NAMI Vermont
National Alliance on Mental Illness

Laurie Emerson, Executive Director
National Alliance on Mental Illness of Vermont
February 4, 2021

Chairman Lippert, Madam Vice Chair Donahue and Members of the House Health Care Committee,

Thank you for allowing NAMI Vermont to provide testimony to your committee for Mental Health Advocacy Day/Week. My comments will focus on two areas: 1) mental health crisis response; and 2) Telehealth testimony in a psychiatric facility from a community member.

This year's Mental Health Advocacy Day was held virtually bringing together over 250 advocates and organizations on Feb. 1st. If you were not able to attend, we recorded the event. Here is a link: www.youtube.com/watch?v=6OyOBW8JWLc&feature=youtu.be

When a mental health crisis happens, it should get a mental health response. The handcuffing and pepper-spraying of a nine-year-old girl in Rochester, New York, last Friday by local law enforcement after a crisis - DESERVED HELP - not handcuffs and pepper spray. NAMI believes that responses to situations like this family's crisis should be met by well-trained mobile crisis that provide the de-escalation, help and support people need – these teams should include peer and family support advocates. A police response to a mental health crisis is NOT the answer. Police are trained to respond to criminal encounters.

We have seen countless times when police respond to a mental health crisis, it can escalate a situation and the likelihood of criminal charges being filed – or worse yet someone is injured or killed. We need to avoid these encounters by having alternatives to responding to mental health crises.

Many families or community members do not know or understand what options and alternatives exist within their community other than calling 9-1-1 or bringing their loved one to the emergency room – which should be a last resort and only if someone is an IMMEDIATE danger to self or others.

Last year, federal adoption of 9-8-8 as a three-digit number for mental health, substance use, and suicidal crises, which will be effective nationwide by July 2022, provides a path forward to accelerate better options for communities across the country. NAMI Vermont advocates for state and local crisis systems that combine well-trained call centers with mobile crisis teams that includes peer support (to meet people where they are at) and crisis stabilization programs. Other states are creating legislation that will ensure a well-funded system is in place once the 9-8-8 phone number is active. Vermont needs to revisit their plan to ensure the 9-8-8 is comprehensive and addresses mental health, substance use, and suicidal crises – and NOT to serve as just a Suicide Prevention Lifeline.

We can set up call centers and crisis teams, but what is next? Where do people go to get immediate help? Do we continue to bring people to the emergency room? No. We need to invest into crisis

stabilization programs. A program that allows drop-ins, that allows people to stabilize within 24 hours in a home-like setting and then are referred back to the community and followed up on.

Another example of a crisis response model is from Eugene Oregon. The CAHOOTS program has been in existence for 31 years. It is a non-police, trauma-informed, mobile response to children and adults in crisis. Last year, out of a total of roughly 24,000 CAHOOTS calls, police backup was requested only 150 times. [1]

As Vermont builds crisis response systems that includes mobile mental health crisis clinicians, it is critical that we also include people living in long-term recovery from mental illness to be part of the design, planning, and workforce. Some people respond better to the peer approach. Every community and individual have unique challenges and needs, and each response needs to be tailored to fit that local environment and person.

Additionally, NAMI Vermont and Team Two Vermont are scheduling screenings of the Ernie & Joe: Crisis Cops documentary that includes an interactive panel discussion with different communities in Vermont. I would highly encourage the Senate Institutions committee members to attend the next screening in April. The documentary follows two San Antonio police officers from the mental health unit and how they approach crisis intervention by de-escalation and diverting people from the criminal justice system. I will forward this information to you once it becomes available.

We request that the state and your committee continue to establish alternatives to mental health crisis intervention and crisis stabilization which will help diversion from the criminal justice system.

Thank you for listening to our comments.

Respectfully Submitted,

Laurie Emerson, Executive Director
NAMI Vermont

NAMI Vermont is the independent Vermont chapter of the National Alliance on Mental Illness. We are a statewide, non-profit, 501c3, grassroots, volunteer organization comprised of people who live with a mental health condition, family members, and advocates. As our mission, NAMI Vermont supports, educates and advocates so that all communities, families, and individuals affected by mental illness or mental health challenges can build better lives.

References:

1. CAHOOTS: https://whitebirdclinic.org/

February 4, 2021
To: House Health Care Committee
From: Anonymous Resident of Middlebury

Dear Chairman Lippert and House Health Care Committee Members,

NAMI Vermont provided a training to help community members write and share their story. We wanted to include the following testimony from an anonymous resident from Middlebury to ask for your support to have "on site inpatient psychiatrists instead of video psychiatric care at inpatient facilities as normal standard of care".

One of the most difficult issues for her was with her psychiatric care during an inpatient stay at Brattleboro Retreat in 2019. When she met with her psychiatrist, she was surprised when she was put in front of a video screen. Having been out of the retreat for a couple years she was shocked at the changes when she came back – with video telehealth being the biggest change. When she asked further about this practice, she was told that most psychiatrists at the retreat are no longer physically present and only see patients via video. A rotating practitioner would be there as well, but the video practitioner was a normal standard of care in the inpatient facility at the retreat. She was suffering with depression, desperate for help, needing human interaction and assistance, and questioning her worth. To treat anyone who is in a critical psychiatric situation with a video screen felt very cold and uncaring. To her, it felt as if the hospital didn't find her worthy to have an in-person dialog. Human interaction is critical and in particular during a crisis. Being alone with a video screen and no physical presence felt inappropriate, unsupportive, and cold.

She eventually found a different facility in Vermont where this practice did not happen - and the feeling of care and compassion was conveyed through direct interaction.

By not having that physical presence, it makes people feel alone and unwanted and impacts the crisis even further. Instead of meeting the patient in a manner which is uninhibited, the limited visibility and communication through the screen is one more obstacle in the way of psychological progression and recovery.

Inpatient facilities require hands on interaction, we are all human and the more impersonal you make it, the harder it can be for someone to actually feel like they are being listened to or cared for appropriately. We need to get psychiatrists back into inpatient facilities with real interactions. There is no substitute for in-person care and it will lead to better outcomes.

She would ask that "all inpatient facilities in the state of Vermont require, as a standard of care, in-person visits with their primary inpatient psychiatric practitioner at a minimum 5 days per week". This would mean inpatient facilities would not be allowed to have video sessions, more than 2 days per week with patients, pertaining to the subject of inpatient psychiatric care.

Additionally, NAMI Vermont has heard from other members who were in the emergency room being evaluated via video through a phone camera to be assessed for voluntary admission to a psychiatric hospital – this was pre-COVID time. They found the experience impersonal, uncaring, and dehumanizing. However, when we hear from members who have anxiety and/or live in rural areas

without transportation or internet access, a phone appointment is very beneficial for them to be involved with outpatient care such as counseling appointments or primary care visits.