Senate Health & Welfare
Wednesday, January 26, 2022

S. 194 and S. 195

WITNESS TESTIMONY

Devon Green

Gloria van den Berg

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Mourning Fox

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DEVON GREEN

Thank you, Devon Green, Vermont Association of Hospitals and Health Systems. And I'll keep this fairly brief.

I just want to start out by saying we wholeheartedly support both of these initiatives S.194 and S 195. As I mentioned before, we have people waiting in our emergency departments, anywhere from 10 to 30% of the people waiting in our emergency departments are waiting for community options, and don't need inpatient treatment. And so to the extent we can provide more of those community options through the peer operated respite centers, we think that that's a good idea. This will add more resources to the system and provide alternatives to the emergency department. So we wholeheartedly support that initiative.

We also appreciate that in the legislation, there is a requirement for those community centers to report individuals likely diverted from emergency departments, we think this is a great metric and should be attached to all the mental health initiatives just so we can get a sense of which initiatives are working and which initiatives maybe aren't as effective. So we think it's a great proposal, and we hope we wholly support it.

For certification of mental health peer support specialists, again, we also support this. It will provide not only support for those outside emergency departments, but we're hoping to get more peer support inside emergency departments. I think we have had hospitals who have successfully worked with peer support in the past. I think there's a little bit of a cultural block. Our hospitals are rule followers. And if they see an organization that isn't certified or in some sort of framework, they feel a little nervous about working with those folks. So having this in a more formalized framework is much easier. And also similar to the coaches for substance use disorder. I think that's a lot easier for hospitals to understand. And we've heard that there's been a lot of great back and forth between hospital emergency departments and the current substance use disorder coaches and a greater understanding between them and we think peer support for mental health is a great way to create that link in the emergency department to community resources both for the patient and for the healthcare workers so wholeheartedly support that initiative.

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STEPHANIE WINTERS

Great, thank you for having me back. So, Stephanie Winters. I'm speaking on S 194 and 195. And I'm wearing my Vermont Psychiatric Association hat. And I want to speak in support of both of these bills. We see both of these pieces of legislation as steps in continuing to build the mental health infrastructure; putting standards in place and creating a certification for peer workers in order to ensure qualified staff. So, very supportive. And I just wanted to include a couple of quotes from members.

They've had dozens of patients who've used Alyssum or Soteria, successfully when experiencing significant levels of distress. The peer run programs are careful about who they accept. And in their experience, the vast majority of clients are highly satisfied with the services they receive. But the opinion is that the more hospital diversion options that we have, and that patients have, the better and we're in favor of having as many non-medical options as possible for those who prefer that route.

And one psychiatrist said in all honesty, if I was in significant distress and had a choice between a psychiatric hospital or a peer run program, I would choose the latter.

Another member goes on to say many of the patients I've seen in the inpatient setting and in the emergency room would benefit from having respite facilities like these to go to. Most need a few days away from their stressors before they're ready to get back to it, and many don't need or even want to be in the hospital, but they have no other choice.

This would free up some of the inpatient beds to those who would benefit from hospitalization, and more economically alleviate congestion. The beds could be used as hospital diversion at discharge or step down from the hospital. So those are just a couple of examples. But again, my testimony is really short and we support both of these as tools in the toolbox to help support our system. Thank you.

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HILARY MELTON

My name is Hilary Melton and I'm the founding executive director of Pathways Vermont. Our mission is to end homelessness and provide innovative mental health alternatives. Today I'm here to testify in support of S.194 and S.195, acts related to peer operated respite centers and certification of mental health peer support specialists.

Since Pathways Vermont began providing services 12 years ago, it was clear that Vermont's system of care was lacking in alternatives to hospitalization for people experiencing mental health challenges. Time and time again, people who are struggling, people who are in need of support, and people who simply do not feel safe alone turned to the emergency room for relief. One bright spot in Vermont is Vermont's only peer respite, Alyssum, in Rochester, Vermont. However, the problem with Alyssum is that it is always full. And there is always a waiting list. We have a model that has a 10-year track record of success.

With S.194, we simply want to invest in what is working so Vermonters have access to peer respite and don't unnecessarily go to the hospital.

S 195 is a tandem bill to the peer respite bill. Currently mental health peer support is offered in Vermont without any standards of experience and training, no competency standards and no ethical standards. If it becomes law, S.195 would validate the discipline of peer support as a distinct practice, define the scope of practice, standardize qualifications and competencies and allow services to be billed to Medicaid, which would reduce the state's costs.

These last few months as I have been meeting with legislators in the community about S.194 and S.195, a question invariably comes up that I would like to preemptively answer today. The question is this. Do Vermont's peer organizations have the capacity or the knowledge to be able to get seven peer respites and peer certification programs up and running?

The answer is a resounding yes.

We are a strong capable group of organizations. I want to share with you a little bit about my organization Pathways Vermont as an example. Pathways Vermont's provide services in every county in Vermont, with a 9 million plus dollar budget. Our funding partners include the Substance Abuse and Mental Health Service Administration, the United States Department of Housing and Urban Development, the Vermont Department of Mental Health, the Vermont Department of Corrections, the Vermont Department of Aging and Independent Living, the University of Vermont and various, local United Way chapters, local towns, cities, among others.

Pathways is a specialized service agency for the Department of Mental Health. And we bill Medicaid for housing for services, an evidence-based model that we introduced to Vermont in 2009.

We have been writing service plans documenting service delivery and billing Medicaid for over eight years. Just last quarter, our Housing First program logged approximately four thousand hours of service delivered in person and in the community. Pathways currently has 128 employees and 80% of 80% of us, including myself, have a variety of lived experiences of mental health challenges, substance use homelessness, incarceration, and or trauma. We practice a relationship model of support informed by intentional peer support, a curriculum developed by Sherry Mead.

In addition to our work ending homelessness, we also operate several innovative mental health programs, including the Pathways Vermont Community Center in Chittenden. County, the Pathways Vermont Support Line, which is a statewide service and our Soteria House as Senator Lyons mentioned, a five-bed, licensed residential program available to anyone in Vermont.

For the past two years, we have spearheaded the Department of Mental Health Workforce Development Initiative, whose purpose is to improve consistency, infrastructure, communication and resource sharing among the peer workforce community. I am here today to assure you that we are ready, willing and more than able.

Thank you for your time and consideration.

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MOURNING FOX

Thank you for having me. Again, for the record, Mourning Fox, Director of Mental Health Programs for the Department of Public Safety.

I will keep my comments brief. S 194. and S.195. Complete and utter support from both myself as an individual, as well as the Department of Public Safety. This is something that I have been in support of for many years. I think Gloria has even heard me talk about Alyssum as a model for all crisis beds throughout the state in the past, and that's has been my position and continues to be my position.

Even though I'm not with the Department of Mental Health anymore that was my position then and it continues to be to this day.

The other piece, in particular, is that this does have a direct impact on the work that I'm doing in Public Safety as well. As I mentioned in some of the work I'm doing I'm looking at developing an alternative response model for our state. I want to include in our response model, people with lived experience as part of that response model. Most of the response models, not all, but most of the response models that have been developed across the country include either licensed social workers or other mental health quote unquote professionals, along with maybe an EMT, or specially trained officers or something of that sort. There are a few that are starting to include peers in that type of response. And from what I've been able to gather in my own research, they've been extremely successful as well. And everything from the Bureau of Justice, to SAMHSA to other federal agencies also support the use of peer support workers, not only in as we've been discussing in the testimony today, but also in the crisis response as what I'm looking at. So again, I'm in full support, and the Department of Public Safety is in full support of both S.194 and S.195.

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GLORIA VAN DEN BERG

I'm Gloria Vandenberg. I'm the founding executive director of alyssum. I am now in my 11th year. And I'm going to address three things today. That came up in some of your past questions. One, the first one is startup. And the second one is who who are guests where they come from. And the third one is accountability. I will pause after each one and answer any questions that you may have. Startup is alyssum set to be startup. We just talked about startup, I will say that up both on our website and in some of our written stuff, we have gotten letters and videos of our neighbors and towns people thanking us for having a listen in their community. The I have people that come up to me on the street and say, We're so happy you're here. People use it that our local people who are local who have family members who are suffering from mental health issues are appreciative of that we have something that different in town. So we did have pushback at startup, we did have to talk with the town we had many meetings, they required us to do an additional screening process to start up, which has been helpful in the long run for us. So as far as zoning and location, we are looking to set up to bed crisis respite, which will not need licensure. alyssum doesn't need licensure, we may have zoning variances that will apply, we had to get a zoning variance for alyssum. And lo was on route 100, we had to get a more multi use zoning variance to have that there because it's it's more than a domestic residence. So we carry insurance, we carry all kinds of insurances. So our our connections for insurance are all set to go.

it's built, you know, we've been piloting this for 10 years, we have all the documents, we have all the pieces of paper, we know how to do this, we've done this before, we know we have to set it up to be handicap accessible, we have to be able to make whatever adjustments and changes to that. We also know that a program like this even though we are so world, I mean alyssum is 1200 People in the middle of a valley between two mountains. And people come from almost all over the state. And we have a long pending list. So we know that people can get there. We know that we have some flexibility about where we if we say we want to build a place in Barrie, we know we have some flexibility around where exactly it needs to be. It doesn't need to be right next to the hospital, it could be out of town a little bit or it could be in town. So I think that we are all set to go to build something we've done all the groundwork Hilary's done, the groundwork was Sotiria. We know what we know how to do this. We know how to start something. Do you have any questions about that? So our guests currently are being recorded as mostly self referrals. That is because because our guests come from all over the state, they're being recorded as self referrals. Now, it's kind of a gray area because many of our guests come from designated agencies. Now you got to bear in mind these designation agencies also have their own crisis pets, but they're choosing to come to alyssum. So So when somebody who's been there before, calls us from a designated agency and asked to be put on the pending list and does their intake with us. We log it as a self referral, even though they do

have a case manager and they do have a psychiatrist and they do have other services and they are getting arrived through their designated agency to our program. We still log it in as a self referral. We but we do do a lot of work with hospital staff. We do outreach presentations to hospital staff and other group homes and programs. We have relationships with all of the designated agencies. We have relationships with Washington County Emergency Services teams who are fall back should we have to make an emergency call, which we make very little love. We have a very strict and clear screening process that is dedicated to keeping our other guests safe and keeping our staff safe. We don't take in just anybody and we need to talk to the person individually. Before they come in, we don't just take a referral from a case manager who says they have somebody who's a good fit and take them in, we have to talk to the person, we have very low incident to know incident. It doesn't mean that we're not taking people who aren't acute. It's the screening process and the interview process. And the conversation that we have before somebody comes in is what protects the program and keeps everybody safe. We have a very well trained staff body who knows what they're doing. So that's our guests thing. We have more with women than men, which is normal. We have transgender, non binary people that come. We have non binary staff members, we have male and female staff members.

Well, we have on average, five to nine people on our pending list, if it goes over that we are telling people, you should be trying to find something somewhere else. People fall off of it, people don't make it in people either wind up going to the hospital or feeling better, when our pen linguist is that long. The people on it are eligible to make warm line calls to the staff so that the our warm line calls are like around 250 calls a month. So So yeah, no, but we have to have a list. So. So it is difficult, you know, we get all these people who want to come into the program, that the thing that this program does, okay, that's different from other crisis beds, this program works one on one with people it does, like, I want to call it therapy, but it's not therapy. It's it's, it's a mutual meeting of the mind. It's a sharing of ideas. It's it's giving skills to people, so that when they leave, they're leaving with more skills and more ideas and more ways to take care of themselves than when they came. And that's different than going into a crisis bed, taking your medication for three days stabilizing and going home. So so it's it's really a very interactive program. So I think that's why people try to wait and they try to hold on and they try to wait.

SEN HARDY:
Miss Vanderburgh. How long does the average stay for somebody once they get in? So what's the sort of turnover rate? Five days, five days. So within five days, people feel well enough and stable enough to be able to move on?

GLORIA VAN DEN BERG
That’s an average. So, let's say we take somebody who's a step down from the hospital, right, they've been through three months of hospitalization, they've had a major medication adjustments, their home is blown up, they don't have a home anymore, they're having to go to a motel next. That person might be with us for two to three weeks. Then let's say we have somebody who calls us who's been to the program before, their cat just got run over on the road, and they're having a crisis about their cat that got killed, it was their favorite cat, you

know, they're just really fragile. They know all the staff, they can come in for two days, we bump them in, before the step down gets there, they come for two days, it just helps reset them, they stay in touch by phone, and they can go home. So when we start averaging out the days, we got down to five days.

SEN LYONS
I have a question about the the person who has a depression and may have thought about suicide, and that the are those those people self refer? Or do you see families bringing folks in when they're sort of in a crisis?

GLORIA VAN DEN BERG
We have families call us, and say, you know, my son needs to come in or whatever, but we really need to talk to the person themselves; they have to want to come to us and they have to understand what we have to offer. So, we would count it as a self -eferral once that person wants to come but say it was something like you're describing somebody who's extremely depressed -- the town asked us to do this screening process.. So let's say in your case, the screening process that the town put us on is that we would call somebody who knew that person well, who was in the medical profession that could tell us about this person because they didn't trust us as peers to be able to do that for ourselves. So we, we took that on. And within two years, the town said, never mind about all that you guys are doing a great job, we're not worried about you. You don't have to do any of that stuff. But we kept it because it was really helpful. So that somebody who's really depressed like in this, your example, somebody was really depressed, and they call us we would want to talk to their psychiatrist, their case manager, somebody other than their family, we would want to know that they don't need medication, or that they're stable enough with you know, that they're not going to go you know that they haven't just taken off, taken all their medication away and are going to go into a deep dive while they're with us. We don't provide medication, we don't have nursing staff. We do take people who are suicidal, we take them all the time. But we were very careful that we can provide them with the services they need. And we do that through having the conversations that we need to have with them.

SEN LYONS
Are you seeing people from all socio economic levels?

GLORIA VAN DEN BERG
Yes. We see medical professionals, case managers and psychiatrists.

The last bucket I want to talk about is accountability.

I wanted to assure you that we are very accountable for what we do. We report monthly to the Department of Mental Health and we report quarterly. Our quarterly report is much more lengthy. Our monthly report basically covers about 40 items. The Department of Mental Health, according to our grant, requires us to report census at 80% or more admission, 75 people annually or more; guest satisfaction 85% or more; program satisfaction 85% or more; departure

satisfaction 75% or more; for being better off and staff turnover. Our census occupancy this year to date is 86%. And that includes the fact that we were closed for 10 days because staff came down with COVID. Our admission this year is probably going to be around 88 or 92 people and DMH is only requiring 75; our guest satisfaction goals requires 85%. Right now we are at 93%. Overall program satisfaction is always between 98% and 100%; staff turnover is either less, or at 10%.

Our acute service reduction -- it's a survey we do -- DMH requires our acute service reduction --. that's people reporting that they're having used Alyssum and continuing to use Alyssum is reducing their need for emergency medical services. DMH requires it to be at 75%. Our records right now are at 97% and 100% of the people come to us would recommend the program to another person.

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LINDA LIMOGES

First of all, I'm so appreciative to be here and listen to the input of all the previous speakers. I also share many of the concerns for the issues previously discussed this morning. And there are often obstacles, but I am so grateful to have these discussions to help remove those obstacles.

My name is Linda Limoge, and I currently reside in Bennington County, Vermont, I want to express my gratitude for this opportunity to offer support for this truly invaluable program. I'm both honored and intimidated to be a recipient of services. I have been using the services at Alyssum for nearly 10 years now.

This may be considered my story. However, our personal stories all share common threads that are woven together by our existence within humanity. Trauma may occur at any time in one's life. And PTSD can affect people in all walks of life, regardless of education, socio economic status or age. This is my truth.

My formative years were challenged by a considerable amount of adverse experiences, which in turn resulted in PTSD, chronic pain and a number of other various labels, which hindered my path like having untied shoelaces, until I started going to Alyssum.

I spent much of my life trying to disengage to avoid uncertain situations. Working together with a caring, non-judgmental team at Alyssum and engaging in peer support has taught me to disengage from unpredictable triggers when they present themselves.

Then a few years ago, a very sudden, an unimaginable trauma occurred, which totally shattered the lives of those involved as well as my own. My sense of self was greatly fractured. But my sense of hope was restored by the constant support of those that Alyssum. I regained my will to live. And I found my way through my grief with meaning and purpose.

The reason which peer support works so well for me was that I knew that each person who was working with me truly understood my circumstances through common experiences. I was not there to receive a label, or be inundated with sedating medications. I was there learning basic self-care skills, which greatly improved the quality of my life and still provides me today with the tools for coping with additional stressors.

The environment is nurturing and homelike, with opportunities and spaces for cooking healthy meals, writing our music, meditation, yoga, dancing, gardening, engaging with nature, and playing with their do, Prince, all conducive to self-reflection and personal growth.

Contact with Alyssum has also helped keep me sober, has improved my interpersonal relationship skills and reminded me to relax as well as well as play.

However basic all these may seem, these activities which are so essential to the very nature of our personal well being have enhanced my quality of life through self care. I have shifted from having disassociated behaviors to becoming more grounded.

I am no longer hidden beneath my shield of shame, which prevented me from moving forward. Today I thrive.

We not only need Alyssum to continue, but it would be advantageous to emulate this program in order to benefit the growing needs of others. My wish now is that the lives of other Vermonters may be enhanced, as well through implementing additional programs.

After listening this morning, I added that asides from the needs for funding and my lack of understanding of the logistics, I am surprised to hear that turning towards the Medicaid model is expected to improve the services. I have never had an issue of competency or ethical standards with any of the staff on the Alyssum team.

While the traumas of the past still remain in the outskirts of my mind, like shadows, I now have the ability to remember that the sun is always there, even on the cloudiest of days.

I have grown so much in the past nine plus years, through my relationships with all of the people at Alyssum. Using both the services of going there and spending time, sometimes a short stay like two to three days and others longer. But also being able to use the telephone and having it be consistent with people that I recognize. And they know me and they've known me over the years. And it's been very helpful. And I wished for so many years that Alyssum would be available to more people. So, I would encourage that.

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SERA DAVIDOW

So thank you for having me here. I think I might be the only person who is testifying who is not in Vermont. And so I just want to say briefly why I was asked to be here today.

So as you said already, my name is Sera Davidow. I'm here today because of my work based in Massachusetts, and on the national and international peer respite front.

In 2006. I actually wrote a grant for what is now known as the Wildflower Alliance, which formerly was the Western Mass Recovery Learning Community. And I became a part of their leadership team when it was first funded in 2007.

And the Wildflower Alliance has many parts, including three centers and support groups, and the training and consultation division which are entirely peer to peer.

In 2011, I wrote a grant for Afiya Peer Respite. You'll see some information on the on screen here. I also wrote a second grant to retain the contract in 2017, when it went out for automatic rebid, which is just a part of the Massachusetts regulations requiring rebidding every so often. And that same year, I actually, or the Wildflower Alliance published the Peer Respite Handbook in collaboration with Intentional Peer Support Central, which is based with you all in Vermont, and I served as the primary author and it remains the only comprehensive peer respite handbook currently available.

And then in 2020, I and my co workers offered several presentations for and consultation to a national peer respite and Sotiria House summit, and Afiya was also recognized by the World Health Organization as one of about two dozen exemplary right space programs in the world.

Over the course of these years, I've also had opportunity to visit several other peer respites including California, New Hampshire, New York, and Maine, as well as similar types of programs and other countries, including Denmark and Germany. And although I'm mostly going to be focused here on S.194. I do want to add that I was a trainer for about a decade for the Massachusetts certified peer specialist training program, as well as a curriculum developer for them, and I continue now offering continuing education for certified peer specialist people in Maine.

So, it is with that experience in mind that I'm testifying before you today.

And as you may or may not know, peer respites vary in many regards, but those that are following the tradition of what peer respite was meant to do, they share several things in

common. And those include being voluntary in nature, building a team of supporters who all have some first-hand experience with life interrupting emotional distress, psychiatric histories, trauma and similar. And they all have a mission that is geared towards turning what so often gets called crisis into a learning and growth opportunity.

And so I just want to talk quickly about what you'll find if you were to look and I did include links if you do want to look directly at some of the guidance that I've mentioned. So in the peer respite handbook, there is a lot of information that touches on what y'all are talking about today. But particularly, I want to focus on the idea of peer respite as connected to community centers. Because there is something really important I think, peer respite, obviously, Alyssum has had tremendous success, even though they operate pretty independently. But there's something I think really important about the idea of peer respites connected to community centers. And you'll see in the handbook, I just pulled out an excerpt, that there's a couple of just things mentioned there, including that it can pave the way to a continuing relationship with the organization even after leaving the respite. So, I know that Alyssum and others have accomplished some that some of that with phones, but having a community center that people can be connected to after they've been in respite or before, as a way of learning about the respite can be really powerful, and also creates an automatic partnership, and extra support for the respite team when things are difficult, they're extra support is needed, people are out unexpectedly

You'll also find in the World Health Organization guidance documents, that the section that is about Afiya, specifically, there's one piece highlighted there that I really want to emphasize, which is that individuals don't need to be in crisis to access support, if there's a community center available and other supports available, in addition to the peer respite.

I think that's so important, because I think that we can really get into this place of kind of training people almost to be in crisis in order to get support when there's not enough of a network available. This is a slide that I often use in trainings on suicide, we do a lot of trainings and something called alternatives to suicide. And I've added an arrow here, this black arrow over on the left, which has, you know, one of the reasons people say they're suicidal is because the system trained them to say that in order to get services.

There's actually a number of things like, you know, lack of housing, and no one listens to people, if they don't say something sort of more extreme sounding that are highlighted on this chart, as well as reasons why people say they're suicidal, and the ability to form a broader network of not only the peer respite, but also of the supports that surround them, like community centers, which I know is one of the focuses of A.194. It's just so important to breaking that cycle.

And when that isn't happen, when there isn't a broader community that they're a part of the risk increases that the respite becomes this life raft rather than a bridge to a full and meaningful life. And it also increases the risk of replicating what I was just talking about that one must be in crisis to access support mindset, which, if you've done any work in the mental health field, it's

just such a pervasive issue, that people, people learn how to meet their needs, in ways that are not actually always so helpful to their lives.

And, and it also risks the, you know, a relatedly in risk increases the risk that people will get into the cycle of being in and out of services, rather than kind of getting to a point where they have the support they need and going on with their lives.

So I really can't emphasize enough how important it is that there be the broader supports connected. And when I say those broader supports, I really am talking about peer to peer supports. I think there's so many clinical supports that people find value in and when they're coming from different philosophies, there's can be a lot that gets lost there. So a peer respite that is surrounded by lots of clinical supports can still have great value. But when someone leaves the peer respite and they go back to the clinical supports, the approach often changes dramatically, and it can undo some of the progress for some people that they weren't able to make. It's just not quite the same.

And there's lots of people who are just avoiding clinical support based on past experiences and particularly experiences that have led to loss of liberty by forced hospitalization or similar. And I think the peer respites really are able to maintain a connection as well as the peer to peer centers that sometimes the clinical system, even if it's offering really useful things isn't able to.

But I also wanted to emphasize the importance of having enough respites. I know the point here, and it sounds like there's a tremendous amount of support in the state for that, the that the point of peer respite is, there's many obviously points, but one of them is to try and support people to not have their lives be massively disrupted by things like being inpatient in a psychiatric facility. And, again, catching people who might otherwise be avoidance of supports until they are really at the worst point possible and no longer have the option to avoid. And one of the things we struggle with in Massachusetts, is that for most of the time, we've been around, we've been the only peer respite in Massachusetts. And we have three bedrooms, in one house, in an area that has eight psychiatric units with I don't even know how many beds. And so when you the thing I have on the screen is from 2017, one of our annual reports, we certainly have more recent statistics, but not as neatly put together in the reports I pulled this. And what you'll see here is that of the contacts that we received in 2017, that did not lead to someone staying at the peer respite 990 of them, were due to we had no space. And if you go back, I put also there 2016 and 2015, you'll see 899 and 724 contacts did not lead to a stay peer respite, because we had no space.

And when we talk about peer respite, as having a fundamental purpose of hospital diversion, you know, I don't think staying out of the hospital has to be the number one top listed thing for anyone ever. But it's really important to a lot of us. And when I see this, what I really want to emphasize here is it's impossible to have peer respite fully realize its potential, or any alternative fully realize its potential if it doesn't have enough access. And if the clinical supports remain the ones that are actually most available by choice or by force. And so it's really, I really appreciate that Vermont is doing something that Massachusetts has not yet done, which is to

really push for there to actually be access and actual opportunity to see the true impact that this can have.

So, as I think you've already heard from others, there's a growing body of research out there that tells us that peer respite and peer support in general is effective. I often cite the research specifically from Human Services Research International and Second Story Peer Respite in California, it shows market decline in use of inpatient psychiatric facilities, for people who engage with peer respite and someone asked earlier about whether or not five days is enough, that research would suggest that five days is enough to really impact that for a lot of people. And that actually, those returns start diminishing after you go over the two week mark. So there's a window in which it becomes really impactful. And then after, you know, longer stays, it starts to diminish the actual impact.

So I'm not going to tell you that peer respite is absolutely essential for everyone. But it has a really big impact for a lot of people, even though it sounds quite short. And this does mean that there's significant cost savings for the community. And that's great because peer respite is absolutely less expensive than psychiatric facilities, or clinical crisis stabilization units as well in most instances.

But I guess one of the last things I just want to offer you is that we get caught up in cost reduction far too often. It is important but even if the costs were equal, it's so much more humane, it's so much less traumatizing, it's so much less disruptive to people's lives, they're able to go get jobs, and that's a different sort of loss and gain for community because they're not being pulled out by going to a psychiatric facility. There's so many other things they're able to realize in their own lives and their own dreams. And again, we're catching people who need support, but are afraid to get it from the clinical system based on past experiences or the way that things get approached.

Peer respite is also really a harm reduction approach. And I know you're probably most used to hearing that with drugs, but I would say with suicide, with hearing voices, with all the things that peer respites address, there's a harm reduction approach there that doesn't say, we must get rid of this in order for you to go on and have a full life. In fact, what we focus on more is supporting people to change their relationships with suicidal thoughts, or hearing voices or things that might be distressing them so that they can have a sense of power over them and see them as signs or messages that maybe something in their life isn't working or what have you. So often and for so many people, they're just not getting that message in the clinical system.

So there's so much that is so important in how we approach things differently. And ultimately, this does require funding. As you all know, that's why we're here today and enough access so that the peer respite themselves, as well as the networks of support around them can be built and the impact can be fully realized.

And so I, I think with that, I'm just going to say, I ask that you support S.194 in its entirety, and I so appreciate that I'm already hearing that people are really speaking in that direction. So thank you.

Senate Health & Welfare
Wednesday, January 26, 2022

S. 194 and S. 195

WILDA WHITE

Thank you, Senator Lyons. Good morning committee. My name is Wilda White and I am the founder of an organization called Mad freedom, which is a human and civil rights advocacy organization dedicated to the mission of securing power and influence to end the discrimination against people based on their perceived mental state or mental illness.

I am also an attorney and spent a lot of my career as a businesswoman, both running businesses and counseling CEOs and senior managers of Fortune 50 companies. I also was the inaugural chairperson of the Mental Health Crisis Response Commission here in Vermont. I was the executive director of Vermont Psychiatric Survivors. And I'm here this morning with a team who together area bringing this legislation for your consideration. And that team includes people you see on the screen here. Hilary Melton, the Executive Director of Pathways Vermont, Gloria van den berg, the executive director of Alyssum, which is a peer respite, Ken Russell, the executive director of Another Way Community Center in Montpelier, and Karim Chapman, who's the executive director of Vermont Psychiatric Survivors.

What I'd like to do with the time I have is give you a little bit of background about this bill, answer some of the questions that came up during the walkthrough, and then turn it over to some of the witnesses to provide more of the details of what these bills would do.

These bills are the culmination of decades of experience by peer led organizations in providing both peer support, peer respite, and community centers. They're also supported by rigorous analysis, both in a white paper that that this team authored, which I have submitted to the record, and also a research report that looked at peer certification programs throughout the United States and Canada, and what were the leading practices and implementing those programs. So this isn't not something that we dreamed up overnight. This is really the result of a lot of work, pilot programs, if you will.

I know some of you mentioned that perhaps this should be done as a pilot, I want to assure you that Alyssum is that pilot program that's been operating for 10 years. And because of the success of that program, we brought this bill, because we want to roll that out throughout the state because Alyssum is oversubscribed with a long waiting list, and a really unprecedented occupancy rate.

We also have two existing community centers in the state, also providing the pilot programs that some of you thought we should have. We have Another Way in Montpelier and Pathways Vermont, in Burlington. And we're also have been providing peer support that has been funded by the Department of Mental Health in the state for many years now, but without the benefit

of training standards, competency standards, or credential and without the benefit of qualifying for reimbursement through Medicaid, which reduces the state's obligation.

For example, you know, Medicaid pays, like $1.68 for every dollar that Vermont pays, leading to a gross of two $2.68. So I think this bill is intended to actually increase the size of the pie that we'll have available to fund mental health services, rather than just reshuffling and re divvying up that time.

So, one of the things that people asked in the last meeting was what is the name of the credential? Well, the bill proposes that that credential be in Mental Health Peer Support Specialist credential, or a Family To Family Peer Support Specialist credential.

There are also questions about what I will call the grandfather clause because there are people currently providing peer support in the state. And so there were some questions about like what happens to them.

While the bill proposes that those people who are currently providing peer support as of December 31 of this year, they would be required to take a mini written test. And then they would become certified and have that same credential that I just talked about. They wouldn't just automatically be grandfathered in without figuring out whether they met any standards.

Our group talked long and hard about this. And some states do that. Some states say, Hey, if you were doing this before this bill, you just walk right in and we'll give you a credential. Our team felt no, we don't want to do it that way. We should make sure they have they know something. And so what we thought a good compromise was not having to go through all the training and taking the long test, but passing a basic competency exam that would be developed in the course of developing the credential.

Others asked about where peer specialists work. Peer specialist work everywhere. They work in prisons, they work in hospitals, they work in emergency departments, they work in people's homes, they work in peer respite, they work in educational institutions, they work in mobile crisis support. So the places that they work are limitless. It's where people are, and where people are who are maybe in some kind of distress.

There's another question about whether certification programs in other states are designed exactly as this bill proposes? Or are they're identical other identical states? I will say at the outset that states design their own programs, many design their programs like the one we have designed here. So what we've done is we've divided a peer certification program into three buckets. One we say, is developing the program. A peer run entity would respond to a request for proposal from the Department of Mental Health to say yes, we will help you develop this program along the lines that are laid out in the statute. And then once the program is developed, there's two other buckets of tasks that need to be done to operate the program. That first bucket is screening people who apply for the training and then training them. So that would be another request for proposal for an entity that would do that screening and training.

Then the third bucket is people who would administer a test, once people have been trained. And if they've passed the test, then make sure they sign the code of conduct, and then certify them. And then you'd have to keep track of continuing education requirements, which is required for Medicaid reimbursement. And you'd also have to if there were complaints that someone had violated the scope of their practice or the code of ethics, then you'd have to investigate and make a decision about revocation. So those are the three buckets. Some states the way they've designed their program peers perform all of of the functions in those buckets, some states, it's led by the Department of Mental Health. In some states, it's led by their Office of Professional Responsibility. And in some states, they actually contract with consortium called IC & RC and they work through that consortium. Medicaid allows states to design their own programs, it has a lot of flexibility.

We elected this path, because based on a General Accounting Office research study of peer certification programs in eight major states, they identified as a leading practice the involvement of peers in the development and operation of peer certifying programs. And that's the very reason why we don't think it would be appropriate to put this in something like OPR, or Office of Professional Responsibility, or a technical college or university. Because the leading practice, meaning the most successful programs, they're run by peers consistent with peer values.

There was another question about the difference between a recovery coach which we now have recovery coach academies, and the difference between what we're proposing here as a peer support specialist. The difference is one of the scope of practice. I like to think of it as you know, an orthopedist, a podiatrist, a chiropractor, are all eligible to work and qualified to work on someone's ankle, but they all do it in a different way. And it's the same with a peer support specialist. The scope of practice is much broader than a recovery coach, which is exclusively -- and I interviewed the people at the recovery coach Academy about this. So I will get it right. They're focused on two things, motivational interviewing, and finding resources for people to help them curate their own recovery.

The scope of practice for peer support specialists as much broader; they can operate as case managers, they can operate as Whole Health Practitioners, , they can work in the forensic sphere, they can work in psychosocial education, they can work in what you traditionally know, was kind of counseling, but it's not really counseling., it's mutual, it's a mutual peer support. So it's really the scope of practice.

So and then there was also a question about these entities that would be able to kind of bid to run these programs, would they have to be based in Vermont. The proposed legislation is silent about whether they would have to be based in Vermont, but I can imagine that it might improve the legislation to put in a requirement that anybody who bids on running one of these buckets that I described, would have to have a Vermont location. What we're after here is providing additional opportunities for people with mental health challenges in the state, to tget employed, because currently, we suffer a lot of employment discrimination. People with mental health challenges have the highest rates of disproportionate unemployment of any population.

And it's not because we're not able or we're not willing to work. Surveys have revealed that employers are just not willing to hire us, with 25%, saying they would fire us if we had not disclosed a mental illness. 70% said they would never hire someone who was currently taking an anti psychotic medication and half saying they wouldn't hire someone with a mental illness. And then 58% of employees saying they don't want to work with someone with a mental illness. This keeps us underemployed and unemployed. And I have personal experience with this because despite my experience as attorney, and a businesswoman and a Harvard MBA and being on the faculty at UC Berkeley Law School, as soon as I experienced a psychotic manic episode, I was unemployable. And so this bill creates opportunities beyond just providing a peer support, it provides more entrepreneurial opportunities like starting a business to provide some of these services; it creates a career ladder. Because once you get this credential you can stack on to; you can become a specialist, I'm going to specialize in geriatric, I'm going to specialize in people who are criminal justice system involved; I'm going to specialize in youth or LGBTQ, I'm going to become a supervisor and get a supervisor credential for peer support. So it creates a career ladder and hope for people who are now stuck either underemployed or unemployed.

There were fewer questions, I think on the peer respite portion of the bill. I think I've addressed the question why not pilot programs.

There was a question about why not Addison and Franklin counties? And we say thank you for asking that question. Why not? We didn't include it. Because we were trying to think about cost and money, , but hey, yes, why not all 14 counties?

Sen. Hardy, you pointed out a blind spot. And we will never make that mistake again. Because you're right up. Senator Hardy, we do think you can go to Rutland or Chittenden. But no, we want you to have one and Addison. We want people -- the point is for people to stay in their communities. So, thank you for pointing out that blind spot.

And the other question was about what's happening with the designated agencies and their crisis beds. This is what's happening there. Yes, the designated agencies do have those crisis beds. What we've seen though, is those crisis beds are not meeting the departments or they haven't met the department's mark. They want them to operate at 80%. The most recent data we have is that they're offering more at 70%. And what we think is happening is that people are voting with their feet. They would prefer to be in a peer run crisis respite, and you're going to hear testimony about a guest at one of those and you'll learn from her why she prefers that peer run respite to perhaps something run by the traditional mental health system.

So, I want to stop there and give other people an opportunity. I hope I've answered your concerns. I'm available for questions.