GMCB Public Comment
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Topic: use of mental health funds

Comment: I have been a mental health therapist for approximately 18 years. Prior to that I worked in community mental health, vocational rehabilitation, and non-profits. I have worked in many areas of mental health, including mobile crisis in the state of NC. Not that there were not times when people would be "stuck" in an emergency room awaiting placement, but far fewer than I feel is happening here and now in Vermont. Mental Health in NC was divided into regional centers based on population and each receiving a different state reimbursement. It was very efficient and I feel could be modeled. Each regional center had "screeners" to answer calls. They were LPC's, or LCMHC's here. The number for the screeners was widely publicized, and if a person called 911 with a mental health emergency, they were diverted to the screeners. Their job was to assess the callers acuity and determine appropriate level of care. The choices were to refer a person to a local out-patient facility and assisting with that connection to an appointment date. Utilize their skills to attempt to solve the crisis, or call the mobile crisis unit. The on-call person would meet the individual in crisis either at the hospital, or out in the community at a safe location. If the crisis clinician felt it could be unsafe, the PD was called to coordinate. Now comes the difficulty. Finding beds for people. It does not appear that any state in this country has enough beds to meet potential need. However, this service was streamlined and usually found beds for people. The crisis clinician was responsible for that task. Back many years ago, the state of NC had the screeners working from home on state computers HIPPA compliant. It worked for many of them. This system was created to avoid hospitalization. Hospitalization is only appropriate for those with existing long-term mental health diagnosis or newly traumatized people. Far better to receive care in an out-patient setting, which is less intrusive to these individuals. I remember learning in graduate school that one productive session with people and they might not come back because you have helped them solve the problem they were struggling with. This rarely happens, but it does in the case of crisis. NC also had screeners in their ER's. Again, streamlining the process. If the crisis person felt the individual could possibly need immediate hospitalization, the hospital had counselors there 24/7. Mobile crisis was permitted to transport individuals to the hospital if transportation was an issue. I am sure that I left out many other components of the system, but it was some years ago. As is likely gleaned from this conversation, I am not an advocate of hospitalization unless the circumstances are dire, possibly leading to suicide. Another thought.regarding children, those under 18. I once worked with a very wise psychiatrist who had been practicing in a community clinic here in Vermont for years. She said, "children don't raise themselves", look to the dynamics of the family first! Hospitalizing children is a questionable act. Unless the parents were forced to come in daily to have family therapy, I see it as a revolving door. In my humble opinion, and I am not alone, the system is not working for children. Parents need to be held accountable for their role in their child's mental health. Many parents blame the system because we do not force their participation. "Children don't raise themselves". Clearly I have overstayed my welcome here folks, but I appreciate your debating how to spent the dollars. I had sent a similar email to our governor. The system is not working and we need to change it. I would be happy to continue this conversation or get in touch with folks in NC to tighten up procedure. But I actually feel that the state is not ready to change. Vermont has difficulty changing. Actually New England has difficulty changing. Please feel free to contact me if anyone would like a further discussion.

Post Comment: Yes