Thank you for inviting me to testify today. I am speaking to you as a citizen of Vermont.

I have been involved in many aspects of mental health system and advocacy since March of 2016.

I am a NAMI Vermont Board member. I am a member of both DMH's Adult and Children's State Program Standing committees. I am a member of Disability Rights Vermont's PAIMI council. I attend UVMMC's program quality committee meetings. I have attended EIP and Mental Health Block Grant meetings. I was very active in the ACT-82 Legislative Workgroup committees that investigated ways to improve Emergency Department wait times. I participated in a group consisting of people from VCP, VAHHS, DMH, GMCB, UVM SEGS Lab, and a researcher at University of North Carolina to propose the use of analytical approaches to improving our Vermont Mental Health system. I lead a group of peers and peer support professionals that were involved with the detailed planning and design of the Central Vermont Medical Center psychiatric bed expansion.

There are two points I want to talk about today.

1) I support the need for more investment in real Community-Based Resources

2) I am opposed to revising the DAIL licensing regulations for Therapeutic Community Residences that would allow the use of seclusion and restraints in the proposed replacement of the Middlesex Secure facility.

Real Community Based Resources.

It seems that too often our plan for adding community-based resources uses a **"but first"** approach. What I mean by that is it seems there is always another project that needs to be done first before Community Resources. These investments are usually at the point in our System of Care that are most traumatizing, most restrictive, and most financially costly for the person. Yes, people stay too long in emergency departments (ED). There is a consensus that EDs are not therapeutic. Many people call out for more community based alternatives to the ED yet what I here is "we believe there is a need for community resources **but first**….." **But first** we need to expand the inpatient beds at the UVM Central Vermont Medical Center. (There are 20 million dollars of Vermonters money in a UVM Health Network bank that could be used for community-based resources.) Then **but first** we need to expand our Level 1 beds at the Brattleboro retreat. Then **but first** we need to expand and renovate our hospital emergency departments to make them more like mental health crisis centers. And again, I hear **but first** we need to expand our secure residential facility.

	Beds	**Est. Operating Cost/day**	**Est. Annual Operating Cost**
New Brattleboro Level 1	12	$ 1,800.00	$ 7,800,000.00
New Secure Residential	9	$ 1,500.00	$ 4,900,000.00
New CVMC Level 1	8	$ 1,800.00	$ 5,200,000.00
			$ **17,900,000.00**
Current Level 1 Beds	45		
Middlesex Secure Residential	7		

Current Total	**52**		
Planned Total	**81**		

It feels like we have used the ED wait problem multiple times as justification for adding beds.

We decided to add 12 Level 1 beds at Brattleboro. We spent money but the beds are not online. We still have the ED wait problem.

We decided to add 8 Level 1 beds at CVMC. We spent money at CVMC but the beds are not online. We still have the ED wait problem.

We are considering adding 9 beds in a secure residential. We spent a lot of money and the beds are not online.

We have made plans to add 29 beds when it is possible that the 12 new beds at Brattleboro are enough to resolve the ED wait problem.

Is adding inpatient beds really the right solution each time?

Disability Rights Vermont published the report “Wrongly Confined” in March of 2020. This report explains how Vermonters are being held in restrictive setting be due to a lack of sufficient community capacity. People that are stuck in this system can feel a sense of hopelessness.

The following is an excerpt from the report “Wrongly Confined”.

> *“Over twenty years ago the U.S. Supreme Court issued the landmark decision in Olmstead v. L.C. affirming that people with disabilities have a right to live in the most integrated setting appropriate to their needs, and that the failure to realize such integration is a violation of the Americans with Disabilities Act. Yet still today many Vermonters with disabilities are harmed by being held in hospitals, especially psychiatric units, long after their doctors say it is safe and appropriate for them to be discharged.”*

I believe that DMH has already testified to this committee about barrier days and how insufficient resources (ie. group homes, intensive residential services, and independent housing) contributes to this problem. Adding resources as we have been doing doesn’t solve our problems, but it does add to our capacity to wrongly confine people. Maybe we need to stop the “**but first”** approach we have used for inpatient care and put our community resources **first**.

Seclusion and Restraints at the Secure Residential.

I don’t believe we should allow EIPs at the new secure residential facility.

As I understand it DMH’s primary reason for adding Emergency Involuntary Procedures (EIPs) (ie. Seclusion, restraints, forced medication) is that without that capability people who become escalated now need to be transitioned back to an inpatient hospital setting. This transition now includes a traumatic trip through an emergency department before being admitted to a hospital. Seclusion and

restraints are also a traumatic process and does not represent therapy. Advocates have asked for data as to how often these events are happening within Middlesex. DMH has not shared this data. The transfer of a person to inpatient hospitals is likely a very rare event. If EIPs are allowed I expect EIPs will occur much more often than a transfer to inpatient.

So, we are trying to decide between one of two bad things <u>without data</u>. At this point I think it is best to not allow EIPs at the new secure residential facility.

DMH should still use the Six Core strategies approach for reducing EIPs at their secure residential facility. The Six Core strategies is a quality improvement approach that works to eliminate <u>the conditions</u> that cause a person to escalate. The strategy works to <u>eliminate the root cause of the need</u> for an EIP. **The Six Core strategies approach can correct the root cause for EIPs without actually needing them to be performed in the new facility.**

DMH could also explore ways to reduce the trauma involved with transitioning someone from a secure residential facility to an inpatient hospital. For example, why is it necessary for someone to go to a hospital emergency department before being admitted to an inpatient bed. Some people in Vermont are already being admitted to psychiatric inpatient beds without needing to pass through an emergency department.

Thank you for inviting me to speak with you today.

Ward Nial

South Burlington Vt.