery coaching. Peer support services are also available within some DAs, including supports to patients awaiting psychiatric hospitalization in emergency departments and to individuals seen by the DA's Crisis Services team.

Peer-Run Crisis Respite

Alyssum, a peer-operated, peer-staffed crisis alternative located in Rochester, Vermont, opened in the fall of 2011. Alyssum has two beds for adults experiencing a mental health crisis, who may stay for up to two weeks, based on individual need and acuity. Alyssum's mission is to provide a "holistic approach to mental wellness, discovery and recovery for Vermonters who are experiencing a mental health crisis" in a "safe, mutually supportive, non- judgmental, educational, and self-empowering environment."

Residential Recovery for Individuals Seeking to Reduce or Avoid Medical Interventions

Soteria House is a Therapeutic Community Residence for the prevention of hospitalization for individuals experiencing an acute mental health-related issue. This program focuses on providing person-centered adaptive care and treats any pharmaceutical interventions as a personal choice.

Enhanced Collaboration Between Crisis Services and Law Enforcement

Under provisions enacted in Act 79, Vermont's community mental health system began working towards reducing law-enforcement interventions for people in mental health crises through mobile crisis outreach. Peers have also joined some of these teams and/or perform outreach through DMH grant initiatives, providing support in homes and in emergency departments.

"Team Two" training, a statewide interdisciplinary training program for police and mobile crisis responders, began in 2012. All ten of Vermont's mental health catchment areas now have embedded clinicians with Vermont State Police, who assist with mental health- and substance use-related 9-1-1 calls. In addition, DMH has funded other initiatives that embed clinicians with local law enforcement, as well as street outreach initiatives in the Burlington and Barre-Montpelier areas.

Housing for Adults with SMI

Housing options available in Vermont remain expanded for individuals who are homeless and most vulnerable upon discharge from hospitalization. Supported options continue to be transitional housing beds, on models funded both by the federal Department of Housing and Urban Development (HUD) and by the State of Vermont. Since HUD withdrew its support of this model, DMH responded to this action by creating a system-of-care program initiative for state rental assistance for adults who experience SMI, are homeless, and either in the hospital or an acute-care bed.

Supportive housing units continue to assist people in individual apartments with on-site supports. The wraparound supportive services programs continue to serve individual clients with high needs for mental health services, with a focus on return on investment and individual recovery. These wraparound and supportive housing programs target high utilizers of psychiatric inpatient hospitalization, and they maintain a high success rate of assisting individuals to maintain stability within a community setting.

Vermont continues to maintain its housing efforts and has developed a wide selection of other types of housing units and assistance already available for CRT clients, for example:

- CRT Housing Support Funds (for assistance with rentals and other expenses connected with occupancy);
- Subsidized independent living (statewide)
- Transitional housing (five)
- Shelter Plus Care homeless assistance (with more than 120 subsidies)
- Safe Havens (two)
- Private-sector residential care providers
- Health and Human Services/Projects to Assist in the Transition from Homelessness (HHS/PATH)
- McKinney-Vento Homeless Projects, and accompanying HUD-required Homeless Management Information System (HMIS) currently used by PATH grantees

- Finally, the Housing First—Assertive Community Treatment (ACT) model initially funded by the CABHI grant from SAMHSA in 2009 has been granted designation as an SSA in Vermont and is now funded by Medicaid and state funds.

Increased Crisis Beds

The number of adult crisis beds in Vermont has grown over the previous years from 27 to 38. They are now found in all ten DA catchment areas in the state. They are an excellent resource for hospital step-down or diversion from emergency departments at a daily average of 50-75% lower cost than hospitals.

Decentralized Inpatient Hospitalization for People Who Are Most Acutely Ill

Designed and built as the successor to the Vermont State Hospital, the state-operated Vermont Psychiatric Care Hospital opened July 2, 2014, with a capacity of 25 beds. Two DHs, the Brattleboro Retreat, in Southeastern Vermont, and Rutland Regional Medical Center, in South Central Vermont, have contracts with DMH to treat the most acute patients, now called Level I patients.

Reduced Use of Restraints in Adult Involuntary Transport

Beginning in April 2012, DMH has implemented a plan for changing how individuals are transported to inpatient hospitalization with the goal of reducing metal restraints and providing options for transport whenever possible. This plan responds to Act 180 regarding transportation of people who are found to need involuntary psychiatric hospitalization. [11] It is directly connected to reduction in trauma for the patient in transport. DMH's approach to this initiative has proven to be effective, there has continued to be a downward trend in use of restraints since these data began being collected.

DMH Care Management

The DMH Care Management Team works with community partners to facilitate the placement of clients to the appropriate levels of care, which includes admissions and discharges to hospitals, Intensive Recovery Residences, transitional housing programs, and supportive housing units. In addition to triaging admissions and discharges, Care Management provides support to DAs with oversight for people on an Order of Non-Hospitalization (ONH). The Care Management team also supports community re-entry efforts for inmates with significant functional impairments due to mental illness. Acting as a managed-care organization in partnership with the State Medicaid Office, Department of Vermont Health Access (DVHA), part of the Care Management team performs utilization reviews for Medicaid-enrolled clients.

DMH Quality Unit

The DMH Quality Unit continues to utilize quality assurance, quality improvement, and performance improvement methodologies to ensure the highest standards of care for

Vermonters. This team works with the Department's directors and managers to designate both community mental health centers and hospitals, review critical incidents, and oversee adherence to the requirements of managed care entities for special populations. This team also works with sister departments within the AHS to implement interagency quality standards, compliance, and improvement.

Ongoing Stakeholder Involvement

DMH provides monthly updates and a discussion forum for a wide variety of issues and developments through the State Program Standing Committees for Adult Mental Health and for the Child, Adolescent and Family Unit, as well as the Act 264 Advisory Board. Additionally, the State's Mental Health Block Grant Planning Council offers the opportunity to hear from a multitude of stakeholders, both within and outside of state government, that ensures consistent involvement on the Vermont system of care and its impacts on adults with SMI and children with SED, including their families. Also, each DA has its own Local Program Standing Committee (LPSC), per requirement of the state's Administrative Rules on Agency Designation. Finally, DMH has an Emergency Involuntary Procedures Review Committee, which meets quarterly and is comprised of a large cadre of stakeholders.

Peer-Run Services for Young Adults

Another Way is a peer-operated drop-in community center in Montpelier that offers individual support and crisis intervention as well as a host of groups and classes focused holistic wellness. The program serves people with both mental health and addictions issues. Resources include shower facilities and free community meals.

Pathways Vermont Community Center provides peer support to adults who are seeking community, support, and connection around mental health experiences, including those who have experienced trauma and/or are experiencing mental health or addiction challenges. Programming includes individual and group peer-to-peer support and support groups as well as regular activities and educational workshops around creative arts, music, food and nutrition, and financial literacy. Additionally, this center offers support in finding and maintaining employment.

Vermont Cooperative for Practice Improvement and Innovation

Founded in 2013, the Vermont Cooperative for Practice Improvement and Innovation (VCPI) is a non-profit cooperative supported operationally within Vermont State University. It is a statewide, membership-based partnership promoting innovation, practice improvement, implementation, and workforce development to enhance the outcomes of individuals and families experiencing mental health and substance use disorder conditions. DMH has previously contracted for several projects with VCPI, including implementation of:

- Six Core Strategies© to Reduce Seclusion and Restraint: Quality and practice improvement initiative aimed at reducing emergency involuntary procedures (EIP) in Vermont hospitals, specifically the three hospitals licensed as Level 1 facilities.
- Collaborative Network Approach (Open Dialogue): Programs are focused on clinical training, model implementation, evaluation of outcomes, and recommendations on future implementation in Vermont.
- Dialectical Behavioral Therapy (DBT): An eight-day intensive DBT training for participants from the state's DAs, an introductory training on DBT, and an ongoing Learning Community facilitated by content experts that is focused on expanding DBT training, dissemination of content, and implementation of the practice statewide for both children and adults.

Supported Employment

The evidence-based practice of Individual Placement and Support Supported Employment is the longest-established practice in Vermont. Employment continues to be an essential part of recovery and a personal goal for many individuals living with a mental illness. Historically, all ten DAs participated in IPS practice fidelity assessments to determine areas of success and areas of needed improvement.

Vermont Psychiatric Survivors

Vermont Psychiatric Survivors (VPS) is an independent, survivor-run statewide organization founded in 1983 to provide information, education, and technical assistance regarding issues of mental health. The organization's primary purpose is to ensure that those who have experienced serious mental illness and its challenges have an effective voice in advancing the issues that are important to the well-being of those individuals.

Both Community Mental Health Services Block Grant funding and State general funds, in addition to federal grant funding, helps support VPS's annual budget.

Vermont Medicaid & Mental Health

Vermont's Global Commitment to Health Demonstration, which is the Section 1115(a) waiver, has been the principal vehicle for major health care reform and transformation initiatives via Vermont's Medicaid program, including those at DMH. Through the authority of this waiver, DMH has implemented three different alternative payment models, including value-based payments, approved by the Centers for Medicare and Medicaid Services: Integrating Family Services (IFS) model, Northeastern Family Institute (SSA that primarily serves children with SED), and the Vermont Mental Health Case Rate model. Each model has moved from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service) to monthly case rates, as well as a value-based payment component made through separate quality payments that assess performance on a select set of metrics.

The 1115 has also increased access to care for adults with SMI by creating a CRT Expansion Group. This authority allows adults with SMI, who have incomes above the Medicaid limits, to receive a robust set of community mental health services regardless of income.

Strengths of Children, Youth, and Family Mental Health Services

The DMH Child, Adolescent and Family Unit (CAFU) and partnerships with DAs continue to make improvements to core capacity services offered throughout Vermont, achieving outcomes that improve quality of life for consumers, and broadening our approach to include public health model strategies around prevention.

Vermont's DAs served 10,742 clients assigned to Children's Services in FY 2022, the most recent full fiscal year for which DMH has complete data.

Each DA provides specified core community mental health services to their catchment area in the state. Core community-based services and supports for children, adolescents and their families include:

- Immediate Response: Direct consultation and clinical evaluation of individuals experiencing a psychological, behavioral, or emotional crisis and/or short-term intervention for children and adolescents experiencing a mental health crisis. These services are intensive and time limited.
- Outreach and Clinic-Based Treatment: These services employ best practices in clinical service delivery and are available in the mental health center, home, school, and general community settings. The level of the services is based on the acuity of the child and family, and the family's request for specific services.
- Support Services: These services can be instrumental in reducing family stress and providing parents and caregivers with the guidance, support, and skills to nurture a child who has complex high-level needs. Each DA provides or refers out to community partners for support services for families and youth. These services are offered in partnership with parents and consumer advocates.
- Prevention, Screening, Referral and Community Consultation: Each DA provides and/or has direct involvement in creating and/or maintaining community agreements that promote psychological health and resilience for families and youth. Primary prevention efforts focus on promoting healthy lifestyles and healthy communities for all youth and families. Secondary prevention efforts focus on reducing the effects of risk factors, minimizing trauma, and maximizing resiliency potential.

In addition to core capacity services provided by DAs in each catchment area of Vermont, intensive residential services, hospital diversion programming, and hospital inpatient services are available throughout the state to children and adolescents with acute needs.

- Residential Treatment Programs that provide twenty-four hours a day, seven days a week staffing, medical/psychiatric services, psychological assessment, and treatment services.

- Hospital Diversion Programs are community-based programs that provide a very high level of care and divert youth from inpatient hospitalization.
- Brattleboro Retreat, in Southeastern Vermont, serves youth in need of inpatient psychiatric hospitalization.

1) Expanded mission to focus on mental health promotion and prevention for all Vermonters.
2) Ongoing input from children, adolescents, and families through:
    - Annual perception of care surveys;
    - State Program Standing Committee for Children, Adolescents, and Family Mental Health, which advises CAFU and must have a minimum of 51% individuals with lived experience or their family members ; and
    - Act 264 Advisory Board and State Interagency Team, which provides this state team with annual recommendations for the interagency system of care for children and adolescents in need of coordinated care.
    - Ad hoc community forums to gather input on current system topics (e.g., emergency department wait times)
3) Continuing focus on quality domains:
    i. <u>Access to Care</u>
        - Consistently, over 10,000 Vermont children and families have been annually served by the community system of care;
        - Clinical mental health services are available in most schools throughout the state's supervisory unions and school districts;
        - Continued work on integrated pediatric mental health and primary care with different models being tested including co-location of mental health clinicians at the primary care offices to provide timely access to mental health services and increased access to psychiatric consultation with primary care providers .
        - Pediatric-focused workgroup that is part of the state's Mental Health Integration Council that includes broad representation across the system. This workgroup is led by CAFU and is focused on improving integrated pediatric care.
        - To increase ease of access to care, DMH:
            - Created the Psychiatric Fellowship program with the Center for Children, Youth, and Families (a division of The University of Vermont Medical Center). It provides assessments for high-needs children in underserved areas as well as consultation to primary care and pediatric physicians who may be the best long-term support for such children and their families.
            - Contract with one child psychiatrist to provide psychiatric consultation to pediatric practices in the most rural and least resourced region of the state the state, especially for children with Medicaid-funded services.

- Early childhood mental health connections, technical assistance, and consultation are available to various childcare agencies (e.g., Parent-Child Centers and Head Start programs) in Vermont's communities.
- Under federal (HRSA) cooperative agreement, VDH and DMH collaborated on Screening, Treatment, Access for Mothers and Perinatal Partners (STAMPP) project to enhance provider capacity, evidence-based practices, and access to perinatal mood and anxiety disorder screening, treatment and supports across targeted regions of the state with goal to reach statewide by the end of the project in 2023.
- Under the Youth in Transition (YIT) system, there is increased outreach to young adults through teen centers, recovery centers, homeless youth programs, and through intercepting at critical intervention points within the juvenile and criminal justice systems.
- DMH received legislative approval for APRA funding for a one-year (SFY22) pilot in one region of the state for Mobile Response and Stabilization Services (MRSS). This pilot implemented a community-based MRSS program to help children, youth, and families in distress through offering a continuum of crisis care services within non-hospital settings. MRSS is an upstream crisis service that offers mobile, face-to-face response to a family-defined crisis to provide support and intervention in a location of the family's choosing (typically home or school) before the situation escalates to a higher level of care. Vermont also applied for the ARPA state planning grant opportunity to evaluate mobile crisis supports across the state and across the age span and needs (mental health, substance use and aging & developmental/intellectual disabilities).

ii. <u>Practice Patterns in Care</u>

- Vermont's community mental health agencies go through an agency review, minimum standards chart review, and re-designation process every four years to maintain status as a state designated agency or specialized service agency by the DMH Quality Team. Included in this four-year designation is that an agency must have a quality improvement plan that incorporates feedback from clients and families.

iii. <u>Results of Care</u>

- Children's mental health services directly benefit children and adolescents by helping them to thrive and to remain in their own family, school, and community.
- Until 2014, DMH successfully sustained a six-year SAMHSA grant of $9 million that focused on youth transitioning to adult life (ages sixteen through twenty-one inclusive). As a result, there was integration and implementation of a more robust system of care for youth transitioning to adult life. Despite the end of the federal grant, the State of Vermont has sustained three-quarters of the funding

for youth in transition community plans, which will continue the funding for nine out of twelve communities.
- Monitoring of DAs and SSA through annual contracts that includes specific performance measures.

iv. Administration
- DMH incorporates family voice:
  - Governor-appointed state advisory boards are required to have a majority of disclosed members who are people with lived experience and family members.
  - LPSCs of client and family representatives, and other key stakeholders, to advise agencies on programming. Each LPSC must have a minimum of 51% people with lived experience and family members to ensure family voice is heard and integrated.

References:

1. Vermont Act 15 (2008): http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/acts/ACT015.htm
2. Vermont Act 79 (2012): https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/ACT_79.pdf
3. Vermont Department of Mental Health, Act 264: https://mentalhealth.vermont.gov/document/act-264
4. Vermont Integrating Family Services: https://ifs.vermont.gov/
5. Vermont Department of Mental Health, Success Beyond Six: https://mentalhealth.vermont.gov/services/children-youth-and-family/services-and-supports-children-youth-and-family/school-aged-0
6. United States Census Bureau, American Community Survey, Demographic and Housing Estimates: https://data.census.gov/table?q=United+States&g=010XX00US_040XX00US50&tid=ACSDP1Y2021.DP05
7. Vermont Business Magazine. Vermont childhood poverty among lowest in US. Published: October 4, 2022. https://vermontbiz.com/news/2022/october/04/vermont-childhood-poverty-rate-among-lowest-us#:~:text=Vermont%27s%20overall%20poverty%20rate%20is,over%20poverty%20rate%20was%209.1%25.
8. Census Report. Burlington-South Burlington VT Metro Area: https://censusreporter.org/profiles/31000US15540-burlington-south-burlington-vt-metro-area/?ref=kirbykersels.com
9. Vermont Act 140 (2020): https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT140/ACT140%20As%20Enacted.pdf
10. Vermont Department of Mental Health. Interim Report to the Vermont Legislature: Mental Health Integration Council in Accordance with Act 140, Section 4. https://mentalhealth.vermont.gov/sites/mentalhealth/files/doc_library/DMH_MHIC_Report_042023.pdf
11. Vermont Act 180 (2006): http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT180.htm

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system

The Vermont Department of Mental Health (DMH), along with the Vermont Agency of Human Services (AHS), and system of care partners that includes Vermont's Designated Hospitals (DHs), Designated Agencies (DAs), Specialized Services Agencies (SSAs), and other human service providers, continues to navigate challenges faced by Vermonters with mental health needs. The past few years have provided novel challenges from the Covid-19 pandemic, specifically the toll that was taken on Vermonters seeking mental health care and mental health providers in both inpatient and community settings. This pandemic presents sustained challenges to Vermont's healthcare system including economic shifts, service delivery guidelines, and workforce capacity issues related to recruitment and retention, especially within the mental health system of care. Vermont mental health providers face challenges related to, providing the array of required services to meet the needs of Vermonters, ensuring sustainable finances based on limited staffing capacity and programming, and addressing their own self-care as healthcare providers. The Covid-19 pandemic continues to have a sustained impact on Vermont's mental health system of care, specifically the mental health and co-occurring issues experienced by Vermonters that include depression, stress, trauma, anxiety, isolation and loneliness, substance use, exacerbation of other physical health chronic conditions, and other signs and symptoms of underlying mental illness that had a disproportionate effect on adults with SMI and children with SED.

Vermont has observed an ongoing demand for the limited number of inpatient beds to serve individuals with acute mental health needs with an accompanying need for intensive residential recovery, secure residential, and crisis beds that supports the system of care. At all times, DMH works to assure that Vermonters are cared for in the least restrictive setting, that wait times for admissions continue to be actively monitored and managed, and that the continuum of services throughout the system are of the highest quality. Through various initiatives, DMH continues to partner with other state government departments, healthcare providers, and key community partners to develop a robust system of care for marginalized, historically underserved, and vulnerable populations in Vermont. This system is data-driven, equitable, assures value to the system of care in terms of quality and cost, and involves collaboration with the above mentioned entities to ensure successful outcomes.

Vermont's funding priorities are identified based on current system of care needs, input from stakeholders and alignment with Vision 2030.

The currently identified needs in our system of care include:

1) Workforce Challenges across DA/SSAs

- Vermont has not recovered from the workforce shortages that occurred as a result of the Covid-19 Pandemic. Systemwide, the staff vacancy rate was approximately 15% at DAs and SSAs for Calendar Year 2022 with many positions being eliminated at agencies.

2) Reducing children and adults waiting in Emergency Departments

- Implement mobile crisis programming and other support services across the crisis continuum of care.

3) Shortening wait times and reducing waitlists for mental health services at DAs and SSAs

- While wait times across the system of care have shown improvement over the past year, wait times grew for adult outpatient services from an average of 78.5 days in February 2022 to 85.3 days in January 2023

4) Increasing peer supports

- Expanding access to peer services in both community and inpatient settings to offer support, provide information, and advocate for individuals with mental health needs.
- Peer specialist credentialing system and overseeing implementation of a certification process.
- Increasing peer respite beds and community centers

5) Suicide Prevention

- Vermont continues to experience a higher suicide mortality rate than the national average at 20.3 deaths by suicide per 100,000 total population and lost losing on 142 Vermonters in 2021. [2]

As well, Vermont is leveraging ARPA funds as allocated through the legislative process to do the following:

- Make existing housing and community-based service facilities providing mental health services more accessible, safe, and compliant with the Americans with Disabilities Act or to expand capacity in community settings.
- Allocate funding to each of the 10 DAs to hire an additional case manager to provide case management services to Vermont residents who may not previously have been part of an agency's caseload but whose lives have been significantly disrupted by the COVID-19 pandemic and who are now urgently in need of these agencies' supports.

Funding has continued to be appropriated to help meet the mental health needs of Vermonters, as well as mental health providers. This includes funding for staff recruitment and retention, increase annual allocation to DAs and SSAs, psychiatric services at DHs and VPCH, travel nurses at DHs to stabilize the inpatient workforce, and continued training on trauma-informed care for mental health professionals responding to the increasing demand for mental health treatment.

Many of the other unmet needs in public mental health services are similar to past years because these issues tend to be long-term, requiring imaginative, complex solutions that often strain available resources. Nevertheless, these issues are worthy of continued attention and effort because they are fundamental to the values and goals that inform the public system of mental health services in its search to help all clients lead fulfilling lives in their communities.

1) For high utilizers of hospitals:

- There is a need for increased multi-bed supported housing and treatment programs. Among the individuals supported in this manner, hospitalization rates are significantly lower.

2) Integration of physical health, mental health, and substance use care: DMH, in collaboration with VDH and a multitude of state government and community partners, co-leads Vermont's "Mental Health Integration Council", which is charged with improving the coordination and integration of mental health, substance use disorder, and physical health services within all parts of the healthcare delivery system.

- Providing leadership within Vermont's healthcare reform efforts to ensure that mental health and substance use disorder care is accessible and integrated within the unified health system that is being developed (this includes current efforts to integrate community mental health and substance use disorder services into Vermont's unified health system).

3) Affordable housing: A perennial gap in Vermont's mental health service system. While the state has many innovative ways to facilitate getting and keeping affordable housing for clients, there is never enough to meet the need.
4) Suicide prevention planning: As described in other sections of the application, Vermont has continued with implementation of the Zero Suicide model to address our rising rate of suicide across various age groups and populations
5) Veterans who do not receive services through the Veterans Administration (VA). DMH has maintained an ongoing working relationship with the VA and the National Guard to improve access to mental health services for veterans and other armed forces members (e.g., National Guard members who have not been deployed and are not eligible for veterans' benefits). DMH is currently working on regional planning with the Veterans Administration, the Vermont National Guard, and the DA system to improve crisis response and acute-care services for service members and veterans (SMV).
6) Increased communication between/amongst hospitals, first responders, DAs/SSAs health programs, and care managers in support of SMV who require crisis intervention and treatment

- Assessment of the current state of acute-care services for SMV and identification of barriers to receiving appropriate care
- Development of clear next steps to identifying solutions for overcoming barriers to care.

7) Transportation: This is an ongoing need in all of Vermont's ten catchment areas. Lack of easy access to means of transport, public and/or private, simply goes along with being in a rural place. Vermont is not a very large state, neither is the population, and consequently there is not enough demand in a large enough market to encourage entrepreneurship in travel development except for very basic transportation needs. Creativity and informal improvisation can often fill the need when more sophisticated networks are lacking.

Needs of Adult Mental Health Services

Vermont's basic needs throughout the system for Adult Mental Health for Fiscal Years 2024-2025 remain fairly close to those stated in previous applications for Community Mental Health Services Block Grant funding, which include:

1) Reducing wait times in hospital emergency departments for inpatient psychiatric: Vermont continues to observe high numbers of people, both children and adults, awaiting inpatient hospitalization in emergency departments and long duration of wait times. Vermont has an "Alternatives to Emergency Departments" initiative, which is a comprehensive, multifaceted, blended-funding approach to improve timeliness to accessing and utilizing the appropriate levels of mental health care.
2) Improved interoperability of electronic health records at Vermont's DAs and other health care and human services providers:

- Vermont Care Partners, a collaboration of a 501(c)(3) non-profit organization and a 501(c)(6) non-profit trade association, is working with state government to connect to the state-run health information exchange, in order to improve care coordination and reporting.
- DMH continues to work with sister departments in AHS on a replacement to the current Medicaid Management Information System (MMIS) that will include all DMH's business needs within the framework.

3) Workforce development and training opportunities in the community system;
4) Expanded staff recruitment and retention activities;
5) Offering competitive salaries for the mental health workforce;
6) Increased reimbursement rates from both public and private insurers at levels that will support adequate services for clients of community mental health; and
7) Maintaining inpatient bed capacity for patients who require the highest level of care.

Many of Vermont's needs are persistent, complex, long-standing issues requiring resources beyond the capacity of state government or any single entity, which have been exacerbated by the Covid-19 pandemic. In addition to the needs outlined above, the passage of Act 82 by the Vermont General Assembly in 2018 provided several needs and critical gaps based on extensive testimony and data analysis from DMH, as well as Vermont hospitals and community providers. These findings included:

- As aforementioned, Vermont has experienced a dramatic increase in the number of individuals in mental health distress experiencing long waits in emergency departments for inpatient hospital beds.
    - Currently, hospitals average approximately 70% occupancy for adults, while crisis beds occupancy for adults is approximately 50% and approximately 55% for children and adolescents. Issues related to hospital discharge include limited staffing in community programs, insufficient community programs, and an shortage of housing.
- Individuals presenting in emergency departments reporting acute psychiatric distress often remain in that setting for many hours or days under the supervision of hospital

staff, peers, or crisis workers until a bed in a psychiatric inpatient unit becomes available. Many of these individuals do not have access to a psychiatric care provider, and the emergency department does not provide a therapeutic environment. Due to these conditions, some individuals experience trauma and worsening symptoms while waiting for an appropriate level of care.

- Hospitals are also strained by workforce shortages, as well as staff burnout that continues to contribute to rising turnover rates. Many hospitals have invested in therapeutic rooms for psychiatric emergencies and hired mental health technicians to work in emergency departments.
- Traumatic waits in emergency departments for children and adolescents in crisis are increasing, and there are limited resources for crisis support, hospital diversion, and inpatient care for children and adolescents in Vermont.
- There is a shortage of psychiatric care professionals, both nationally and statewide. Psychiatrists and psychiatric advanced practice providers in Vermont have previously testified that they are distressed by the length of time individuals with psychiatric conditions remain in emergency departments and the lack of health care parity between mental and physical health.
- Evidence regarding the impact of social determinants of health (SDOH) on individuals and families has continued to be apparent. Improving an individual's trajectory over the lifespan requires addressing the needs of children and adolescents in the context of their family and support networks. This means Vermont must work within a multi-generational framework. While these findings primarily focus on the highest acuity individuals within the adult system, it is important also to focus on children's and adolescents' mental health. When the SDOH are addressed, social determinants can improve an individual's mental and physical health and wellbeing; therefore housing, employment, food security, and natural support must be considered as part of this work as well.

Needs of Children, Youth, and Family Mental Health Services

1) As DMH continues to work with stakeholders on the integrate mental health and physical health, there is an increased focus on early intervention in underrepresented populations for children and families. Specific activities in this area include:

- Continue mental health consultation and education with teachers, early care and learning providers, and other direct service providers;
- Increased youth suicide prevention supports such as UMatter® and Zero Suicide;
- Increased support of implementation of PBIS in schools;
- Increased use of outcome data to track results and drive strategies;
- Stabilizing the workforce to ensure children and youth can receive services when needed to decrease higher levels of care including the use of emergency departments for children and youth in crisis.

2) Treatment gaps that include:

- Access to high-quality clinical supervision to ensure client- and family-centered treatment planning that is goal-oriented, use evidence-based practices, and identify treatment outcomes that are time-limited and achievable;
- Development and implementation of a strategic plan to positively impact agency workforce recruitment and retention;
- Documented use of standardized assessment tools (e.g., Achenbach System of Empirically Based Assessment [ASEBA], and Child and Adolescent Needs and Strengths [CANS] Assessment) and outcome measurement tools for all children and families served;
- Expansion of capacity for clinic-based treatment, especially:
  - Child psychiatric supervision for agency clinical staff and consultation with pediatricians, and
  - Services specifically to treat children, adolescents, and families with complex and intense trauma histories.
- Development, promotion, and implementation of integrated family health service approach to physical and mental health for children, adolescents, and their families.

3) System Development needs that include:

- Integration of mental health services across all healthcare sectors;
- Training for evidence-based practices focusing on trauma, suicide, depression
  - Trauma, Zero Suicide/UMatter®, Maternal Depression, and Attachment, Regulation, and Competency (ARC);
- Healthcare transitions for adolescents and young adults from pediatric models of care to adult models of care;
- Sustained funding with focus on meeting needs of children, adolescents, and families for stable housing, employment, post-secondary education, health care, and positive relationships with peers and families;
- Increased collaboration of CAFU within Vermont's early childhood mental health system of care, specifically assessment of needs and resources for this population;
- Addressing the permanency needs of children receiving treatment in out-of- home placements;
- Enhanced mental health staff training, services, and supports for children and adolescents who have been adopted;
- Increasing the capacity of hospital diversion/crisis bed programs to divert youth from inpatient hospitalization;
- Expanded community-based alternatives for children and adolescents who otherwise might require a residential level of care, including therapeutic foster care.

References:

1. Vermont Agency of Human Services. Preliminary Report on the Impact of Provider Rate Increases: In accordance with Section E.301.3 of Act 185 of 2022: An act relating to making appropriations for the support of government.https://legislature.vermont.gov/assets/Legislative-Reports/Assessing-Impact-of-FY23-Rates-4.17.23.pdf
2. Centers for Disease Control and Prevention. Suicide Mortality by State (2021). https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Community Rehabilitation and Treatment (CRT) Services for Adults with Serious Mental Illness

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Delivery of services to adults with serious mental illness enrolled in CRT programs statewide.

Strategies to attain the goal:

1. Continue to fund CRT programs at community mental health agencies.
2. Manage client loads within the resources allocated.
3. Monitor service utilization (both statewide and by individual community mental health center) for those services delivered to this population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with serious mental illness served in CRT programs..

Baseline Measurement: 2,769 clients served (FY12)

First-year target/outcome measurement: Target: maintain or increase/Outcome: 2,448 clients served (FY21)

Second-year target/outcome measurement: Target: maintain or increase/Outcome: 2,228 clients served (FY22)

Data Source:

Monthly Service Reports (MSR) submitted to the Vermont Department of Mental Health from the community mental health centers (Designated Agencies). Number of clients served each SFY are not typically available until late fall/early winter.

Description of Data:

MSR data consists of client and service level information, including types of services provided, duration, standard demographics, and clinical outcomes. Clients are categorized by last-reported program assignment during the fiscal year.

Data issues/caveats that affect outcome measures:

Data issues: The system structure used for MSR reporting is outdated and relies on monthly extracts from community mental health centers. The Vermont Department of Mental Health regularly conducts data quality checks and supports community mental health centers with troubleshooting related to submitting data on a monthly basis.

Caveats: Overall, Vermont has a significantly aging population and had not seen a population increase in approximately 20 years until the Covid-19 pandemic, which led to an increase in population of approximately 40,000 individuals. Since SFY 2012, the number of adults with SMI served by CRT programs has decreased from 2,952 in FY12 to 2,228 in FY22.

Indicator #: 2

Indicator: Number of older adults (age 60 years and older) served by Elder Care Clinician Programs or CRT Programs

Baseline Measurement: 1,052 clients served (FY12)

First-year target/outcome measurement: Target: maintain/Outcome: 1,042 clients served (FY21)

Second-year target/outcome measurement: Target: maintain/Outcome: 1,028 clients served (FY22)

Data Source:

Monthly Service Reports (MSR) submitted to the Vermont Department of Mental Health from the community mental health centers (Designated Agencies). Number of clients served each SFY are not typically available until late fall/early winter.

Description of Data:

MSR data consists of client and service level information, including types of services provided, duration, standard demographics, and clinical outcomes. Clients are categorized by last-reported program assignment during the fiscal year.

Data issues/caveats that affect outcome measures:

Data issues: The system structure used for MSR reporting is outdated and relies on monthly extracts from community mental health centers. The Vermont Department of Mental Health regularly conducts data quality checks and supports community mental health centers with troubleshooting related to submitting data on a monthly basis.

Priority #: 2

Priority Area: Community based mental health services for children and youth experiencing or at risk of experiencing a serious emotional disturbance and their families.

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Delivery of services to priority population of children, youth, and their families.

Strategies to attain the goal:

1. Continue to fund children, youth, and family service programs at community mental health agencies.
2. Manage client loads within the resources allocated.
3. Monitor service utilization (both statewide and by individual community mental health center) for those services delivered to this population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of clients and families served in Children, Youth, and Family Services programs

Baseline Measurement: 9,783 clients served (FY12)

First-year target/outcome measurement: Target: maintain/Outcome: 10,517 clients served (FY21)

Second-year target/outcome measurement: Target: maintain/Outcome: 10,742 clients served (FY22)

Data Source:

Monthly Service Reports (MSR) submitted to the Department of Mental Health from Vermont's Designated Agencies. Numbers of clients served each SFY are not typically available until late fall/early winter.

Description of Data:

MSR data consists of client- and service-level information, including types of services provided, duration, standard demographics, and clinical outcomes. Clients are categorized by last-reported program assignment during the fiscal year.

Data issues/caveats that affect outcome measures:

Priority #: 3

Priority Area: Identify the number of Vermonters experiencing early serious mental illness, including first episode psychosis

Priority Type: ESMI

Population(s): SMI, SED, ESMI

Goal of the priority area:

Vermont has not historically reported on the number of individuals (incidence and prevalence) who experience early serious mental illness, including first episode psychosis

Strategies to attain the goal:

Conduct retrospective analysis of the identified data sources, in order to attain objective

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Vermonters who experience early serious mental illness, including first episode psychosis

Baseline Measurement: Baseline measurement year (FY24)

First-year target/outcome measurement: Not applicable

Second-year target/outcome measurement: Not applicable

Data Source:

Monthly Service Reports (MSR) submitted to the Vermont Department of Mental Health from the community mental health centers (Designated Agencies). Number of clients served each SFY are not typically available until late fall/early winter.

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 4

Priority Area: Emergency Services for Children, Youth, Adults, and Families

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Delivery of emergency services to all Vermonters statewide.

Strategies to attain the goal:

1. Continue to fund CRT programs at community mental health agencies.
2. Manage client loads within the resources allocated.
3. Monitor service utilization (both statewide and by individual community mental health center) for those services delivered to this population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of clients and families served by Emergency Services programs

Baseline Measurement: 5,873 clients served (FY12)

First-year target/outcome measurement: Target: maintain or increase/Outcome: 9,425 clients served (FY21)

Second-year target/outcome measurement: Target: maintain or increase/Outcome: 10,648 clients served (FY22)

Data Source:

Monthly Service Reports (MSR) submitted to the Vermont Department of Mental Health from the community mental health centers (Designated Agencies). Number of clients served each SFY are not typically available until late fall/early winter.

Description of Data:

MSR data consists of client and service level information, including types of services provided, duration, standard demographics, and

clinical outcomes. Clients are categorized by last-reported program assignment during the fiscal year.

Data issues/caveats that affect outcome measures:

Data issues: The system structure used for MSR reporting is outdated and relies on monthly extracts from community mental health centers. The Vermont Department of Mental Health regularly conducts data quality checks and supports community mental health centers with troubleshooting related to submitting data on a monthly basis.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023   Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$120,000.00						$32,961.00			$30,000.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$334,474.00						$117,934.00		$244,555.00	$80,000.00
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$34,990,534.00	$3,180,032.00	$24,395,510.00		$159,366.00				
8. Other 24-Hour Care		$260,000.00	$97,977,141.00		$12,592.00		$63,234.00	$40,000.00			
9. Ambulatory/Community Non-24 Hour Care		$1,552,372.00	$418,881,055.00	$8,710,298.00	$17,716,792.00			$170,141.00		$1,348,050.00	
10. Crisis Services (5 percent set-aside)[f]		$977,876.00						$110,755.00			$25,000.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$100,000.00	$7,199,668.00	$9,970,358.00	$8,482,170.00			$49,440.00		$72,137.00	$3,656.00
12. Total	**$0.00**	**$3,344,722.00**	**$559,048,398.00**	**$21,860,688.00**	**$50,607,064.00**	**$0.00**	**$222,600.00**	**$521,231.00**	**$0.00**	**$1,664,742.00**	**$138,656.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
-COVID-19 Supplemental Total Amount Received: $1,415,844
-ARP Supplemental Total Amount Received: $2,445,549
-BSCA Supplemental Total Amount Received: $138,656

Planning Tables

Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total	**$**	**$**	**$**	**$**

[1] The 24-month expenditure period for the COVID-19 Rel ... 21 - **March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins ... res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo ... oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1] Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

In 2020, Vermont's State Assembly created the Mental Health Integration Council (MHIC) to address integration of care on a system -wide level (Act 140, which updated 18 V.S.A. §9375). The legislation required the MHIC to address issues including the promotion of mental health and prevention of mental health conditions as well as provision of holistic, integrated care in a seamless manner for Vermonters. This Council met from July 2021 to September 2023, and facilitated problem-solving discussion among leaders from all areas of healthcare. A primary focus for the Council was to address upstream efforts, including an emphasis on providing stigma-free, equitable care for those with serious mental illness. Overall, an integrated system of care will reduce care coordination challenges across all sectors of health care, advance the standard of care for patients and their families, and improve the overall well-being and health of Vermonters. This Council has four associated workgroups that have made the following recommendations to achieve this work:

1. Integration of Primary Care Workgroup: Pursue implementation of a mental health peer or community health worker in a primary care practice as a single point of entry that is person-centered, equity-based, and wellness-focused and provided in accordance with Vermont's laws regarding parity.
2. Integration of Pediatric Care Workgroup: Incentivize with resources (financial and implementation assistance) the integration of mental health within primary care serving child, youth, and family through pediatric-specific applications of the locally selected integrated care model(s) to ensure wellness, rather than focusing on responding to problems and increase integration of healthcare in Coordinated Services Planning for children and youth with disabilities.
3. Integration of Funding & Alignment of Performance Measures Workgroup: Conduct a formal needs assessment to assess the parity of covered services by Vermont's health insurance payers, and the use of performance measures across health care providers and organizations, state government entities, and health insurance payers and pilot selected integration care models using rigorous improvement science methodology in order to study the effect on health care delivery funding and any improvement on established performance measures.
4. Integration of Workforce Development Workgroup: Align with the work of the Health Equity Advisory Commission, identify opportunities for shared or leveraged staffing through contracting with Federally Qualified Healthcare Centers (FQHCs), Designated Mental Health Agencies (DAs) and exploring the potential for Certified Community Behavioral Health Clinics (CCBHCs), explore how care may be "best served" at a Designated Mental Health Agency (or a CCBHC) or an FQHC, and develop guiding principles for Workforce Development

The MHIC's members have agreed to continue work on implementation of the above recommendations, as well as to address additional challenges faced by Vermonters in seeking mental health, substance use disorder, and co-occurring disorders treatment.

Additionally, the Vermont Department of Health Division of Substance Use Programs, Department of Vermont Health Access (Vermont State Medicaid Office), and DMH continue to partner to develop, promote, and support policy and evidence-based practices that directly contribute to the integration of mental health and primary health care including services for individuals with co-occurring mental and substance use disorders, and provides for the inclusion of primary, specialty care and community- based settings. This includes CMS-approved alternative payment models that offer mental health, SUD, and co-occurring disorder treatment providers flexibility in providing services in a more streamlined manner through prospective, capitated payment structures.

Finally, the three above-mentioned sister departments have established inclusionary governance, leadership, and decision-making structure with shared goals, priorities and values. The outputs from this partnership are grounded in the Vermont Model of Care as the foundation for care delivery transformation. This model includes key elements that directly contribute to integration: person-centered services and supports which addresses the whole person; actively involved primary care provider to advance access, holistic care and evidence-based practice; single point of contact such as a care or case coordinator; assessments and screenings to determine the type(s) and level of service; comprehensive care plan that is indicative of person-center/holistic care; interdisciplinary care team; support during care transitions; and use of technology for information sharing such as adoption of electronic health records.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

As part of the Vermont Mental Health Integration Council's Integration of Funding & Alignment of Performance Measures workgroup, one recommendation made was to conduct a formal needs assessment to assess the parity of covered services by Vermont's health insurance payers. This recommendation has been recently undertaken by the Vermont Department of Financial Regulation, in collaboration with DMH, to assess parity of covered mental health services by the state's health insurance providers and to study the reimbursement rates of each service paid for by these insurers, in order to advance equity and accountability.

Additionally, as part of the State of Vermont's efforts to advance its Mental Health Payment Reform initiative that aligns with the state's Accountable Care Organization (ACO) model agreement and further advances implementation of its Global Commitment to Health 1115(c) waiver, DMH collaborates with other sister departments in the Agency of Human Services to improve these reform efforts and ensure that both the children and adult mental health case rates cover the core set of mental health services required by DMH. This payment reform commenced on January 1, 2019, and it is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve while also placing additional focus on quality of care through a value-based payment incentive based on performance of a set of quality-related measures.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Through the State of Vermont Blueprint for Health, Community Health Teams in each of Vermont's Health Service Areas to coordinate with primary care practices that offer patient-centered medical homes to supplement medical home services and provide links for individuals and families with the social and economic services. These CHTs work to meet the needs of the local population by providing services that include:
-Patient-centered medical home patient population / panel management and outreach
-Individual care coordination
-Brief counseling and referral to more intensive mental health care as needed
-Substance use disorder treatment support
-Condition-specific wellness education

CHT staff may be co-located/embedded within a primary care practice or centralized at convenient location for easy access. In addition, each team builds referral relationships with the local providers who offer:
-Hub and Spokes that treat opioid addiction
-Specialty health practices that participate in the Pregnancy Intention Initiative
-Medical, social services and community-based organizations

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Care coordination in Vermont occurs through different methods and programs to improve care coordination and the experience of care for clients and families. The Vermont Chronic Care Initiative provides holistic, intensive, and short-term case management services to Vermont residents enrolled in Medicaid VCCI works with members referred for complex case management by health care and human services providers, state colleagues and partners, as well as through the Department of Vermont Health Access (State Medicaid Office) care management predictive modeling methodology. VCCI case managers and outreach coordinators are also welcoming members new to Medicaid (NTM), and screening members to identify and prioritize needs that includes assessing access to care, identification of health conditions/concerns, and screening for social drivers of health (housing, food and safety). The VCCI team works to connect members with medical homes, community-based self-management programs, local care management teams and help members to navigate the system of health and health related care. Additionally, care coordination occurs through state designated community mental health centers who provide case management services for adults with SMI and SUD, and children and youth with SED and co-occurring disorders through Community & Rehabilitation Treatment programs and Children, Youth, and Family Service programs. These services are funded from a number of different sources, which include state general funds, "Global Commitment To Health" Section 1115(a)(1) Demonstration funds, and Community Mental Health Block Grant funds.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Screening and assessment, which includes screening for depression, trauma, and substance use, for both adults with SMI and children with SED occurs at each of the state designated community mental health agencies as part of Vermont's Mental Health Payment Reform initiative via the Value-Based Payment (VBP) component of this initiative. The Vermont Department of Mental Health monitors these activities through performance measures where data is collected quarterly and evaluated through identified targets that must be met to achieve full VBP.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf

[2] https://health.gov/healthypeople

[3] https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf

[4] https://thinkculturalhealth.hhs.gov/

[5] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[6] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◯ Yes ◉ No

b) Ethnicity ◯ Yes ◉ No

c) Gender ◯ Yes ◉ No

d) Sexual orientation ◯ Yes ◉ No

e) Gender identity ◯ Yes ◉ No

f) Age ◯ Yes ◉ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ◯ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◯ Yes ◉ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ◯ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ◉ Yes ◯ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◯ Yes ◉ No

7. Does the state have any activities related to this section that you would like to highlight?

Vermont received a Certified Community Behavioral Health Clinic (CCBHC) Planning Grant in March 2023 and part of this grant-related work will be to identify health disparities that exist for specific subpopulations of Vermonters, in order to improve access to and utilize of health care services to improve health equity for individuals and families who are marginalized and historically underserved. This work will be conducted in collaboration with the state's Health Equity Advisory Commission to leverage a newly enacted state statute related to health equity (18 V.S.A. § 251-253).

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ● No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☑ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
668198	411791

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

   Currently, community providers, specifically those organizations focusing on individuals adults with early serious mental illness or at risk for first episode psychosis, are able to bill the state's mental health case rate for “Residential Treatment” that includes intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, and include the use of approved peer supported and peer run alternatives. Additionally, “Housing and Home Supports” services are reimbursable under this case rate that includes mental health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

   The Department of Mental Health (DMH) funds residential programs that target young adults with ESMI. These programs are based on the Soteria model and also utilize evidence-based practices, such as Wellness Recovery Action Planning, Intentional Peer Support, Open Dialogue, and Individual Placement and Support (IPS Supported Employment). These programs are effective for both individuals with serious mental illness (including those with ESMI) and individuals at risk of serious mental illness.

5. Does the state monitor fidelity of the chosen EBP(s)?

   ○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

   ○ Yes ◉ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

   As noted in the Footnotes of this section, Vermont does not currently have a Coordinated Specialty Care program, which is the only SAMHSA-identified evidence-based program for individuals who experience first episode psychosis. The Department of Mental Health continues to support training for its community providers on Wellness Recovery Action Planning, Intentional Peer Support, Open Dialogue, and IPS Supported Employment for mental health programs that work with individuals with serious mental illness (including those with ESMI) and those at risk of serious mental illness. DMHalso supports a state-wide advisory committees (one for adults; one for children, youth, and families) focused on identifying and promoting evidence-based practices for young adults with ESMI.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

   DMH plans to implement a Coordinated Specialty Care program in accordance with SAMHSA’s requirement on an evidence-based program to serve individuals with FEP. This work with span both FY24 and FY25.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

   To be determined as part of the state’s plan to implement a CSC program.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

    221 people total (15-29 year olds: 110 people; 30-59 year olds: 111 people).

    Estimates based on this population-based sample study: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

    As previously noted, DMH is working on implementing a Coordinated Specialty Care program in the state. No program of this kind currently exists. DMH plans to engage with a comprehensive group of health care providers, community partners, and peer organizations to ensure that individuals with FEP are able to be identified and referred to this CSC program for services.

    Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Vermont is working with SAMHSA and its technical assistance partners, to develop a comprehensive plan to implement a Coordinated Specialty Care program in the state, as one does not currently exist. Vermont plans to utilize its 10 percent set asides, from both its annual base awards and remaining supplemental awards, to fund this work.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Rules, regulations, governance and oversight of mental health services all serve to build a system of care that is driven by and centered around the individual at the center of every interaction. The Department of Mental Health (DMH) regularly reviews services for clients and families provided by state designated community mental health centers (Designated Agencies; DAs) and Specialized Service Agencies (SSAs) for coordination, continuity of care, and appropriateness and quality of care.

Per the State's Administrative Rules on Agency Designation, agencies must document the participation of clients and families/caregivers in treatment planning to ensure that person-centered planning occurs. Within the agency re-designation process that occurs every four years, the chart audit component has multiple areas that assesses person-centered and family-centered treatment planning that includes an agency's policies. DMH staff specifically look for the following:

- If the individual/family/youth's signature is present on both the Individualized Plan of Care and intake paperwork to ensure that they are aware of their rights and agree with the plan that is being created with them, not for them.
- Goals/outcomes are meaningful to and have been developed in partnership with client and family.
- The objectives have realistic, measurable action steps that clearly define the work and expectations between service provider and family.
- The Individualized Plan of Care is accessible and easy to understand for the consumer.
- Clear evidence in the progress notes that positive interventions and supports are utilized, are tied into the treatment goals, and any restrictions related to safety concerns are well documented and used only after attempting positive interventions and supports.

DMH is mandated through statute to have both a State Program Standing Committee (SPSC) for Adult Mental Health and one for Children, Adolescent, and Family Mental Health, and also requires the DAs/SSAs to have Local Program Standing Committees (LPSCs). These advisory bodies are required to be made up of a majority of people with lived experience (in the case of adults) or family members (in the case of children/youth) for the demographic they represent to provide a person-centered and informed perspective on policy, the hiring of key management, grievance and appeal trends, local system of care plans, and re-designation.

Additionally, DMH encourages membership on the SPSC to include mental health providers, consumers, and agencies that provide peer support and/or advocacy. Currently, multiple peer representatives and family members serve on both SPSCs to expand the representation of people with lived experience and the systems that support them. DMH provides administrative support for all SPSC meetings and can ensure that they are advising the department and that their feedback is incorporated whenever possible. DMH reviews the minutes of, and meets with, the LPSCs during the Agency Review and Designation processes and assesses whether agencies are making decisions that are informed by the LPSC, when applicable.

4. Describe the person-centered planning process in your state.

Federal Medicaid regulations at 42 CFR § 441.725 “Person-centered service plan” describe expectations for any individual receiving Medicaid "Home- and Community-Based Services" (HCBS). In the State of Vermont, the requirement for person-centered planning and an individualized plan of care is a requirement for all practitioners of mental health treatment services, per the State’s Administrative Rules on Agency Designation.

Since 2012, when the Vermont General Assembly passed Act 79: An act relating to reforming Vermont’s mental health system, the focus within Vermont’s public mental health system of care has been to achieve the provision of services that meet the definition of person- centered care. While Act 79 does not use the term “person-centered,” the services described and required meet the definitions provided above.

Act 79 directs the DMH to build a mental health system as a coordinated continuum of care in which “the individual’s treatment choices shall be honored to the extent possible.” This legislation requires that mental health services are offered as close to the patient’s home as possible; that all ranges of services be made available to those who need them, regardless of their ability to pay.

Act 264, passed in 1988, requires that human services and public education work together, involve parents and coordinate services for better outcomes for children and families. This legislation developed a coordinated system of care so that children and adolescents with SED and their families receive appropriate educational, mental health, child welfare, juvenile justice, residential, and other treatment services in accordance with an individual plan. Under the Interagency Agreement of 2005, eligibility was expanded to include all children/youth with a disability who receive services from the Agency of Education and the Agency of Human Services.

The State Interagency Team clarifies that “under Act 264, children and adolescents experiencing a SED who need services from multiple agencies are entitled to a coordinated services plan.” A Coordinated Services Plan (CSP) is a written plan developed in collaboration with the family and the treatment team for a child/youth who requires services from more than one agency. It is designed to meet the needs of the child within their family or in an out-of-home placement, and in the school and the community. A CSP is intended to be family-driven and to consider the child/youth’s and family’s identified need(s) and the accompanying supports to achieve this outcome. Every Designated Agency has a parent representative contracted through the Vermont Family Network to provide support to parents/guardians engaging in the CSP process to help them understand their rights, help maneuver the system, and ensure that their voice is heard.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Within the agency re-designation process, the chart audit component includes a line item to assess whether an advance directive is on file or if not, whether this is documented in the client’s chart. All agencies must also document that a conversation occurred with all clients who indicate they do not have a Psychiatric Advance Directive, asking if they would like more information about the purpose or support in creating one. DMH has not undertaken any systematic, formal process of directing agencies to this resource but will consider doing so moving forward.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ◉ Yes ○ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ◉ Yes ○ No

3. Does the state have any activities related to this section that you would like to highlight?

   The Department of Mental Health has provided ongoing training and updates regarding the federal statute governing this block grant and the associated programmatic requirements to ensure compliance with this statute.

   Additionally, within its “Standard Provisions” attachment of all contracts, the Vermont Agency of Human Services language states: "Inspection and Retention of Records: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont’s Medicaid program and Vermont’s Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u)."

   Please indicate areas of technical assistance needed related to this section

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

None. Vermont does not have any federally recognized tribes. There are four state recognized tribes: St. Francis Sokoki Tribe/Abenaki Nation at Missisquoi, the Koasek Band of the Koas, Elnu Abenaki Tribe, and the Nulhegan Abenaki Tribe. The Department of Mental Health has held two relationship building meetings with these tribes to date in the past fiscal year.

2. What specific concerns were raised during the consultation session(s) noted above?

While there have been no formal Mental Health Block Grant-specific planning communications with the four indigenous state recognized tribes, the Department of Mental Health and Agency of Human Services have taken steps to begin repairing relationships with this group focusing on improved, consistent communication and trust building. Through this early engagement process, the state has heard the desire for more awareness of Abenaki culture and their need for resources to address the mental health challenges in their communities. There is also a need for mental health care providers who are culturally responsive, and ideally from within the four tribes themselves.

3. Does the state have any activities related to this section that you would like to highlight?

Current initiatives include:
- Meetings semi-annually with Abenaki tribal leadership by the Department of Mental Health,
- Monthly training session for the Agency of Human Services staff on Abenaki culture
- Training series open to the public on Historical and Intergenerational Trauma
- Maintenance of a Department of Mental Health internal work group for anti-racism
- Creation of an Agency of Human Services-wide Abenaki equity workgroup

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Department of Mental Health works with Vermont community mental health centers ("Designated Agencies") to support evidence-based practices that promote rehabilitative outcomes. The core service capacities include an array of rehabilitation, diagnosis-specific treatments, and emergency services including crisis stabilization services. Available services include individual, group and family therapy; medication evaluation and management; community support services; service planning and coordination, including collaboration with physical health care providers; integrated co-occurring addiction services; peer support services; supported employment services; individual and family psycho-education; housing and home supports; family and parenting support service. Transitional therapeutic residential services and crisis bed services are available as needed.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

		Yes	No
a)	Physical Health	○	●
b)	Mental Health	●	○
c)	Rehabilitation services	●	○
d)	Employment services	●	○
e)	Housing services	●	○
f)	Educational Services	○	●
g)	Substance misuse prevention and SUD treatment services	●	○
h)	Medical and dental services	○	●
i)	Support services	●	○
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	●	○
k)	Services for persons with co-occuring M/SUDs	●	○

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Case management services include community support services, and service planning and coordination.

Community supports services are specific, individualized, and goal-oriented services that assist individuals and families in developing skills and social supports necessary to promote successful, person-directed tenure in the community. These supports can include assistance in activities of daily living, supportive counseling, support to participate in community activities, and support to build and sustain healthy personal, family, and community relationships.

Service planning and coordination assists individuals and their families in planning, developing, choosing, accessing, coordinating, and monitoring the provision of services and support that are needed by clients, and families if indicated. Case management supports clients and families in their home and/or the community. Case managers work to support individuals through:

• Referral - supporting clients and families in identifying other needs and making appropriate referrals, which may include outpatient therapy and/or respite

• Assessment – collaborating with clients and families to complete assessments in accordance with DMH policies
• Individual Case Planning - working with clients and their families to develop comprehensive individualized plans of care that meet the complex needs of those served
• Service Coordination - connecting with schools, employers, primary care providers/subspecialty providers, other state government departments, and other community partners to identify and secure services needed to meet goals outlined in individualized plans of care
• Transition Planning – working with clients and families to implement a thoughtful and effective transition from one level of care to another, and to the next developmental level of support across the lifespan.

Designated agency staff work with community partners to ensure success for clients and families. Case managers meet with children both individually, and with families as needed, to meet their goals. Case managers are often embedded within community settings to best support clients' needs.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Adult Mental Health

All community mental health services support wellness and recovery through provision of services aligned with evidence-based practices that demonstrate rehabilitative/recovery outcomes for individuals with mental illness. Decreased hospital use is associated with stable, safe housing; employment; a strong and supportive natural support system; good physical health; and attention to co-occurring substance use disorder as appropriate – all of which are addressed by Vermont's Community Rehabilitation and Treatment (CRT) Programs provided by its Designated Agencies and one Specialized Service Agency that serves adults, in partnership with the individuals served. Vermont's clinical programs also offer trauma treatment – frequently a factor in the etiology and intensity of mental health distress. In addition, in instances of acute distress, intensive case management and therapeutic clinical services can be offered, including outreach services and crisis bed utilization.

Children Mental Health

All supports and services intended to reduce hospitalizations and hospital stays are provided within the framework and principles of the Children's Mental Health System of Care, which is comprised of promotion and prevention, community intervention, and intensive intervention. These supports and services are child-/youth-centered, family-focused, culturally competent, strength-based, individualized, community-based, and collaborative between and among families, agencies, and community. Additionally, these supports and services are not meant to be distinct categories, as they provide different functions for the individual and family. For example, effective treatment for a child's or youth's identified mental health condition also serves to prevent further difficulties for the client and their family, while also reducing the future likelihood of adverse experiences. DMH believes that a combination of promotion, prevention, and intervention to meet the individual needs of children, youth, and families will help to reduce hospitalizations and lengths of stay, as the needs will be able to be addressed in the community when clinically appropriate.

Please indicate areas of technical assistance needed related to this section.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	28,535	221
2.Children with SED	5,682	Unknown

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

These figures were obtained from sources outside of the Department of Mental Health and these are estimates using epidemiological data from research studies. Any planning occurs within the context of DMH's allocated budget and provider performance and community feedback is considered to develop needed service arrays. DMH has not historically calculated prevalence or incidence of either SMI or SED due to the lack of fluctuation in the state's population. The Covid-19 pandemic led to significant population growth (growth of approximately 40,000 people) for the first time in approximately 20 years. DMH does not have the in-house statistical expertise to calculate prevalence and incidence rates of SMI/SED. It is important to note that any system planning does not occur within the context of prevalence or incidence rates since the system is not funded nor structured to meet the mental health needs of all Vermonters, only those individuals who access mental health services via the state's public mental health system.

Please indicate areas of technical assistance needed related to this section.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	◉ Yes ○ No
b)	Educational services, including services provided under IDEA	◉ Yes ○ No
c)	Juvenile justice services	◉ Yes ○ No
d)	Substance misuse preventiion and SUD treatment services	◉ Yes ○ No
e)	Health and mental health services	◉ Yes ○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

Most of Vermont's population resides in a rural area, and transportation - especially coupled with bad weather - is a challenge for many Vermonters. The state's community mental health centers provide outreach services to individuals who find it difficult to access office-based services. Medicaid-funded transportation services are also available.

Providers also offer case management, information and referral to mental health and substance abuse services. These efforts are supported in all areas of the state.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

Vermont's community mental health centers offer case management assistance and community support services to adults with serious mental illness (SMI) to find and maintain housing. Housing subsidies are available for individuals enrolled in our Community Rehabilitation and Treatment (CRT) Program that serves adults with SMI to assist with housing costs while awaiting other state or federal assistance. Also, DMH Housing Subsidy and Care funding is available for homeless adults with SMI who may be hospitalized and awaiting discharge.
Vermont provides outreach services to homeless adults with SMI in six locations through "Projects for Assistance in Transition from Homelessness (PATH) providers, who offer coordinated entry services as part of the Chittenden County and Balance of State Continuum of Care efforts required by HUD. All providers utilize the homeless management information system and self-sufficiency outcome matrix to document outcomes and for reporting purposes.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Older adults are served by Vermont's community mental health centers. In addition, in coordination with Vermont's Area Agencies on Aging, the community mental health centers support Elder Care Clinician Programs that provide in-home mental health services to older adults (age 60 years and older) who are house-bound.

Please indicate areas of technical assistance needed related to this section.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The Department of Mental Health utilizes staff to oversee mental health services providers and coordinate the necessary training and guidance to support this system. These efforts are delegated to several staff provide the necessary support as a portion of a many duties. DMH continues to leverage the State's Mental Health Block Grant Planning Council to advise on how funds are expended and managed.

Emergency Services in Vermont are available to individuals in a mental-health crisis regardless of age twenty-four hours a day, seven days a week throughout the state and are provided by each community mental health center. Core services include:

• Access to psychiatry consultation by emergency screening staff
• Linkage and referral to other resources and services that individuals may require
• Clinical screening for all involuntary psychiatric inpatient admissions
• Screening for all Children's and Community Rehabilitation and Treatment clients' Medicaid-funded psychiatric inpatient admissions
• Screening for state courts

Emergency Services capacity also includes Critical Incident Debriefing support to communities after a suicide or a natural disaster. Over the year, Vermont has embarked on a new statewide community mobile crisis services initiative per The Centers of Medicare and Medicaid Services (CMS) issued 2021 guidance that outlined the scope of services for qualifying community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021 (ARPA). These services will be offered statewide to all individuals, irrespective of insurance coverage or age. Additionally, Emergency Services teams at each community mental health center have an embedded mental health clinician with each Vermont State Police barracks to provide mental health- and substance use disorder-related support for 9-1-1 calls, as needed. Also, all ES staff have received training in the Team Two model, which focuses on the collaborative nature of joint outreach efforts on the part of law enforcement and mental- health emergency staff.

Finally, all Emergency Services have access to local crisis stabilization beds at each of Vermont's community mental health centers, as well as the crisis stabilization beds in other parts of the state. These beds are used to help maintain someone in the community while trying to avoid the need for inpatient psychiatric hospitalization. These beds are also used as step-downs from an inpatient hospitalization to assist someone in transitioning back into the community.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Currently, the State of Vermont continues with the use of all telehealth and audio services at its community mental health centers. The Covid-19 pandemic offered the State the learning opportunity that mental health services can be provided and reach areas of Vermont that otherwise were limited in the delivery of these services, therefore DMH looks to support their continuation. Additionally, the associated Mental Health Payment Reform billing codes for telehealth to ensure that any barriers to treatment are minimized or eliminated. Telehealth is also continuing via Vermont's emergency departments for psychiatry services. This means that someone experiencing a mental health crisis can access specialty mental health care in these settings. Finally, the Department of Mental Health is a participating member on Vermont Program for Quality in Health Care's advisory board for Emergency Telehealth.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Vermont does not have a formal CQI plan in place.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

	Question	Yes	No
1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	○	◉
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	◉	○
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	◉	○
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	◉	○
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	◉	○
6.	Does the state use an evidence-based intervention to treat trauma?	◉	○

7. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [ ] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [ ] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [ ] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [ ] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [ ] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ● No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

○ Yes ● No

4. Does the state have any activities related to this section that you would like to highlight?

As part of Act 78, the Department of Mental Health and Department of Corrections (DOC) entered into a Memorandum of Understanding on June 28, 2017 to coordinate mental health services related to inmates in DOC custody who have been identified by DOC as requiring a level of care that cannot be adequately provided by DOC, placement of inmates coming into the custody of DMH and inmates voluntarily seeking hospitalization who meet inpatient criteria, and consultation regarding placement of inmates designated seriously functionally impaired (SFI) due to mental illness.

Additionally, utilizing a blend of both state general funds and MHBG funds, DOC and DMH has implemented a modified Forensic Assertive Community Treatment (FACT) program, in collaboration with one of Vermont's Specialized Service Agencies (Pathways Vermont) that is administering this program, to assist individuals who are involved with the criminal justice system transition back into the community. These individuals may also have co-occurring substance use and physical health disorder, and serves those

who are 18 or older, under the supervision of DOC, and have mental health challenges such as schizophrenia, depression, anxiety, post-traumatic stress disorder. This program also includes a full-time peer specialist.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Each community mental health center in Vermont (10 total) has its own Emergency Services team that is designated to provide mental health crisis services to a region of the state twenty-four hours a day, seven days a week. Additionally, the state has two 9-8-8 call centers, as well as an out-of-state backup call center if needed. These call centers also provide 24/7 primary coverage. The State's implementation of 9-8-8 included a 9-8-8 Planning Coalition comprised of community partners, people with lived experience, family members, and advocates that guides the state's work. Both 9-8-8 call centers in Vermont are also members of the designated agency community mental health system. When a face-to-face crisis response is required, the 9-8-8 call center will contact the corresponding

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity
- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)
- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:
- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☑	☐	☐	☐
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

Vermont will be soft launching its statewide mobile crisis initiative on October 1, 2023, with all community mental health centers to be participating by January 1, 2024. Additionally, a multifaceted “alternatives to emergency departments” initiative has been launched to better serve Vermonters in community-based settings.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

Someone to call: Currently, the State of Vermont has 24/7 9-8-8 call availability with ramping up chat and text capabilities.

Someone to respond: State of Vermont will have statewide coverage for two-person Mobile Crisis response by January 1, 2024, however some availability will start on October 1, 2023.

Somewhere to go: State of Vermont is actively working on eight “alternative to emergency department” sites throughout Vermont.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Vermont proposes to use the 5 percent set aside to continue funding Emergency Services teams at its community mental health centers.

Please indicate areas of technical assistance needed related to this section.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	◉ Yes ○ No
b)	Required peer accreditation or certification?	○ Yes ◉ No
c)	Use Block grant funding of recovery support services?	◉ Yes ○ No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	◉ Yes ○ No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ○ Yes ◉ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The Department of Mental Health contracts with community providers of mental health services for children with serious emotional disturbance and their families, and adults with mental health conditions and serious mental illness. The public mental health system has 10 community mental health centers (Designated Agencies; DAs) in all geographical areas of Vermont and two Specialized Services Agencies (SSA), one that serves children, youth, and families and one that serves adults.

Recovery for Adults with SMI

All mental health services offered by Vermont providers are expected to adhere to this recovery rehabilitative philosophy. This approach includes strengths-based case management, person-centered treatment planning, shared decision making and self-directed care. Notable practices offered in Vermont's system of care include Intentional Peer Support, person-centered planning, shared decision making, Wellness Recovery Action Planning, Open Dialogue, Hearing Voices, supported employment, and Six Core Strategies to reduce seclusion and restraint. Vermont's commitment to recovery is not limited to specific, distinct practices; it expected that all services and clinical interventions incorporate and adhere to rehabilitative recovery principles.

Through the Vermont Recovery Education Project, the Department of Mental Health has promoted the dissemination of the principles and skills of recovery for adults with severe and persistent mental illness for more than a decade. Two primary models of Recovery Education are available in Vermont:
• Recovery Education as taught by Vermont Psychiatric Survivors (VPS), with emphasis on consumer empowerment, Wellness Recovery Action Plans (WRAP), and other principles and tools working out originally by Vermonter Mary Ellen Copeland. Recovery Education is taught in many of the Designated Agencies and at the Vermont State Hospital.
• Illness Management and Recovery (IMR), which was developed by the New Hampshire based Dartmouth Psychiatric Research Center and has identified by SAMHSA (Substance Abuse and Mental Health Services Administration). IMR is available in several of the Designated Agencies.

Vermont continues to invest in an array of peer services, many of which were developed or enhanced following the passage of Act 79 in 2012. These services include community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. 'Peer' participation in service delivery is encouraged in all programs, both in community mental health centers and in 'peer' operated programs. Vermont encourages inclusion of people with lived experience in all staffing positions. Involvement of people with lived experience in services for people with mental illness offers concrete examples of successful recovery and is a potent source of hope and mentoring.

Peer programming supported by DMH includes:
• Alyssum: Two-bed program providing crisis respite and hospital diversion and step-down. Located in Rochester, Vermont.
• Another Way: Community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving individuals who are not eligible for or choose not to be enrolled in Designated Agency Community Rehabilitation and Treatment services. Located in Montpelier, Vermont.
• NAMI-Vermont: Statewide family and peer organization providing support groups and educational and advocacy groups for individuals with mental health conditions and their families. Headquarters in Williston, Vermont.
• Northeast Kingdom Youth Services: Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization. Focused on St. Johnsbury, Vermont.
• Pathways Vermont – Peer Support Line: Statewide telephone support to prevent crisis and provide wellness coaching. Headquarters in Burlington, Vermont.
• Vermont Psychiatric Survivors: Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings. Headquarters in Rutland, Vermont.
• Pathways Vermont Community Center: Provides community center offering outreach, development/enhancement of natural supports networks, support groups, service linkages, crisis prevention, and employment and housing supports. Specializes in serving young adults who are not eligible or choose not to access Designated Agency Community Rehabilitation and Treatment

services. Located in Burlington, Vermont.
• Wellness Workforce Coalition: Provides infrastructure and workforce development for organizations that provide peer support. Statewide activities include: 1) Coordinating core training (e.g., Intentional Peer Support), 2) Workforce development (e.g., recruitment, retention, career development), 3) Mentoring, 4) Quality improvement, 5) Coordination of peer services, 6) Communication and networking, 7) Systems advocacy. Headquarters in Montpelier, Vermont.
Each of these programs works closely with the Wellness Workforce Coalition (WWC) to participate in core training and mentoring for staff using the Intentional Peer Support Curriculum, a national training resource for peer support providers. These peer organizations work with the WWC to improve their infrastructure (e.g., financial management and board development) and to expand their capacity for collecting and reporting Results-Based Accountability measures, including recovery-oriented measures to determine if individuals receiving support and services are “better off.”

Vermont also contracts with the Copeland Center to provide statewide training, coaching and mentoring on the use of Wellness Recovery Action Planning (WRAP) in both professional and peer organizations.

Lastly, Vermont has adopted SAMHSA’s definition of recovery and expects all service providers within the mental health system of care to provide services that are recovery oriented. This expectation is supported through our quality management and oversight of DMH-funded programs and support of regular training and educational events (e.g., conferences, WRAP training) promoting the concept of recovery.

Recovery for Children with SED

• Vermont’s Act 264 charges DMH’s Child, Adolescent and Family Unit (CAFU) with serving children with a serious emotional disturbance or at risk for serious emotional disturbance within an interagency system of care. CAFU is committed to ensuring the delivery of a comprehensive array of effective mental health supports and services for children and families statewide.
• Together, CAFU and Vermont’s community mental health centers are dedicated to providing and improving the core capacity services, offered throughout Vermont, achieving outcomes that improve the quality of life for children, youth, and families, and broadening our approach to include public health model strategies around prevention. A team of professionals, paraprofessionals, and community volunteers provides or arranges mental-health services for clients, with the intensity and duration determined by each family/individual need.
• Each DA is responsible for providing specified core public mental-health services in a specified region of the state. Vermont’s one SSA provides intensive outpatient services to youth from anywhere in the state.
• Core community-based services and supports that aid children, adolescents and their families in recovery that includes Immediate Response, Outreach and Clinic-Based Treatment, Support services, Prevention, and Screening, Referral and Community Consultation.
• In addition to core-capacity services provided by designated agencies for each region in Vermont, there are three types of services available to the entire state that complete the continuum of care for children and adolescents and their families: intensive residential services, emergency/hospital diversion beds, and hospital inpatient services.
• Vermont has residential treatment programs that have around-the-clock awake staff, medical/psychiatric backup services, and an in-house array of psychological assessment and treatment services. The Brattleboro Retreat, in Southeastern Vermont, serves youth in need of inpatient psychiatric hospitalization.
• Emergency or hospital-diversion beds are community-based programs that provide a very high level of care and have the ability to divert youth from inpatient hospitalization.
• DMH, often in collaboration with a sister department such as the Vermont Department for Children and Families, has promoted the following Evidenced based Practices (EBPs) for effective treatment with children, youth and their families:
• Attachment, Regulation & Competency Framework for children and youth who have experienced complex trauma. This was implemented statewide in the DA/SSA system.
• Child-Parent Psychotherapy is a dyadic attachment-based treatment for young children exposed to interpersonal violence with the goal to strengthen the relationship with the primary caregiver.
• Parent-Child Interaction Therapy is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship.
• Trauma-Focused Cognitive Behavioral Therapy for children and adolescents impacted by trauma and their parents/caregivers.
• Child and Family Traumatic Stress Intervention (CFTSI) “is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD. CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse”.
• The following EBPs address building resiliency: Zero Suicide is a pathway to prevent suicide and includes evidence-based practices such as Dialectical Behavior Therapy (DBT), Counseling on Access to Lethal Means (CALM), and Collaborative Assessment & Management of Suicidality (CAMS).

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

The Division of Substance Use Programs (DSU), part of the Vermont Department of Health, oversees a network of health promotion, prevention, intervention, treatment and recovery services. Their mission is to prevent, reduce and eliminate the problems caused by alcohol and drug use. They work with national, state and community-based organizations to make proven programs and services available to Vermonters. DSU uses data to plan and guide program improvements, and to support

Vermont's statewide system of its SUD "Preferred Provider" network.
Recovery options and support services include:
-Outpatient Programs provide assessment and counseling services while people remain in their homes. This may include meeting with a counselor one-on-one or going to a group meeting one or two times a week.
-Intensive Outpatient Programs, which usually last for about 2-3 hours a day, 3 days a week, for several weeks while people remain at home.
-Residential Programs offer counseling and group services at a treatment center for a few weeks at a time.
-The Hub and Spoke System of Care is a team of health professionals (called "Spokes") and treatment centers (called "Hubs") who provide Medications for Opioid Use Disorder (MOUD) treatment, like methadone, buprenorphine, or Vivitrol to Vermonters addicted to prescription opioids or heroin.

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	Yes No
Home and community-based services	Yes No
Peer support services	Yes No
Employment services.	Yes No

2. Does the state have a plan to transition individuals from hospital to community settings? Yes No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	(●) Yes ( ) No
b) The resilience of children and youth with SED?	(●) Yes ( ) No
c) The recovery of children and youth with SUD?	(●) Yes ( ) No
d) The resilience of children and youth with SUD?	(●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare?	(●) Yes ( ) No
b) Health care?	(●) Yes ( ) No
c) Juvenile justice?	(●) Yes ( ) No
d) Education?	(●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	(●) Yes ( ) No
b) Costs?	(●) Yes ( ) No
c) Outcomes for children and youth services?	(●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	(●) Yes ( ) No
b) Mental health treatment and recovery services for children/adolescents and their families?	(●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	(●) Yes ( ) No
b) for youth in foster care?	(●) Yes ( ) No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	( ) Yes (●) No
d) Does the state have an established FEP program?	( ) Yes (●) No
Does the state have an established CHRP program?	( ) Yes (●) No
e) Is the state providing trauma informed care?	(●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Act 264, passed in 1988, set into law Vermont's development of a comprehensive, integrated system of care for children and adolescents experiencing severe emotional disturbance and their families. At the system level, it (1) mandates and implements principles of interagency collaboration, coordination and parent involvement at all levels of decision-making; (2) creates an

interagency definition of severe emotional disturbance; (3) creates state and local interagency teams; and (4) includes an advisory committee to advise the Secretary of the Agency of Education, the Secretary of the Agency of Human Services, and the Commissioners of the Department of Mental Health, the Department for Children and Families, and the Department of Disabilities, Aging, and Independent Living on the development of a comprehensive, integrated system of care.

At the individual level, it entitles all eligible children to a Coordinated Services Plan. Vermont was also one of the earliest states to receive a grant from the Child and Adolescent Service System Program (CASSP) to support statewide implementation of a system of care. A major part of the work under the CASSP grant was shifting the culture in the state on two fundamental concepts: parents became partners and interagency collaboration became a mandate. Virtually all trainings offered for professional development by the state are open to staff from other departments/agencies and to families.

The work continues into the present through the move toward Integrating Family Services (IFS) under the Agency of Human Services. IFS goes beyond collaboration to integration across each region's social services and continues to enhance integration with education services as well. The Governor believes in the efficiency of an integrated system of care and sees the full-service school model as a vital piece of that picture for children and adolescents. At the local and state level, there are school liaisons in each region and school-based mental health services offered by each designated agency, as well as a clinical care manager position at the Department of Mental Health Child, Adolescent, and Family Unit that oversees school-based mental health services.

Child, Youth and Family Service programs in Vermont can provide mental health treatment and supports for youth up to age twenty-two, if determined appropriate. If it makes sense for that youth to transition to adult supports and services prior to age twenty-two, the local team develops the transition plan at the identified time (it may be as the youth prepares to turn eighteen, or any point before twenty-two). The transition is individualized to the youth's needs. There are state protocols for transitioning youth out of the Vermont Department for Children and Families foster care into Community Rehabilitation and Treatment (CRT) and for transitioning non-custody youth into CRT.

Vermont is one of only a handful of states that combines child welfare and juvenile justice in the same department (Department for Children and Families-Family Services Division). This was done because the state wanted to emphasize the importance of treatment and rehabilitation over punishment for youth. Children in the child welfare and the juvenile justice systems who are in state custody and do not have insurance through their family are enrolled in Medicaid. Even if they have private insurance through their family, they are enrolled in Medicaid as a secondary insurer.
It should be noted that federal confidentiality regulations about treatment for substance use disorder continue to provide a major challenge to the ability to provide coordinated/integrated planning and treatment services to individuals and families.

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Vermont updated the State Suicide Prevention Platform in spring 2023. The State Suicide Prevention Strategic Plan will be completed by July 2024.

Suicide Prevention goals and investments:

Vermont's suicide rate, calculated as the number of deaths by suicide per 100,000 people, continues to be higher than the national averages and is increasing at a faster rate. In 2021, suicide was the 9th leading cause of death for all Vermonters. Vermont rates of suicide are also higher than the rates of neighboring states and the New England Region. The Agency of Human Services has invested in collecting data to inform this issue in our state. The National Violent Death Reporting System (NVDRS) indicates that more men die by suicide than women, and firearms are the method used for nearly two-thirds of the deaths by suicide. Vermont also utilizes the Youth Risk Behavior Survey (YRBS), which indicates 1 in 4 adolescents in Vermont report feeling sad or hopeless, and LGBTQ youth experience this at a much higher percentage, 58%.

The State currently uses a Results Based Accountability scorecard to keep track of key data elements to guide our efforts at reducing the rate of suicide in Vermont. Goals and investments include increasing promotion and prevention activities, expanding universal screening to healthcare practices, developing a skilled workforce through training in evidence-based practices, caring contacts and follow-ups post- suicidal crisis, and supports and resources for loss survivors and survivors.

Partners:
The Department of Mental Health, in partnership with the Vermont Agency of Human Services, works to reduce the rate of suicide in Vermont. AHS recognizes that preventing suicide is a community wide effort that involves a strong collaboration with mental health and physical health care providers. In addition, there is a public-private-academic partnership focused on the surveillance of suicide prevention data and information led by the Vermont Department of Health with participation from the DMH, University of Vermont, and other stakeholders. The Vermont Department of Health holds the Center for Disease Control and Prevention Comprehensive Suicide Prevention grant and the Garrett Lee Smith State/Tribe Youth Suicide Prevention (GLS) grant from the Substance Abuse and Mental Health Services Administration. DMH meets with them weekly to coordinate suicide prevention efforts related to the grants, partner on projects, and communicate updates related to activities.

Vermont's suicide prevention plan aligns closely with the World Health Organization's National Suicide Prevention Strategies, which categorizes actions into three broad interventions: Universal Prevention, Selective Prevention, and Indicated Strategies. Vermont Suicide Prevention Center (VT-SPC) is a key community partner who leads the Vermont Suicide Prevention Coalition, which is comprised of 70 members across public, private, and non-profit sectors representing public health, health care, education, community, social services, state agencies, and people with lived experience. Vermont also partners with Vibrant Emotional Health to collect and monitor data for individuals accessing the 9-8-8 Suicide and Crisis Lifeline in Vermont.

What Works:
Vermont's suicide prevention plan aligns closely with the World Health Organization's (WHO) suggested strategy. The plan categorizes actions into three broad categories; Universal Prevention, Selective Prevention and Indicated Strategies essentially signifying primary, secondary and tertiary prevention strategies. These are broad and take a population health approach to this problem.

Strategy:
DMH works in partnership with other state and community stakeholders to promote effective evidence-based interventions at different levels (Universal, Selective, and Indicated).
Universal Strategies

1. Increase access to healthcare, specifically mental health care.
2. Promote positive mental health.
3. UMatter campaign that works to accomplish the following:
o Promote the message that suicide is preventable.
o Equip people with the knowledge and skills to respond effectively to those in distress.
o Increase public awareness of the importance of addressing mental health issues.
o Establish a broad-based suicide prevention and intervention strategy throughout Vermont.
o Sponsor a media campaign to reduce the stigma associated with being a consumer of mental health, substance misuse, and suicide prevention services.
o Promote positive youth development.
o Put into place long-term, sustainable approaches to prevention and early intervention.
4. Facing Suicide VT
o This statewide prevention initiative provides access to suicide prevention, education, support, and advocacy resources and is led by the Vermont Departments of Health and Mental Health through funding from the Centers for Disease Control and Prevention Comprehensive Suicide Prevention Program.

Selective Prevention
1. Targeted services for people at higher risk.
o Suicide prevention and awareness training, such as UMatter, Question-Persuade-Refer (QPR), and Mental Health First Aid, for those in key positions to identify people at higher risk. Trainees will learn to recognize someone who may be struggling and be able to connect with further help.
2. Helplines:
o Designated Agency (DA) crisis services
o 9-8-8 Suicide & Crisis Lifeline
o Pathways Vermont Peer-run Warmline
o Vermont Network Against Domestic and Sexual Violence hotlines
3. Governor's Challenge on Veterans Suicide
o Federal initiative, led by the Substance Abuse and Mental Health Services Administration (SAMHSA), to develop and implement statewide suicide prevention best practices for service members, veterans, and their families (SMVF) using a public health approach.
Indicated Strategies

Vermont has adopted the National Action Alliance for Suicide Prevention platform, Zero Suicide, which is a set of evidence-based principles and practices for preventing suicide within health and mental health care systems. The four areas of intervention under this systematic suicide care strategy are as follows:
1. Screening and Assessment for Suicidality
2. Developed Collaborative Safety Plan
3. Suicide-focused Treatment
4. Follow-up Aftercare

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ( ) Yes (●) No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Vermont has two primary in-state 9-8-8 Suicide and Crisis Lifeline Centers, and one back-up center in New Hampshire.

One community mental health center, Northeast Kingdom Human Services, began answering Lifeline calls in June 2021, in partnership with the state's other Lifeline Center, Northwestern Counseling and Support Services. The back-up center, Headrest, Inc. began answering Lifeline calls in July 2020.

The suicide prevention coalition has committed to focusing on high-risk populations identified by the data, such as LGBTQ, indigenous, elderly, refugee, and persons with mental illness. Expert panel discussions were developed in December of 2018 and partnerships continue to be in development with leaders from the Abenaki tribal communities, Outright Vermont, and the Vermont Department of Disabilities, Aging, and Independent Living to approach this issue in a way that is culturally responsive to the specific needs of these populations.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Department of Mental Health, in collaboration with its sister departments within the Agency of Human Services, coordinates a multitude of services for adults with SMI and children with SED to ensure the delivery of efficient, effective, and high-quality mental health services. Through various initiatives, which includes Mental Health Payment Reform, the Vermont Chronic Care Initiative, and the Blueprint for Health, DMH continually monitors costs, quality assurance related to state-established standards of care, and service-related data in regular intervals (e.g., quarterly, bi-annually, annually) to produce the best possible outcomes

in the least restrictive, community-based settings.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Vermont Mental Health Block Grant Planning Council (MHBG PC) was involved in the development and review of this application, as well as the review of the last Implementation Report submitted on December 1, 2022.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The Vermont MHBG PC does not oversee the Substance Abuse Block Grant, which is led by the Vermont Department of Health, and therefore cannot speak to the mechanism that the state uses to plan and implement substance misuse prevention, SUD treatment and recovery services.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ● No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ● Yes ○ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Mental Health Block Grant Planning Council meets 5-6 times per year to monitor, review, and evaluate the allocation and adequacy of mental health services in Vermont, review outcomes from previously funded initiatives, review budgetary information, identify their priorities for the mental health system of care, discuss gaps in the system and the service needs of adults with SMI and children with SED, and make recommendations to the Commissioner of Mental Health regarding the use of block grant funds. The MHBG PC is made up of a majority of people who identify as having lived experience with mental health conditions or are the parents of children with SED. Additionally, membership also includes mental health providers and advocates who are able to blend their perspective into the meetings so the council is able to ensure that meaningful input from people in recovery, families, and stakeholders is used to advise the Department of Mental Health on the initiatives that can have the greatest impact.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

VERMONT

State of Vermont
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

Agency of Human Services

[phone] 802-241-0090
[fax] 802-241-0100
[tty] 800-253-0191

Vermont Mental Health Block Grant Planning Council Planning Council Charter

Overview/Purpose

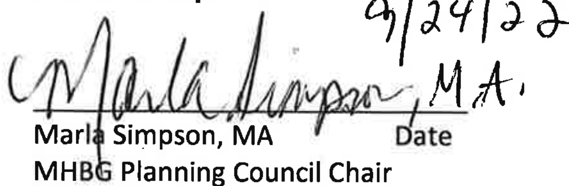
The Vermont Mental Health Block Grant Planning Council is an advisory body to the Community Mental Health Services Block Grant (MHBG) program that makes funds available to the State to help support community mental health services. These funds are overseen by the Vermont Department of Mental Health (DMH). The MHBG program's objective is to support grantees in carrying out plans for providing comprehensive community mental health services. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) administers these MHBG funds.

Mental Health Planning Council

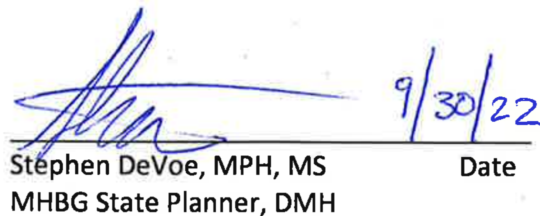
Title XIX of the Public Health Service Act (42 U.S.C. 300x) mandates that all states establish a State Mental Health Planning Council. The council's role is to:

- Review the state MHBG application, contribute to its development, and submit any recommendations it has regarding the state's plan;
- Advocate for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental health issues; and
- Monitor, review, and evaluate the allocation and adequacy of mental health services in Vermont, at least annually.

Charter Acceptance



Marla Simpson, MA Date
MHBG Planning Council Chair



Stephen DeVoe, MPH, MS Date
MHBG State Planner, DMH

This meeting was not recorded. Seven members are needed for a quorum.

7/15/2022
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☒ Marla Simpson (Chair) ☒Dan Towle (he/him) ☒ Alice Maynard ☐ C Rubin ☒ Cinn Smith ☐ Laurie Emerson (NAMI) ☐Michael McAdoo ☐ Laurie Mulhern

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☒ Julie Tessler ☐ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☒ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☒ Anne Rich ☐ Joanne Crawford ☐ Brian Smith ☐ Karen Barber

State of Vermont: ☒Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☐ Victoria Hudson (DCF) ☐ Annie Ramniceanu (DOC) ☒ Emily Trutor (she/her; VDH DSUP)

Agenda

1:00 Convene Meeting and Introductions
1:15 Review April 2022 Meeting Minutes
1:20 MHBG Planning Council Chair Discussion
1:45 MHBG Funding Updates
2:00 MHBG Training/Overview "101" from SAMHSA Break
2:05 Public Comment
2:10 Meeting Wrap-up/Closing
2:15 Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
Convene Meeting and Introductions	**Meeting convened at 1:06 pm** • Reviewed agenda. • MHBG Planning Council Introductions. • DMH Updates. ○ Shayla Livingston has transitioned to her new role as the Agency of Human Services Policy Director. ○ Nicole DiStasio is currently serving as the DMH Interim Policy Director; position is posted online and applications are currently being accepted; position should be filled by August 2022. ○ Eva Dayon is currently serving as the DMH Interim Assistant Director of Quality; position cannot be permanently filled at present due to Nicole DiStasio serving in their interim role. ○ DMH Quality and Program Participant Specialist position is currently vacant due to Eva Dayon serving in their interim role. ○ DMH Quality Management Coordinator position: DMH Team currently conducting interviews and positions will be filled by August 2022. ○ Pay grade inquiry by Dan Towle. ▪ Pay grades and step increases are set by Vermont Department of Human Resources and can be found online here. • Member Updates. ○ None.
Review April Meeting Minutes	• Alice requested amendment from "stack holder" to stakeholder. • Dan raised question/comment about number of follow-up items from April minutes. ○ Suggestion to add "follow-up items" section to meeting minutes to ensure tracking, monitoring, and follow up to any ongoing tasks. **Motion** to accept April 2022 minutes made by Dan. Seconded Heather. No discussion. Majority in favor. None opposed. 1 abstention. Motion passes.
MHBG Planning Council Chair	• History of Mental Health Block Grant Planning Council (MHBG PC) during the tenure of the current chair, Marla Simpson's (*i.e.,* the last 8-9 years). ○ MHBG PC's work accelerated from SAMHSA's previous technical assistance. ○ Impressed by dignity and evolution of MHBG funding to improve health and quality of care for children, youth, families, and adults. ○ Implementation of Results Based Accountability (RBA) framework to projects funded by MHBG. ○ Previously, Vermont MHBG funding was ~$700k; presently, ~$1.4 million with additional COVID-related funding streams. ○ Cinn Smith previously served as Vice Chair; Cindy Tabor was briefly co-chair.

This meeting was not recorded. Seven members are needed for a quorum.

	○ Marla feels that this is an appropriate time to step down. ▪ Alice: no one has been more dedicated to this work. ▪ Dan: joined ~6 years ago, been friend/mentor, helped train me as a peer, fantastic work colleague. ▪ Cinn: best facilitator and meeting agenda; generosity and kindness. • Next steps for election of MHBG PC Chair and Vice Chair. ○ Dan: Alice Maynard nominated; she expressed appreciation for the nomination, but needed to decline. ○ Please reach out to Steve DeVoe, DMH Director of Quality and Accountability, if any interest in serving in one of these roles (stephen.devoe@vermont.gov). ○ Discussion about next steps vis-à-vis Vermont Mental health Block Grant Planning Council Operating Policies and Procedures. ▪ Marla Simpson will serve as interim chair through end of Calendar Year 2022. ○ Cinn Smith: this item should stay on agenda until these positions are filled. ○ Danielle Bragg: what is required of the Chair? ▪ Chair and facilitate meetings. ▪ Letters disseminated by MHBG PC with the final approval/signature of the Chair and Vice Chair. • Annual letter to SAMHSA. ▪ Ensure understanding of and compliance with federal statute (42 USC [United States Code] § 300x). that governs use of MHBG funding. ▪ Assist with recruitment of members.
MHBG Funding Updates	• Overview of SAMHSA MHBG Allocation Tables. • Mandatory set asides (5% crisis; 10% early serious mental illness [ESMI], first episode psychosis [FEP]). ○ Open Dialogue/CNA overview. ○ Focus on how can DMH best support those who are experiencing signs/symptoms of EMSI/FEP. • MHBG Budget Tracker. ○ "Living document" that DMH is using to track the different funding streams of the MHBG ▪ MHBG different funding streams (regular block grant, COVID supplemental, ARPA supplemental, *etc*.) and associated timelines overview to expend these respective funding streams. ○ Pathways, as well as other peer organizations, have received an additional 8% in funding ○ Request for reviewing this tracker at next meeting in August 2022.
MHBG Training/ Overview 101	• Interest from MHBG PC Members for this training/overview. ○ Steve DeVoe will reach out to Steve Fry, previously Vermont's SAMHSA Project Officer for MHBG, to inquire about the possibility of providing an overview of the block grant and its related federal regulations ▪ Question from member regarding what is the historical reasoning for restriction of spending MHBG funding on prevention and promotion?

This meeting was not recorded. Seven members are needed for a quorum.

	• Emily noted that there is a 20% mandated set aside for the federal Substance Abuse Block Grant (SABG).
	• Discussion about restriction on MHBG for spending funds on prevention and promotion
	• Draft letter to Senator Sanders, who sits on the US Senate Committee on Health, Education, Labor, & Pensions.
	    ○ Member noted that terms "SMI" and "SED" are offensive to some community members.
	    ○ Danielle noted that DVHA uses "behavioral health" as an all-encompassing term that includes mental health, substance use (alcohol, drugs, nicotine), and eating disorders as a few examples.

Public Comment	• None.

Meeting Wrap-up/Closing	• Follow-up items from April 2022 to be discussed at August 2022 meeting.
	    ○ Request to add "Follow-up Items" section within agenda and meeting minutes to ensure proper tracking and follow-up to identified tasks/items Meeting (see "Follow-up Items" section below and amend as needed).
	• Member inquired about the Substance Abuse Block Grant's Planning Council, which is facilitated by the Vermont Department of Health, Division of Substance Use Programs, and their meeting schedule.
	    ○ Substance Misuse Prevention Oversight and Advisory Council (Public Meeting)
	        ▪ https://www.healthvermont.gov/alcohol-drugs/reports/public-meetings
	• Marla will continue to serve as MHBG PC interim chair until new calendar year (2023).

Follow-up Items	• FY2020 MHBG Outcomes.
	    ○ Goal Number 8 and 9: Steve will be following up on this question and bring the answer to the next meeting.
	    ○ Goal Number 10: Steve will also provide follow up on the 10% set aside which was led by Counseling Services of Addison County.
	• 2016 SAMHSA audit results of Vermont MHBG.
	• Create, finalize, and publish MHBG Planning Council Member list.
	• Identify next MHBG PC Chair and Vice Chair.
	    ○ Draft letter to SAMHSA.
	• Review MHBG Budget Tracker.
	• Review and discuss Vision 2030 report.
	• Recruitment of community members.

Adjournment	**Motion to Adjourn** • Alice moved to adjourn. Dan seconded the motion. All voted in favor. Abstentions none. Meeting adjourned at 2:33 pm.

This meeting was not recorded. Seven members are needed for a quorum.

10/21/2022
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☒ Marla Simpson (Chair) ☐Dan Towle (he/him) ☒ Alice Maynard ☐ C Rubin ☐ Cinn Smith ☐ Laurie Emerson (NAMI) ☒ Laurie Mulhern ☒ Daniel Blankenship

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☒ Julie Tessler ☐ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☒ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☐ Anne Rich ☒ Joanne Crawford ☐ Brian Smith ☐ Karen Barber

State of Vermont: ☒Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☐ Victoria Hudson (DCF) ☐ Annie Ramniceanu (DOC) ☐ Emily Trutor (she/her; VDH DSUP)

Public: Joe Lord – Eden Valley

Agenda

1:00 Introductions and Member Updates
1:45 Review September 2022 Meeting Minutes
1:50 MHBG Updates
2:05 MHBG PC Annual Review of Initiatives
2:45 Public Comment
2:50 Meeting Wrap-up and Closing Comments
3:00 Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
Introductions and Member Updates	• Department of Mental Health Staffing Updates – The department is currently interviewing for the Assistant Director of Quality position. Hoping to have a decision on the candidate by Monday. • Member Updates – Alice Maynard is resigning from the Council on 12/31/22. Victoria Hudson is leaving the Department of Children and Families, so she won't be able to fill the social services role for this group any longer, but she will remain on the Council. Steve has reached out to the Department of Children and Families for someone else who might want to fill that role. Laurie will send Steve contact info for Beth Sausville who can fill the state social services role. SAMSHA requires there to be someone in the group who is from a housing authority, so Daniel Blankenship is going to be joining the group • Recruitment – Steve is looking into the guidelines around bringing on new members to this group. • Membership Roster Review – Steve shared the membership roster with the group and will email it out to the group after the meeting. The membership needs to be made up of no more than 50% state employees. He would like to share on the Department of Mental Health website.
Review September 2022 Meeting Minutes	• There is not a quorum of members today, so Steve tabled the review and approval of the minutes until the next meeting.
MHBG Updates	• MHBG Bipartisan Safer Communities Act (BSCA) Supplemental Award – We received notify regarding the award at the end of July. It is part of the community MHBG process. It is another supplemental award for $138,656. It is focused on MH emergency preparedness and response. There are required set asides. Need more guidance from SAMSHA. It is more focused on planning and development of collaboration and coordination of mental health providers but also law enforcement, judicial systems, fire departments, emergency medical services, public health agencies and local agencies like community health centers. Do not want to duplicate other initiatives already in place. It was suggested that there be police training. Some suggestions were looking into Team Two or speaking with Dee Barbic and Mourning Fox. Need to have a plan for SAMSHA and it is due December1, 2022. Steve is working on plan that he can share with the group so they can provide feedback. • FFY 2023 Vermont MHBG Mini-Application Update – Steve submitted this to SAMSHA, and it has been approved by SAMSHA. The application has been posted on the DMH website - https://mentalhealth.vermont.gov/about-us/boards-and-committees/state-mental-health-block-grant. • Steve has not been able to find the final report for the 2016 audit.

This meeting was not recorded. Seven members are needed for a quorum.

	• MHBG COVID Supplemental Award and No Cost Extension Revisions – The supplemental award of $1.4 million needs to be spent by March 14, 2023, but that is not going to happen so Steve applied for a no cost extension which would set the deadline as March 14, 2024. • MHBG Implementation Report (due on 12/1/2022) – Steve is hoping to have this drafted in the next couple of weeks and send out to the group to review and provide feedback.
MHBG PC Annual Review of Initiatives	• Ranking Funding Priorities, Assessing Financials (e.g., Invoicing), Performance/Outcome Measures – It was suggested that a list of questions be created to assess the work being done and come up with outcomes. There needs to be a standardized way in which DMH requests outcomes from the receiving organizations. Need to ensure that we do not add undue burden on the organizations to provide reporting. The group will wait to come up with questions until the next meeting. Steve will send out a prompt to the group around coming up with questions for the next meeting. • Development of Standardized Questions for Annual Reporting Template – Steve is working with the Maven group to work on templates that will assist with reporting on outcomes, providing regular updates, etc. • There has been trouble getting invoices from organizations. How does DMH access that work is being done and the organization will be able to meet the deliverables.
Public Comment	No public comment.
Meeting Wrap-up/Closing	The meeting was adjourned
Adjournment	Alice made a motion to adjourn the meeting and Daniel seconded the motion. The vote to adjourn was unanimous. Adjourned at 2:21

This meeting was not recorded. Seven members are needed for a quorum.

9/16/2022
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☒ Marla Simpson (Chair) ☐Dan Towle (he/him) ☒ Alice Maynard ☐ C Rubin ☒ Cinn Smith ☐ Laurie Emerson (NAMI) ☐ Laurie Mulhern

Vermont Care Partners/DAs/SSAs: ☒ Dillon Burns ☐ Julie Tessler ☒ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☒ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☐ Anne Rich ☒ Joanne Crawford ☐ Brian Smith ☐ Karen Barber

State of Vermont: ☒Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☒ Victoria Hudson (DCF) ☐ Annie Ramniceanu (DOC) ☒ Emily Trutor (she/her; VDH DSUP)

Public: None

SAMSHA: Asha Stanly, Kisha Ledlow

Agenda
1:00 SAMSHA Presentation on MHBG
1:30 Introductions and Member Updates
1:45 Review July 2022 Meeting Minutes
1:50 MHBG Updates
2:05 Meeting Follow-ups from July 2022 Meeting
2:45 Public Comment
2:50 Meeting Wrap-up and Closing Comments
3:00 Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
SAMSHA Presentation on MHBG	Representatives from SAMSHA met with the Council and provided background information and statutory responsibilities of MHBG, as well as information on the block grant requirements, and restrictions. The PowerPoint will be shared with the group.
Introductions and Member Updates	Nicole DiStasio is now the Department of Mental Health Program Policy Director. The position of Interim Assistant Director of Quality has been posted. Eva Dayon has been acting that role. The department has now hired Puja Senning to fill the Quality Management Coordinator position. Steve is going to follow up with Julie Tessler on her participation in this group. A member of the Adult State Program Standing Committee might be interested in joining this group.
Review July 2022 Meeting Minutes	The group reviewed the July 2022 meeting minutes. Alice made a motion to accept the minutes with the suggested changes. Cinn seconded. Vote to approve the minutes was unanimous.
MHBG Updates	There is the "big" application federal fiscal year 2022 and then the in between years there is the "mini" application, which is a minor update or revision to the bigger application plan. Steve will collate all the information that was submitted to SAMSHA for this mini application because we are allowed to revise it. Steve was not able to get it to the Council before the September 1 deadline, so members can review it now. We are going to be receiving an additional supplemental award through the Safer Communities Act. Not sure of the amount of the award, but Steve will keep everyone posted. The COVID Supplemental award was approximately $1.4 million. SAMSHA notified DMH that they would be able to apply for a no cost extension. Steve will get the application to the Council to review, which was submitted on 9/8/22. The current period of performance for this award is until March 15, 2023, so this extension will give us until March 14, 2024, to expend the funds. Implementation report is due 12/1/2022. The Council would like to review this report. Council members can have access to the SAMHSA reporting platform, WebBGAS, but there is a lot of technical assistance needed to navigate it.
Meeting Follow-ups	MHBG Outcomes, Goals 8 - 10 At the 12/21 meeting, the Council discussed outcomes reporting. Goals 8 and 9 was for the VT Psychiatric Survivors Organize, Goal 8 was their operating expenses and Goal 9 was their peer operated initiatives. Steve located their quarterly

This meeting was not recorded. Seven members are needed for a quorum.

from July 2022 Meeting	reports. The Council requested the previous two years of their reports, which were quarterly reports between 10-30 pages. Steve asked the Council how they would like him to get the reports to them. To streamline the reporting, maybe the Council can ask for 10 questions from recipients, so that the information is more manageable for all and would be more easily comparable. Current reporting from subaward recipients varies greatly. Need to develop a better reporting system that provides outcomes, as well as performance measures. Steve working with Maven Group to develop standard reporting templates. Steve would like to have the DMH program point person who oversees the subaward to come to the Council to answer questions annually to report on the respective initiative. Members suggested setting up a Share Point site to allow the public to review grants and outcomes. 2016 SAMSHA audit results of Vermont MHBG This draft report is what Steve could find from this site visit in 2016. We may never receive a final report. Ask Kesha Ludlow is there was ever a final report. SAMHSA is pushing to have integrated planning councils between substance use and mental health, but Vermont has historically resisted. We are overdue for a site visit, but due to COVID there is a backlog of required site visits for SAMSHA. Identify next MHBG PC Chair and Vice Chair Marla will be stepping down in December so the Council will need a new Chair. Create, finalize, and publish MHBG Planning Council Member list The MHBG Planning Council Member list should include affiliations for the individual on the Council. SAMSHA also requires representatives from certain categories, and a certain percentage of people with lived experience or family members of those with lived experience. Steve will share the required categories with the Council. Review MHBG Budget Tracker Steve would like to share the MHBG budget information with the Council in a digestible format. What format would the Council like him to use? Spreadsheets are fine.
Public Comment	None.
Meeting Wrap-up/Closing	Lavender Life Company, Organic Lavender Products - Lavender-Life.com Through a collaboration with Lavender Life and Rutland County Foster Adopt and Kin Association, we have an opportunity to gift children meeting those definition foster, adopt and kinship one of these wonderful critters, throughout Vermont We have cats gray, black, and marmalade. If you are interested in having one of these creatures for your kiddo, Please contact our President, Sue Traverse, at 802-770-2420 or sue.traverse@yahoo.com or Cinn Smith 802-353-6817 phone or text We hope that through this interaction with the local association you will see the value of collaborating with us. We meet virtually the last Monday of the month. The link is on our Facebook page Rutland County Foster Parents. When you speak

	with Sue ask her to invite you to the Facebook group and you will have access to our meeting.We are trying to collect some data and will ask permission to share your info with your local association. Carefully designed for everyone to enjoy. Simply warm the removable heating pack in the microwave for a few seconds, giving a minimum of 20 minutes of warmth and therapeutic support. The glow in the dark heart recharges after a few minutes in the sunlight. Place the critter in direct sunlight and grab before bed to see the heart glow. Hand wash to keep your critter germ-free and fluffy
Adjournment	Cinn made a motion to adjourn the meeting and Alice seconded the motion. The vote to adjourn was unanimous. Meeting adjourned at 3:06.

This meeting was not recorded. Seven members are needed for a quorum.

2/10/2023
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☒ Marla Simpson (Chair) ☐Dan Towle (he/him) ☒ Cinn Smith ☐ Laurie Emerson (NAMI) ☒ Laurie Mulhern ☒ Daniel Blankenship (VSHA)

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☐ Julie Tessler ☒ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☐ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☒ Anne Rich ☒ Joanne Crawford ☐ Karen Barber ☒ Laura Flint ☒ Cheryle Wilcox ☒ Tom Coleman (DMH Contractor)

State of Vermont: ☒Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☐ Victoria Hudson (DFR) ☒ Annie Ramniceanu (DOC) ☐ Emily Trutor (she/her; VDH DSUP)

Public: None.

Agenda
1:00 Introductions and Member Updates
1:15 Forensic Assertive Community Treatment Project Update
1:45 Review September and October Meeting Minutes
1:50 MHBG Planning Council 1-1 Meeting Update
2:05 MHBG Updates
2:20 Public Comment
2:25 Meeting Wrap-up and Closing Comments
2:30 Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
DMH Staffing Updates	Recently hired a Director of Suicide Prevention – Christopher Allen. He was previously at Vermont Psychiatric Care Hospital. In the process of hiring a Quality Management Coordinator.
Member Updates	The group might want to consider a membership committee to recruit members. Marla will help start this committee. Steve will follow up with Puja regarding the promotional material that Laurie Mulhern drafted.
Recruitment	-Marla will be continuing as the Interim Chair for the interim. Still would like to have someone step up to become Chair. -By federal statute the group is required to have a Social Services Representative, which was Victoria Hudson, but she is not in the Dept of Financial Regulation, so we will need someone to fill this role. Steve has called the Department of Children and Families (DCF) to see if there might be someone to interested in filling that role. Victoria will remain as an at large member. -Please let folks in the community with lived experience know that there is a need for members.
Forensic Assertive Community Treatment Update	Cheryle Wilcox and Annie Ramniceanu shared a PowerPoint with the group. Forensic Assertive Community Treatment (FACT) is a service delivery model intended for individuals with serious mental illness (SMI) who are involved with the criminal justice system. These individuals may also have co-occurring substance use and physical health disorder. There was a press release from Corrections and the Department of Mental Health (DMH) letting folks know about the collaborations. In September, the Joint Justice Oversight Committee reached out to Cheryle, so she and Annie met with them. Shared information about the program and what we are looking at for outcomes. The program is a two-year grant with Pathways Vermont. Pathways Vermont is the organization providing this service. They are nearly fully staffed. The program serves individuals who are 18 or older, under the supervision of Corrections and have mental health challenges such as schizophrenia, depression, anxiety, post trauma stress disorder, etc. 100% of referrals are accepted to the program. Progress so far, 0 clients have lapsed into homelessness, 50% of participants were connected to the FACT employment specialist and 83% to the substance use specialist. 17% of participants are currently engaged in mental health counseling with an outside provider, and 50% of participants identified an interest in obtaining psychotherapy from FACT team leads. 54% of enrolled participants were actively engaged in some sort of substance use treatment or utilizing harm reduction strategies. Key part of this program is evaluation. Lead research analyst at the Department of Vermont Health Access (DHVA) who is committed to the evaluation and will be analyzing the service utilization when people are in the committee. Already have entire evaluation data definition set. Hoping this does reduce time in incarceration Will reduce emergency room visits. Folks are encouraged to join Alcoholics Anonymous (AA). If someone was reincarcerated they would continue to be a FACT participant. Housing is not available with the program itself, but it does contract with other agencies. Pathways got a van through another grant to help transport clients. There is a full-time peer specialist.

This meeting was not recorded. Seven members are needed for a quorum.

Review September Minutes	Michael Hartman made a motion to approve. Anne Rich seconded the motion. No discussion. There was one absention. The vote to approve was passed.
Review October Minutes	Michael Hartman made a motion to approve. Laurie Mulhern seconded the motion. No discussion. There were two abstentions. The vote to approve was passed.
MHBG Planning Council 1-1 Meeting Update	Tom Coleman from the Maven group. He is currently engaged in having individual discussions with each of the group members regarding the impressions of the planning council generally and related to outcomes management. He wants to give an overview of what they are doing. Maven is a contractor to the Department of Mental Health. There are two tracks: 1. The council seems focused on performance measurement. Need to think through how to implement that. Come up with a standard set of data set of informational data that could be provided to the council that would help with advising the Department of Mental Health with accessing mental health throughout Vermont. 2. Try to understand where you can opportunity to optimize your impact. Find a way to leverage everyone's skills and passions. Maybe add programming for the council. Create a tool that looks at the membership of the council to look at skill mapping. Feel free to contact Tom with input in addition to the individual sessions or reach out to Steve. This is related back to the presentation by SAMSHA in September. SAMSHA has put the Department of Mental Health in touch with other states to check in with regarding how they are using their council. Can Maven share back with some of the ideas that have been shared by council members if names are kept confidential? It was suggested that if council members are OK with putting their name to their info shared, they should feel free.
MHBG Updates	**-MHBG Bipartisan Safter Communities Act (BSCA) Supplemental Award –** This was enacted to assist with updating and improving mental health disaster preparedness. It is ~$138,000. The Department of Mental Health proposal was accepted. We have not received the funds yet but will start working across departments to update the plans that are in place. **-SAMSHA FFY 2024-2025 Block Grant Public Comments –** SAMSHA has put out a public call for comments. Steve put what they are looking for comments on in the agenda. The list is below. The community mental health block grant can not be used for prevention. The council can provide feedback on this policy.

This meeting was not recorded. Seven members are needed for a quorum.

	○ (a) whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; ○ (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; ○ (c) ways to enhance the quality, utility, and clarity of the information to be collected; and ○ (d) ways to minimize the burden of the collection of information on respondents, including leveraging automated data collection techniques or other forms of information technology. ○ See: Federal Register :: Agency Information Collection Activities: Proposed Collection; Comment Request ○ Comments due by ***Monday, February 27, 2023*** The council has various supplemental awards in addition to the base award. The base award has historically gone to the designated agencies. Discussion about a "Special Projects Fund" that would be a set aside for special projects. It is in the early stages but wanted to share an idea with the group and get feedback. This fund would have a "Notice Of Funding Opportunity" (NOFO) call for proposals from organizations or community members to provide one-time funding for projects related to adults with serious mental illness or children with serious emotional disturbance. Need to ensure there is equitable and equal opportunity for community organizations by ensuring it is available to organizations who may not have a grant manager or other types of supports. Need to lower barriers for communities, organizations, and individuals to access funding targeting these populations. DMH does not have set the amount for the project yet. Steve will have a more formal proposal of what this would look like at the next meeting.
Public Comment	No public comment.
Meeting Wrap-up and Closing Comments	
Adjourn	Michael made a motion to adjourn the meeting and it was seconded by Cinn Smith. Vote to adjourn was unanimous. Meeting was adjourned at 2:27pm.

This meeting was not recorded. Seven members are needed for a quorum.

3/17/2023
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☐ Marla Simpson (Chair) ☐Dan Towle (he/him) ☒ Cinn Smith ☐ Laurie Emerson (NAMI) ☒ Laurie Mulhern ☒ Daniel Blankenship (VHSA)

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☐ Julie Tessler ☒ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☒ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☒ Anne Rich ☒ Joanne Crawford ☐ Karen Barber ☒ Laura Flint ☒ Carolyn McBain ☒ Cheryle Wilcox ☒ Tom Coleman (DMH Contractor)

State of Vermont: ☒Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☒ Victoria Hudson (DFR) ☒ Annie Ramniceanu (DOC) ☒ Beth Sausville (DCF) ☒ Emily Trutor (she/her; VDH DSUP)

Public: ☒ David Silverberg ☒ Alison Segar (Vermont Language Justice Project)

<u>Agenda</u>

1:00	Introductions and Member Updates
1:10	Review February 2023 Meeting Minutes
1:15	MHBG Updates
1:55	Break
2:00	MHBG Planning Council 1-1 Meetings Update
2:10	Vermont Language Justice Update
2:40	Public Comment
2:45	Meeting Wrap-up and Closing Comments
2:50	Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
DMH Staffing Updates	None.
Recruitment	None.
Review February 2023 Meeting Minutes	Daniel Blankenship made a motion to approve. Victoria Hudson seconded the motion. No discussion. Vote to approve was unanimous.
SAMSHA MHBG Technical Assistance Project	SAMSHA released information around providing technical assistance (TA) for block grants. This will help states and territories to focus on a particular area of improvement around block grant management, oversight, or planning councils. Because of staffing issues, previously SAMSHA had chosen to no longer issue Technical Assistance directly, and so gave funds to the states to facilitate it themselves. This TA is available again. Regarding peer related work around Technical Assistance, SAMSHA will pull together subject matter experts from around the country as a resource. They will also do needs assessments. They will give you full reports and data. They will also assist with implementation of innovative and evidence-based models. They will provide on-site and off-site assistance. Send recommendations to Steve on how best to use this assistance.
SAMSHA State Planners and Planning Council Members TA Listening Sessions	SAMSHA is providing State Planner and planning council Technical Assistance listening sessions. Steve is the State Planner and he can delegate someone from this group to attend those sessions. This is an opportunity to provide feedback directly to SAMSHA. The sessions will be on April 18 and April 19. Steve can provide more information on this event. I. Tuesday, April 18, 2023, at 4:00 PM EST • https://protect-us.mimecast.com/s/dFimC73Bm5cpAr4i0YGNe II. Wednesday, April 19, 2023, at 6:00 PM EST • https://protect-us.mimecast.com/s/ZaAzC9rEo5i3kJLuGW9uE
MHBG "Special Projects Fund" Notice of Funding Opportunity	The special projects funds is a way for organizations who have innovative ideas on how to support individuals with severe mental illness or children with severe emotional disturbance. The council last months said yes to moving forward with these projects. Lee Dorf and Steve developed a "Notice Of Funding Opportunity" (NOFO) form. Steve shared the form with the group for review. Broad outreach is important in order to be sure to include a wide range of organizations. What is the criteria for the organizations that may want to apply? We need to think strategically on how to get the money out the door. Be careful about awarding to agencies/organizations that are already spread too thin

This meeting was not recorded. Seven members are needed for a quorum.

	and potentially could not complete the work. Timeline for posting NOFO is the next few months with work to start in Fall 2023. This the first time of working on this so need to work out any wrinkles.
Break	
MHBG Planning Council 1-1 Meetings Update	Update from Tom Coleman from Maeven Group on general themes that he has collected from the one-on-one interviews he has had with members of the group. He still needs to meet with four more members. Everyone has been very candid. Once the meetings are done, he will produce a list of ideas that came up. There will need to be a refresher or rebase outlining on the planning council; what it is, the statutory roots and what other states have done. This will make sure everyone is on the same page. Look at different roles that the council can take. Do some skill and interest mapping. Who can we leverage for what kind of topics. Will be doing some preliminary outreach to other planning council to see what they have been working on. Will focus on similar size states.
Vermont Language Justice Project Update	**https://www.vtlanguagejustice.org/** **https://www.youtube.com/watch?v=e3XkzHyHagg&list=PL0uaGz81U--4qm3iFDMfvZJbQEXOulnzX&index=1** Alison Segar started the VT Language Justice Project three years ago. The impetus for the project was the fact that COVID resources were only produced in English. Anyone who did not speak English was left without the information needed to stay safe and health. The first of the videos produced by the project were about COVID. They are now part of CCTV (community access television). So far, over a 100 videos have been put out. COVID test videos went out in 16 languages and American Sign Language. There are over 400 plus subscribers to their YouTube channel with 27,000 hits on the channel. Working on videos on suicide right now. One for adults and one for youth. Anyone that would like to reach out to Alison can contact her at asegar@cctv.org.
Public Comment	A member of the public asked the Council revisit First Episode Psychosis initiatives. David S. brought his story to the Vermont Department of Mental Health and Steve invited him to this meeting. Is there a way to find out how much the state spends on early childhood mental health? Yes, it can be found in the Department of Mental Health's budget line items. **http://www.vermontbusinessregistry.com/BidPreview.aspx?BidID=57567** **http://www.vermontbusinessregistry.com/bidAttachments/57567/RFP%20EEP%20Initiative%202-15-23.pdf** The designated agencies were unable to diagnosis this individual's family member's psychosis.
Meeting Wrap-up and Closing Comments	What is this council doing to advocate besides sitting in meetings and approving budgets? The group should start thinking about this. It was requested that this be put on the next month's agenda.

This meeting was not recorded. Seven members are needed for a quorum.

Adjourn	Laurie Mulhern made a motion to adjourn. Anne Rich seconded the motion. The vote to adjourn was unanimous. Meeting adjourned at 258p.

This meeting was not recorded. Seven members are needed for a quorum.

5/19/2023
Mental Health Block Grant Planning Council Minutes *****FINAL*****

Present Members: ☒ Marla Simpson (Chair) ☒Dan Towle (he/him) ☒ Cinn Smith ☒ Laurie Emerson (NAMI) ☒ Laurie Mulhern ☒ Daniel Blankenship (VHSA)

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☒ Julie Tessler ☒ Michael Hartman ☒ Molly Shriver Blake (Pathways Vermont)

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☒ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☒ Anne Rich ☒ Joanne Crawford ☐ Karen Barber ☒ Laura Flint ☐ Carolyn McBain ☒ Tom Coleman (DMH Contractor)

State of Vermont: ☐Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☐ Victoria Hudson (DFR) ☐ Annie Ramniceanu (DOC) ☐ Emily Trutor (she/her; VDH DSUP)

Public: ☒ Sandi Yandow (Vermont Federation of Families for Children's Mental Health) ☒ David Silverberg

Agenda

1:00 Introductions & Member Updates
1:10 Review March 2023 Meeting Minutes
1:15 MHBG Updates
1:30 MHBG Planning Council 1-1 Meetings Update
2:00 Pathways Vermont Support Line Overview
2:15 Public Comment
2:25 Meeting Wrap-up and Closing Comments
2:30 Adjournment

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
Introductions	Introductions were made.
DMH Staffing Updates	Hired a new Communications Director, Alexandra Frantz, and 2 new data analysts, Jess Whitaker and Michelle Rogals. Legislative session is wrapping up that includes mental health-related bills.
Member Updates	Are there funds that can be used to assist some of the people who will be or are homeless? This group can take a look at possibilities.
Recruitment	-Mental Health Block Grant (MHBG) PC Chair/Vice-Chair -At-large Members Marla will stay on as Interim Chair until someone else fills that role. Still recruiting for members at large, specifically individuals with lived experience or family members of those with lived experience. Please share information about the group widely.
Review March 2023 Meeting Minutes	Dan made a motion to approve. Anne seconded the motion. No discussion. Vote to approve was unanimous.
SAMSHA Planning Council Introductory Manual	Steve received a "SAMHSA Planning Council Introductory Manual" manual from Vermont's Project Officer at SAMSHA. This guidance was just released on Tuesday, 5/16/23. They are looking to have some standardization on how planning councils are utilized nationwide for block grant oversight. Dovetails with the interviews that Tom has been doing. If you have not seen the manual, Steve can send a copy to you.
SAMSHA MHBG Technical Assistance	There is technical assistance (TA) available related to the block grant. It can be used for anything related to the block grant. How do we measure from a performance standpoint, are we measuring the right things to make sure what we want is occurring? Need standardization to make sure we can compare and see how it is impacting people's lives. This TA is free for Vermont, specifically this council. SAMSHA has recently called out Vermont on its use of the 10% set aside for first episode psychosis and early serious mental illness (FEP/ESMI). These funds need to be used for evidence-based programs. The only evidence-based program that they have identified is the "Coordinated Specialty Care" program. Vermont met with SAMHSA this past Monday, 5/15/23, and SAMHSA stated that Vermont is the only state that does not have a CSC program. SAMSHA does not recognize Collaborative Network Approach/Open Dialogue (CNA/OD) as an evidence-based program. A question was asked if the funds can be used for the Soteria House. Steve thought that Vermont could potentially use these 10% set aside funding for Soteria House. Steve will put some links in the meeting minutes around what coordinated specialty care is so people are aware of it. • An Overview of Coordinated Specialty Care (CSC) for Persons with First Episode Psychosis | National Association of State Mental Health Program Directors (nasmhpd.org)

This meeting was not recorded. Seven members are needed for a quorum.

	• NIMH » Recovery After an Initial Schizophrenia Episode (RAISE) (nih.gov) • evidence-based-treatments-for-first-episode-psychosis.pdf (nih.gov) • The American Psychiatric Association Practice Guideline for the Treatment of Patients With Schizophrenia | American Journal of Psychiatry (psychiatryonline.org) Is there any discussion around doing this regionally? SAMSHA said they would like one program in Vermont set up.
DMH Special Projects Fund Notice of Funding Opportunity Update	As a department, DMH is moving forward. These funds will be intended for one-time specialty projects. DMH is looking to have a certain amount of MHBG funds set aside to fund proposals/projects, once they have been reviewed and approved. It was asked if Steve could get some examples for other small states on what programs they are funding, but it is unclear whether it is possible to know this information at present. Steve will follow up with Vermont's SAMHSA MHBG Project Officer.
Update from Tom Coleman, Maven Group/RiverNorth	Vermont Mental Health Block Grant Planning Council (MHBG PC) Member Impression Update: He has had one on one sessions with most of the council members. Working on process improvement initiatives. Working to come up with outcomes which will be complied into some findings. Conducted 12 interviews. Goal is around 4 areas: What does the MHBG PC currently do well? What challenges does the MHBG PC have? Where are there opportunities to improve impact and efficiency of the MHBG Pc? What are the individual members' passions and strengths? Expected Outcome: There results of our discussions will be anonymized and provided to DMH in a summary report and shared with the MHBG as well. MHBG Strengths: • Consistent and Effective DMH Representations • Passionate Membership who care personally • Strong working relationship between PC and DMH • Increased focus on performance monitoring • Remote meetings help with participation • PC facilitation is not overly burdened with process MHBG Challenges: • Difficult for new members to get up to speed

	• Difficult accommodating all schedules • Challenge attracting non-state members • Unclear understanding of statutory program authorities • Discomfort concerning dissenting opinions Improvement Suggestions: • Generally: The improvement suggestions that we collected reflect a mix of suggestions that address perceived weaknesses or ideas about how the MHBG PC could provide additional value if the necessary bandwidth and skills could be marshalled. Next Step: • When all interviews are conducted, we will distribute the final suggestions list to the MHBG and DMH for consideration. Suggested Improvement: • Develop a new member primer – Create an onboarding • Periodic Programmatic Updates from SAMSHA or DMAH • Improved Performance Management • Statewide/Political Advocacy • Enhance Public Outreach – Define a Public Outreach function with specific initiatives tht the MHBG PC can take on that can publicize mental health • Establish Simple Data Visualizations for Outcomes – Create data visualization templates for existing data sources (budgeting, performance measurements, etc.) • Improvements to Meeting Scheduling – Take a multi-pronged approach to scheduling which provides sufficient advance notice of expected meeting times with the flexibility to pivot as needed to maximize participation closer to the time of meetings. • Establishing Communication Norms – Document agreed upon principles for how the MHBG PC and its members communicate and conduct business • Survey Grant Recipients on Experience and Impressions – Seek MHBG PC Grantee inputs on targeted questions or their experience with the MHBG PC program generally

This meeting was not recorded. Seven members are needed for a quorum.

	• Host Expert Panel Discussions – As part of its mission to assess the mental health system, the MHBG PC could organize topical panel presentations to the MHBG that provide state, academic, practitioner, and lived experience insights • Coordination with SABG and/or other State Councils – Determine whether there are opportunities from a subject-matter or best practices perspective to work with other State boards and councils
Molly Shriver-Blake, Pathways Vermont Rapid Rehousing and Community Services Manager	Molly is the Pathways Vermont Rapid Rehousing and Community Services Manager The Pathways Vermont Support line is a warm line where folks call in and tend to be in less of a crisis. Working with 9-8-8 to partner in this work. There are no barriers for calling. Completely confidential. Currently in 4th quarter of this fiscal year. In the last 3 quarters, the call volume has increased and thinking that the increase is due to the partnership with 9-8-8. Averaging 1,271 calls a month which includes texts. 60% came from unique numbers. There are some folks who call every day. One of the metrics Pathways reports is on the number of people who speak with an operator within 24 hours. Some folks who call are diverted from Designated Agency Emergency Service Teams. They did not have to connect anyone this quarter with 9-1-1. The line is peer run and managed. Operators come from a place of understanding. Most of staff have been through their own lived experiences. People call for support and for connection, and many calls are around grief or loss, substance use, extreme states, thoughts of suicide. Most calls are coming from Rutland County, then Washington and Chittenden Counties. Is there a breakout of where calls come from in the state? Yes. There are highlights on their website. Pathways Vermont Support Line - Pathways Vermont Steve asked for materials that she might be willing to share with the group. She will provide back to the MHBG PC.
Public Comment	A guest at the meeting to discuss CSC with the Council. Key to connect folks with programs out of state. No early intervention available right now. He suggested wilderness therapy of a good possibility for youth.
Meeting Wrap-up and Closing Comments	None.
Adjourn	Marla motioned to adjourn the meeting and Dan Towle seconded. Vote to adjourn was unanimous. Meeting adjourned at 231p.

This meeting was not recorded. Seven members are needed for a quorum.

7/21/2023
Mental Health Block Grant Planning Council Minutes *****DRAFT*****

Present Members: ☒ Marla Simpson (Chair) ☒Dan Towle (he/him) ☒ Cinn Smith ☒ Laurie Emerson (NAMI) ☒ Laurie Mulhern ☒ Daniel Blankenship (VHSA)

Vermont Care Partners/DAs/SSAs: ☐ Dillon Burns ☐ Julie Tessler ☒ Michael Hartman

DMH: ☐ Eva Dayon (they/them) ☒Steve DeVoe (he/him) ☐ Trish Singer (she/her) ☐ Nicole DiStasio (they/she) ☒ Anne Rich ☒ Joanne Crawford ☐ Karen Barber ☒ Laura Flint ☒ Carolyn McBain ☐ Tom Coleman (DMH Contractor)

State of Vermont: ☐Heather Bouchey (AOE) ☒ Danielle Bragg (DVHA) ☐ Diane Dalmasse (DAIL) ☒ Victoria Hudson (DFR) ☐ Annie Ramniceanu (DOC) ☐ Emily Trutor (she/her; VDH DSUP) ☒ Beth Sausville

Public: ☒ Christopher Rotsettis ☒ David Silverberg ☒ Kristin Brynga

Agenda
1:00 Introductions & Member Updates
1:10 Review May 2023 Meeting Minutes
1:15 MHBG Updates
1:35 MHBG Planning Council 1-1 Meetings Update
1:45 Public Comment
1:50 Wrap-up and Closing Comments
2:00 Adjourn

This meeting was not recorded. Seven members are needed for a quorum.

Agenda Item	Facilitator/Timekeeper: Steve DeVoe; Minutes: Joanne Crawford
Introductions	Meeting called to order at 1:03.
DMH Updates	Ramping up Certified Community Behavioral Health Clinics (CCBHCs) Planning Grant work that DMH received along with the Vermont Department of Health Division of Substance Use Programs. DMH has met with some Designated Agencies (DAs) who also have SAMSHA CCBHC grants: Clara Martin Center, Rutland Mental Health Services, Health Care & Rehabilitation Services, and Northeast Kingdom Human Services. The other 6 DAs also submitted CCBHC applications and they would hear in September 2023 if they received the grant. The State's CCBHC Core Project Team is Laura Flint is Project Director, Nicole Distasio is the Policy Lead, Shannon Thompson is the Finance Lead, Steve DeVoe is the Mental Health Clinical and Quality lead, and Megan Mitchell is the Substance Use Clinical Lead. It began March 2023 and will go through March 2024. DMH is exploring possibility of applying to become a CCBHC Demonstration State. Vermont was one of 15 states that were selected for this round. DMH created a web page on the DMH website for folks to find more information. https://mentalhealth.vermont.gov/about-us/department-initiatives/ccbhc Manatt is the contractor working the DMH. If people have more questions they should feel free to email Steve to discuss.
Member Updates	Tabled until the next meeting.
Recruitment	-Mental Health Block Grant (MHBG) PC Chair/Vice-Chair. This group is still looking for someone to consider running for Chair or Vice-Chair. -At-large Members
Review May 2023 Meeting Minutes	There was one change suggested regarding the attendees at the last meeting. Michael Hartman made a motion to accept with the change and Dan Towle seconded. The vote to approve was unanimous.
FFY 2024-2025 MHBG Application	Steve is currently working on drafting the FFY 24-25 Mental Health Block Grant application. The "big" application needs to be submitted every other year and a small application on the off years, so this year is the big application. Steve will send the group a copy of the application so they can provide input. There is a short turnaround time for reviewing an application of this size. Steve has scheduled for this group to review it between August 1-8. After this group reviews it, it will also need to be reviewed by the DMH Commissioner's Office and the AHS Secretary's Office. Steve will need a letter from the Chair by the end of August 2023 for the application.
SAMSHA MHBG Technical Assistance	Steve submitted a request to SAMSHA for technical assistance on implementing a Coordinated Specialty Care (CSC) Program in Vermont using the 10% set aside for First Episode Psychosis award amounts. https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.05.5.1 CSC is the identified evidence practice for people with first episode psychosis. We are one of two states in the US that does not have a Coordinated Specialty Care Program. Steve will send information on Coordinated Specialty Care Program to the group. There will be a lot of stakeholder input.
MHBG Planning	Steve shared the document that Tom Coleman from the Maven Group sent to him which is an overview of the results from the 1-1 interviews. Some of the strengths that were shared were: 1) Consistent and strong facilitation, 2) Members care

This meeting was not recorded. Seven members are needed for a quorum.

Council 1-1 Meetings Update	about mental health, 3) Strong working relationship with DMH, 4) Moderate progress on performance monitoring, 5) Remote meetings enable participate, 6) MHBG PC is not burdened with process. The weaknesses that were shared were: 1) No clear on-boarding process, 2) Sporadic attendance, 3) Need for Better Organization, 4) Challenges in attracting non-state members, 5) Need for communication norms.
Public Comment	A member of the public was able to work Mass General hospital and have their daughter participate in a Coordinated Specialty Care program. She is much improved after being part of the program.
Meeting Wrap-up and Closing Comments	Steve will share a website for resources from the flooding. https://mentalhealth.vermont.gov/flood https://www.vermont.gov/flood#gsc.tab=0 A minute of silence was held for those affected by the flooding.
Adjourn	Laurie Emerson made a motion; Victoria Hudson seconded the motion. The vote to adjourn was unanimous and the meeting was adjourned at 1:52pm.

Vermont Mental Health Block Grant Planning Council
Operating Policies & Procedures

1. Scope

The Vermont Mental Health Block Grant Planning Council (MHBG-PC) Operating Policies & Procedures shall act as guidance to the operation of the MHBG-PC. The current edition of Robert's Rules of Order Newly Revised shall govern the MHBG-PC in all cases to which they are applicable and in which they are not inconsistent with these operating procedures and any special rules of order the MHBG-PC may adopt.

2. Overview/Purpose

The Overview/Purpose of the Vermont Mental Health Block Grant Planning Council is defined in the Planning Council Charter adopted on April 27, 2017.

3. Membership

3.1 Appointment

Membership on the Planning Council is by appointment of the Governor of Vermont, as delegated to the Secretary of the Agency of Human Services (AHS). Members shall serve for the tenure of the Secretary with the authority of the Governor [3 V.S.A. §3024 (2016)].

3.2 Composition

The federal law (42 USC [United States Code] § 300x-3 [c]) states that planning councils must contain the following people:

- Representatives from the following State agencies: Mental Health, Education, Vocational Rehabilitation, Criminal Justice, Housing, Social Services, and the State Medicaid Agency.
- Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.
- Adults with serious mental illness who are receiving (or have received) mental health services.
- Families of such adults and families of children with serious emotional disturbance.

3.3 Size and representation

The MHBG-PC will consist of 18 members or more, providing that at least 51% of the members are other than state employees or providers of mental health services. Consideration will be given to a diversity of membership including but not limited to racial, ethnic, LGBTQ, geographic and age diversity.

- The ratio of parents of children with serious emotional disturbance to other members of the council must be sufficient to provide adequate representation of such children.

3.4 Resignation

Any planning council member may resign at any time upon delivery of his or her resignation in writing to the Mental Health Block Grant Planner. Such resignation shall be effective upon delivery unless specified to be effective at a later date.

3.5 Removal
If a member fails to notify for three missed meetings, it is assumed that the member has resigned from the group.

4. Meetings
The MHBG-PC shall meet at a minimum five times a year to have sufficient time to fulfill their responsibilities.

4.1 Quorum
Seven members shall constitute a Quorum.

4.2 Voting
Members may vote in person or when participating in a meeting telephonically or other electronic means.

5. Officers
The membership shall elect a Chair and Vice Chair each of whom shall serve for a two-year term. The election shall take place at the first meeting following the new calendar year.

5.1 Chair
The Chair shall preside over all meetings of the MHBG-PC and work in collaboration with the state planner to develop the agenda for council meetings.

5.2 Vice Chair
In the absence of the Chair, the Vice Chair shall assume the duties of the chair.

6. Committees
Standing and Ad Hoc Committees may be formed by a vote of the membership as the need arises.

6.1 Executive Committee
The Executive Committee shall consist of the Chair, Vice Chair, and Chair of those committees that may be established by the membership.

7. Reimbursement
Members appointed to the MHBG-PC who are not otherwise paid to attend meetings or to participate by telephone may request reimbursement of mileage and/or a stipend from the Department of Mental Health consistent with expense reimbursement policy that apply to meetings of constituent groups.

8. Revisions to Operating Procedures

The MHBG-PC may from time to time revise these operating procedures by an affirmative vote of a quorum provided that notice of the proposed revision is given at a minimum of fourteen (14) days in advance of the meeting.

9. Operating Principles

9.1 Results Based Accountability

The MHBG-PC shall embed a Results-Based Accountability approach into its work. This describes two levels of accountability to improve outcomes: Population Accountability and Performance Accountability.

9.2 Collaboration with Standing Committees

The MHBG-PC shall collaborate with the State Program Standing Committee for Adult Mental Health and the State Program Standing Committee for Child, Adolescent, and Family Mental Health in a manner that complements the particular role and expertise of each group in order to enhance the mental health services system, sustain advocacy, and avoid duplication of effort.

10. Annual Survey

10.1 The MHBG Planning Council shall conduct an annual survey of members relating to their experiences on the council.

VERMONT

State of Vermont
Department of Mental Health
280 State Drive, NOB 2 North
Waterbury, VT 05671-2010
http://mentalhealth.vermont.gov/

Agency of Human Services

[phone] 802-241-0090
[fax] 802-241-0100
[tty] 800-253-0191

Substance Abuse and Mental Health Services Administration
Office of Financial Resources, Division of Grants Management
5600 Fishers Lane, 17E25D
Rockville, MD 20850

August 24, 2023

Dear SAMHSA Grants Management Representative:

Thank you & warm gratitude to you & everyone at SAMHSA for your consideration & help! We continue to live in unprecedented times. Vermont was just rocked in a terrible way with extreme flooding. This natural disaster echoed many memories of Hurricane Irene in the summer of 2011. "Vermont Strong" was our message then, & it remains so.

We are all so grateful for the Mental Health Block Grant funding and express sincere thanks, as well, for additional block grant supplemental funding.

We would like to reach & support people at all levels of life & being. We are pleased to share that Vermont led the country, per capita, in 2021, in vaccination rates. Throughout the pandemic our Mental Health Block Grant Planning Council (MHBG PC) met & still holds meetings remotely/virtually.

The Vermont MHBG PC remains comprised of many robust & independent thinkers who contribute, with devotion, to our collective goals. We are happy to report that Members still work collaboratively & communicatively with the Vermont Department of Mental Health (DMH). We continue working towards alignment of funding priorities with the system of care plan. MHBG PC Members are solidified by a blend of advocates, professionals, people with lived experience, family members, & state employees. The MHBG PC continues to be a valuable Advisory Body to DMH. In addition, the Council has help from the Maven Group to help organize & prioritize the needs & goals of our group.

Vermont also continues to reveal unique approaches to humane & holistic areas of care in mental health & well-being. It is vital to note that the MHBG PC votes & updates its priorities. Last year, our compelling themes shifted somewhat. The following were our voting results for this past funding cycle:

- Reducing Emergency Rooms as mental health "parking lots";
- Suicide Prevention;
- Vermont Department of Corrections DOC pre-custody mental health screening & evaluation;
- Crisis Interventions;
- National Suicide Prevention Lifeline;
- Children's Respite; Mental Health Services for people in custody;
- Mental Health reducing stigma/discrimination (e.g., Public Service Announcements);
- Housing (vouchers, supported housing, rental assistance); &

- Youth in Transition.

Following the above, we also have Peer Services. The Council would also like to research & assist with more drug & alcohol treatment, as well as prevention advocacy. Further, suicide prevention & supports are one of our leading urgent topics of conversation & planning. We politely request that SAMHSA add "PREVENTION & PROMOTION" as acceptable goals & missions of funding dollars. It is so much easier to be useful to people if we are being preventative & aware versus letting the situation explode into emergencies & chaotic crises. Below is a list of current, relevant areas in need of attention & further development.

Vermont is one of the most welcoming states in support of diversity, as well. Our Council would like broad representation & continue to be inclusive. We would like more Veterans on the Council, for example. Vermont is also sensitive to refugees & people fleeing war-torn countries to try to find safety & solace. The War on The Ukraine worries & saddens so many of us; many in Vermont have rallied to help support & send much-needed-supplies to the country in the spirit of "Act Locally but Think Globally."

A myriad of people exist in crisis. Very often I hear "there are no [hospital] beds available." We still have a big problem with the crises in our state’s emergency departments. Too many people, of all ages, wait for hospital beds, yet Vermont is doing its best to fix & heed attention to this problem.

While on the topic of some upsetting things, I need to convey concerns of our Council Members about SAMHSA's "archaic", "outdated", & "derogatory" use of language. Specifically, pejoratively labeling people with "SED," "SMI," "Consumer," & "Behavioral Health." We also object to lumping BIPOC & LGBTQ together in surveys. This is very unfair to people. These antiquated methods only keep people away from seeking services. In a collaboration, Vermont would like to erase mental health stigma. Please evolve SAMHSA's language into the 21st Century & 2022. A couple of suggestions are calling people "Individuals," or "Clients." Please replace “illness” with “mental health conditions”. Would SAMHSA be willing to make these important language changes?

Mental health populations are aging rapidly. If we do not keep up with the hopes & needs of our younger generations, then they will not as readily seek services. Please, join Vermont in the "Transformative Powers of 2022 & Beyond." We still aim, as well, to lessen or eradicate any coercive actions. i.e., "Seclusion/Restraints," "Un-necessary force by Police." Vermont’s program of embedded mental health specialists with the Vermont State Police is a welcome change of the traumas of the past, yet that can still bleed into our present times. We strive for humane & compassionate care & consideration of all people. "It's not what's *wrong* with you, but what *happened* to you." This is an 11-year-old-or-more saying from IPS [Intentional Peer Support].

The Green Mountain State is fortunate, though, to have leading, innovative, & remarkable preventative services, as well: The VT Support Line (24/7); The Crisis Text Line; The Suicide Lifeline; & Peer-Hosted Crisis Respites (alternatives to costly, expensive hospitalizations & step-downs from hospitals); designated community mental health agencies; crisis lines; a multitude of valued services. We would like to see people thrive & enjoy being alive. It is fair to say that Vermont pushes forward into the future for exemplary quality & accountability.

Former U.S.A. President Calvin Coolidge, from VT, said this: "Vermont is a state I love. I could not look upon the peaks of Ascutney, Killington, Mansfield and Equinox without being moved in a way that no other scene could move me. It was here that I first saw the light of day; here I received my bride; here my dead lie pillowed on the loving breast of our everlasting hills. I love Vermont because of her hills and valleys, her scenery and invigorating climate, but most of all, because of her indomitable people. They are a race of pioneers who almost beggared themselves to serve others. If the spirit of liberty should vanish in other parts of the union and support of our institutions should languish, it could all be replenished from the generous store held by the people of this brave little state of Vermont."

Therefore, on behalf of the MHBG Planning Council, I'd like to share that last year, in 2021, Vermont was rated as "BEST ACCESS TO MENTAL HEALTH CARE in the U.S.A." [NAMI-VT Conference; February 2021]. We all realize a vast amount of work awaits us, still. It's important to note that DMH's Leadership for The Council continues to blossom with excellence. We are very impressed by their attention to detail; specific information they impart so well; the highly advanced graphs, charts, outcomes using the Results Based Accountability framework.

The Vermont Mental Health Block Grant Planning Council would like to thank SAMHSA for its generous regard & consideration of Vermont. On behalf of the whole Council, we convey our sincere gratitude. Everyone working together is what makes this group "Priceless." Hellos to you all from our 'brave little state of VT."

Respectfully & warmly submitted:
M.S. Simpson, M.A.
Chair
Vermont Mental Health Block Grant Planning Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Daniel Blankenship	Providers	Vermont State Housing Authority		
Heather Bouchey	State Employees	Agency of Education		
Danielle Bragg	State Employees	Department of Vermont Health Access		
Kristin Brynga	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Diane Dalmasse	State Employees	Division of Vocational Rehabilitation		
Laurie Emerson	Others (Advocates who are not State employees or providers)	NAMI--Vermont		
Michael Hartman	Providers	Lamoille County Mental Health Services		
Victoria Hudson	Others (Advocates who are not State employees or providers)			
Laurie Mulhern	Parents of children with SED			
Annie Ramniceanu	State Employees	Department of Corrections (Criminal Justice)		
Anne Rich	State Employees	State of Vermont Department of Mental Health		
Christopher Rotsettis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Beth Sausville	State Employees	Department for Children and Families		
David Silverberg	Parents of children with SED			
Marla Simpson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Cynthia Smith	Parents of children with SED			

Dan Towle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	3	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	2	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**9**	**52.94%**
State Employees	6	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**8**	**47.06%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**17**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://humanservices.vermont.gov/about-us/central-office/fiscal-operations/vermont-human-services-plan/2024-human-services-plan

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

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Footnotes: