Legislative Testimony
Dr. Haley McGowan
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Good morning everyone. Thank you to Senator Lyons for the invitation. I'm truly grateful to be here. I'm privileged to be in the company of the others testifying today. Challenging work is happening around the state, in a state of crisis, and there is great solidarity amongst those of us on the ground.

My name is Haley McGowan, and I'm a board-certified child and adolescent psychiatrist based at UVM Medical Center. Senator Lyons asked me to share my perspectives on the treatment of children for psychiatric emergency, and what is needed to close the gaps.

About 2.5 years ago, UVM Medical Center created my position to help meet the community's longstanding child mental health needs in the hospital setting. So, I was the first child psychiatrist assigned specifically to the Emergency Department. I also co-direct the joint child psychiatry and psychology consult program, which serves the medical floors at the children's hospital. In my role, I've cared for hundreds of children for whom the general emergency department was their best option for acute mental health needs. This is most commonly related to suicidal thoughts or behavior, but also includes agitation, aggression, psychosis, mania, and everything thing else that threatens a youth's safety in the community setting.

What this also means is that nearly every child who has "boarded" in the emergency department over the past two and half years has been under my care. So for better or worse, my passion for this is personal. Children and adolescents came to the ED for mental health needs long before the pandemic. But 2021 saw a 111% increase in patients seen by my service in the emergency room. To give you an idea of where we are now, on Monday morning, there were 11 youth in the UVM Medical Center Emergency Department for mental health needs, and their average length of stay at that point, in the emergency room, was 11.2 days. If we include children waiting elsewhere in the hospital for whom we do not have appropriate placement, the average wait extends to 15 days. You've heard it before and I don't need to belabor the point, but this does not happen for medical patients. What does unfortunately happen for medical patients, however, is their care can be delayed because of the strain that mental health patients place on an emergency department that is not designed to care for them. My colleague Dr. Pulcini, who is a pediatric emergency medicine physician at UVM, testified to this earlier this week. Dr. Pulcini has also been immensely helpful in terms of data gathering to capture our experience and the experience of children and families. Needless to say, we are a united front.

I will be honest, it's heartbreaking work supporting these children and families day in and day out. Because my team, in conjunction with First Call, Chittenden County's crisis service, spends what feels like most of our time trying to cobble together creative but totally insufficient plans for children and families because we cannot connect them to what they need. As a specialized

physician, I've been extensively trained to assess what a child needs, and to know what the evidence supports for good outcomes. We rarely provide it in a timely way, and often we can't provide it at all. And what's worse is that we have to watch children get worse before our eyes, and before their parents' eyes, because they're trapped in the countertherapeutic environment that is the emergency room.

The emergency dept is an absorption point for the stress of the healthcare system. It's a difficult lens to have. In this setting, my team does not get to experience much of the good news. I'm increasingly aware of the exceptional work happening in the community, and noteworthy efforts to implement systemic change. But, the people doing the work are exhausted.

UVM certainly fields the highest volume, but relative to EDs around the state, we are well resourced. We have child psychiatry, Child Life support, nurses with psychiatric training, case management. It's not enough, because it's decidedly not treatment, but we're doing what we can to soften the stay. This includes creating new physical spaces in the hospital for patients to await placement, coordinating and bolstering outpatient supports when feasible, training staff on trauma-informed care and de-escalation strategies, seeking to provide more support to families. This is the right thing to do, but I don't want it to be a distraction from the greater needs because it shouldn't have to happen.

I'd like to briefly offer my take on the gaps in care. I don't offer these in isolation. I speak regularly with colleagues around the region who have been working in child mental health in VT at all levels for decades longer than me. What VT has long been lacking is a continuum of care. Do we need more capacity at the inpatient level? Of course. But with investment in the right intermediate services, the demands on the inpatient system would be far less. We need geographically diffuse programs outside of hospitals. I think about this in three categories:

1) **Partial hospitalization and intensive outpatient programs.** These are programs that provide intensive mental health treatment, but kids sleep at home each night. Importantly, these can be step-ups when outpatient supports are not enough, or step-downs from inpatient level of care, to support efficient throughput.
2) **Brief crisis stabilization.** An example is the PUCK program in Bennington. These are programs that give kids a few days to stabilize in a safe setting. They create an opportunity for intensive but short-term therapeutic interventions, and creation of treatment plans.
3) **Far more investment in intensive, home-based, wrap-around services that support kids in their communities.** Under this falls respite services for families, and mobile crisis, which responds to psychiatric emergencies in the community to prevent presentation to the emergency department. Many, many of the children we see do not need a secure inpatient child psychiatry unit. They don't even need psychiatrists like myself. We are simply not the lifeblood of this work. To name a few, it's residential counselors, community first responders, therapists, skills workers, school-based clinicians, respite providers, case managers, and all those who provide family-focused treatment services.

Which leads me to my final point. Vermont needs to appropriately value and compensate the work being done by these foundational members of the care team. I don't want to sugar coat this. I've been shocked to learn how the system undercompensates those providing direct clinical care to our most vulnerable youth. It is often complicated and emotionally grueling work, and if we want to keep these talented and caring individuals in the roles that they **want** to serve, we need to compensate them in a way that is motivating, that recruits and maintains the most skilled and dedicated people, and that creates a desire to stay in mental health care in VT.

I'll finish by saying that I think the right conversations are happening and initiatives are being pushed forward at the state level, related to mobile crisis, community programs, and workforce retention. American Rescue Plan Act federal funding and other grants have created some rich opportunities, and I feel hopeful.

Vermont is not alone in what often feels like an insurmountable challenge. This is very much a national story. But Vermont is a small state, built on community and relationships, and grit. I really believe that with the right vision and an allocation of resources commensurate to how we value this rising generation of Vermonters, we could become the gold-standard and an example to the rest of the country of what's possible.

Thank you again for this opportunity to share my perspective and I look forward to your questions.