Vermont Department of Mental Health

Mental Health Response Services Guidelines

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VERMONT

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Legislative Language

Sec. 1. 18 V.S.A. § 7260 is added to read:

§ 7260. MENTAL HEALTH RESPONSE SERVICE GUIDELINES

(a) The Department shall develop guidelines for use by municipalities, including use by emergency medical technicians and public safety personnel, such as law enforcement officers as defined by 20 V.S.A. § 2351a and firefighters as defined in 20 V.S.A. § 3151, who are employed, volunteer, or are under contract with a municipality. The guidelines shall recommend best practices for de-escalation and for mental health response services, including crisis response services. The Department shall make the guidelines available to municipalities and publish the guidelines on the Department's website.

(b) In developing the guidelines required pursuant to subsection (a) of this section, the Department shall consult with the following entities:

(1) the Department of Health;

(2) the Department of Disabilities, Aging, and Independent Living;

(3) the Department of Public Safety;

(4) the Vermont Care Partners;

(5) the Vermont Psychiatric Survivors;

(6) the Vermont chapter of the National Alliance on Mental Illness;

(7) the Vermont Criminal Justice Council;

(8) the Vermont League of Cities and Towns;

(9) Disability Rights Vermont;

(10) the Department's State Program Standing Committees; and

(11) any other stakeholders the Department deems appropriate.

Statement of Purpose

The purpose of this document is to establish a comprehensive framework for effectively managing mental health crises within the community, aimed at all first responders. It seeks to provide essential knowledge about common mental health conditions, de-escalation techniques, and crisis management through a trauma-informed lens.

We aspire for this document to serve as a useful resource for both experienced first responders and those with limited experience in mental health best practices. This framework is intended to enhance current procedures and practices, not replace them.

Ultimately, our goal is to equip first responders with the insights and tools necessary to assist individuals experiencing mental health crises, enabling them to receive appropriate support in the least restrictive environment possible.

Acknowledgements

These guidelines were developed with support and input from the following entities: Vermont Department of Health, the Department of Disabilities, Aging and Independent Living, the Department of Public Safety, Vermont Care Partners, NAMI Vermont, MadFreedom Advocates, Vermont Criminal Justice Council, Vermont League of Cities and Towns, Disability Rights Vermont, and the Mental Health Program's Standing Committees.

Best Practices in Mental Health Crisis Response

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and individual safety, civil rights, extraordinary and unacceptable loss of lives, and the misuse of resources. [1]

Crisis services include:

- Crisis lines like 988, which accept calls from individuals in the community experiencing a crisis - as defined by the person - and offer necessary support.
- Mobile crisis teams dispatched to locations within the community such as homes, schools, and other areas where a person might be experiencing a crisis.
- Crisis receiving and stabilization facilities, such as the Alternatives to the Emergency Department programs being opened in Vermont.

In Vermont, we are currently strengthening our resources to provide support for our most vulnerable communities. Vermont is committed to developing a strong crisis response. We aim to provide guidelines for first responders to enhance their readiness and effectiveness in handling mental health crisis situations. We hope this document will serve as a valuable resource for your teams, and we are also prepared to provide additional training upon request.

Crisis services are accessible to all Vermonters, including those who may belong to marginalized populations. In addition, 988 serves as a connection to specific lifelines for LGBTQIA+, veterans, and Spanish speakers. Other marginalized populations, such as youth, individuals with disabilities, and those who identify as Black, Indigenous, and People of Color, can also seek assistance. The State of Vermont is dedicated to building on local, state, and national efforts to promote equity and social justice. It recognizes the crucial role of the government in eliminating structural barriers, and in promoting meaningful inclusion and representation, especially regarding the mental health of those living, working, and thriving in Vermont. [2]

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[1] SAMHSA. (2020). *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[2] State of Vermont Office of Racial Equity. (2024). *Home page*. https://racialequity.vermont.gov/

Perhaps the most potent element of all, in an effective crisis service system, is relationships. Crisis response should lead with empathy and compassion for those who struggle. We understand that immediate access to help, hope and healing saves lives. SAMHSA believes that the three main components of crisis care are: ***Someone to Talk to, Someone to Respond, and A Place to Go.***

Overview of Mental Health, Substance Use, and Intellectual and Developmental Disabilities

There is a myriad of both mental health and substance use conditions that first responders might encounter. Note that these symptoms may present in a person with an Intellectual or Developmental Disorders (ID/DD) or Autism diagnosis and are not a result of ID/DD and Autism. Just as there can be co-occurring mental health and substance use disorders, there can be co-occurring mental health and ID/DD or Autism. Some common mental health diagnoses are listed below[3] along with what people might see when working with someone experiencing a challenge related to their mental health:

Thought Disorders

- Defined as having one of the following domains: delusions (belief in something others do not recognize as true), hallucinations (hearing voices or seeing things others do not), a feeling of not being connected to or an alternate reality, disorganized thinking or speech (rapidly switching from one topic to another, responding to questions with something totally unrelated, etc.), grossly disorganized or abnormal motor behavior (including catatonia), social withdrawal, loss of pleasure, lack of motivation, and disengagement.

Mood Disorders

- Mania is characterized by elevated mood, grandiose feelings, decreased need for sleep, and increased activities.
- Depression is categorized by down or depressed mood, loss of pleasure or interest in things, loss of energy, feelings of worthlessness or suicidal thoughts.
- The person may experience a variety of emotions associated with either depression or mania such as anger, sadness, and ambivalence.
- A person can experience similar symptoms when they are intoxicated or withdrawing from a given substance such as alcohol, amphetamine, cocaine, or hallucinogens.

Personality Disorders

- A personality disorder is a long-standing pattern of inner experiences and external behaviors that deviate from the norms and expectations of a person's culture or community and are usually fixed and developed in adolescence and lead to distress and impairment. Borderline Personality Disorder is commonly seen in crisis and is marked by instability in

[3] American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.)

relationships, diminished self-awareness and fluctuating or shifting sense of self, impulsivity, and thoughts or behaviors of self-harm or suicidal thoughts.

Substance Use Disorders

- These encompass a wide array of drugs ranging from alcohol to opiates. All drugs (even caffeine) taken in excess can activate brain reward systems. This can result in the user wanting or craving more of the substance and potentially using it more frequently. Using it more frequently puts the user at an elevated risk for dependence, tolerance, and withdraw.

Anxiety and Trauma or Stressor-Related Disorders

- Fear related to a real or perceived threat are common hallmarks of anxiety disorders. These can include hypervigilance, muscle tension, cautious behaviors, being avoidant, panic attacks, and thoughts of immediate impending danger. These can lead to a fight, flight, or freeze response. Because of the level of activation that the anxious or traumatized person may go through, they may experience a higher than usual reaction to psychological distress (from calm to acutely dysregulated quickly).

Neurodevelopmental Disorders

- These disorders manifest in childhood during development and are characterized by impairment of personal, social, academic, or occupational functioning. These disorders frequently co-occur with other mental health disorders.
- Autism Spectrum Disorder is when there are deficits in social interactions and reciprocity (including non-verbal communication), and skills in developing and maintaining social relationships. In addition, individuals display the presence of restricted, repetitive patterns of behavior, interests, or activities. Presentation can change as the person gets older, but the symptoms can still significantly impair functioning.

Suicidal Thoughts

- All people, regardless of whether they have a diagnosed mental health condition, can have suicidal thoughts. However, the risk of suicide is increased with mental health or substance use disorders.

Some signs and symptoms that a person in crisis may present with: [4]

Mood swings
- Big shifts in emotion (can be rapid in nature)

Social Withdraw
- Isolation and withdrawal from friends and family

Disorientation
- Problems with thinking, basic memory and/or recall, speech, and concentration.
- Difficulty in focus and what is being asked of them.

Overstimulation
- Sensitivity to light, sounds, crowds, touch and smell
- Avoidance of anything that is "too much"

Apathy
- Loss of desire to participate or follow directions

Disconnection
- A sense of un-reality and feeling of disconnection from themselves or their surrounding
- May see or hear things that we cannot

Illogical Thought
- Unusual beliefs about personal powers to understand meanings or influence events
- Regressive thinking

Nervousness
- Fear or suspiciousness of other
- A strong feeling of anxiety of the unknown

Unusual Behavior
- Acting peculiarly, oddly, or uncharacteristically

Appetite and Sleep Changes
- Increase or decrease

[4] Benas, Nick and Michelle Hart. (2017). *Mental Health Emergencies*. United States, Hatherleigh Press.

Screening for Suicide Risk for All Ages with the C-SSRS

Screening for suicide risk is a crucial tool in preventing suicide and approaching individuals who may be at risk. Police officers, firefighters, emergency medical technicians, and paramedics may be the first to assess suicide risk. Properly identifying the risk helps first responders determine next steps and can ultimately save lives.

The Columbia-Suicide Severity Rating Scale (C-SSRS), also known as the Columbia Protocol, was designed to help determine suicide risk through a series of simple, plain language questions that ***anyone*** can ask.[5] The answers help the questioner determine whether someone is at risk for suicide, the severity and immediacy of that risk, and gauge the level of support that is needed. ***Anyone*** can use this tool to screen for suicide risk.

<table>
<tr><td colspan="2"><u>Always Ask Questions 1 and 2</u></td><td>Past Month</td></tr>
<tr><td>1</td><td>Have you wished you were dead or wished you could go to sleep and not wake up?</td><td></td></tr>
<tr><td>2</td><td>Have you actually had any thoughts about killing yourself?</td><td></td></tr>
<tr><td colspan="3"><u>If YES to 2, ask questions 3, 4, 5, and 6.</u>
<u>If NO to 2, skip to question 6.</u></td></tr>
<tr><td>3</td><td>Have you been thinking about how you might do this?</td><td></td></tr>
<tr><td>4</td><td>Have you had these thoughts and had some intention of acting on them?</td><td>High Risk</td></tr>
<tr><td>5</td><td>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</td><td>High Risk</td></tr>
<tr><td colspan="2"><u>Always Ask Question 6</u></td><td>Life-time</td><td>Past 3 months</td></tr>
<tr><td>6</td><td>Have you done anything, started to do anything, or prepared to do anything to end your life?
Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc.
If yes, was this within the past 3 months?</td><td></td><td>High Risk</td></tr>
<tr><td colspan="4">If the answer is yes to 2 or 3, seek support from 988 or your local Mobile Crisis Team.
If the person answers yes to 4, 5, or 6 seek immediate help by calling or texting 988, call 911 or go to the emergency room.</td></tr>
</table>

5 *First Responders - The Columbia Lighthouse Project*. The Columbia Lighthouse Project - Home of the Columbia-Suicide Severity Rating Scale (C-SSRS): a series of simple, plain-language questions that anyone can use to assess suicide risk. (2024, April 5). https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/first-responders/

Trauma can be a life-changing experience. Traumatic events can happen at any age to any person and may affect an individual's daily life and cause long-lasting harm to the individual's physical and mental health and well-being. Trauma recovery and healing is possible through appropriate and adequate support at the individual, family, and community levels.

Some Words on Trauma and Trauma-Informed Care

In the United States, 90 percent of adults report exposure to at least one traumatic event, with women reporting higher rates of direct interpersonal violence, sexual assault, and physical assault than men. This can also include the BIPOC and the LGBTQIA+ populations. Unaddressed trauma can lead to mental illness and substance use disorders, as well as chronic physical health conditions, including cardiovascular disease and cancer.[6]

Six Principles of a Trauma-Informed Approach

1. **Safety**: Occurs in physical settings and interpersonal interactions
2. **Trustworthiness and Transparency**: Operations are conducted, and decisions are made with transparency, consistency, respect, and fairness to build and maintain trust.
3. **Peer Support**: Support from those with lived experiences of trauma, or in the case of children with history of trauma, their family members.
4. **Collaboration and Mutuality**: Partnering with and leveling of power differences between and among staff and clients.
5. **Empowerment**: Individuals' strengths and experiences are recognized and built upon.
6. **Cultural, Historical, and Gender Issues**: Moving beyond cultural stereotypes and biases.[7]

Trauma can take many forms, including toxic stress at home or work, experiences of racism, discrimination, or oppression, flashbacks, anxiety, and emotional detachment in veterans, bullying, harassment, and traumatic loss for people with disabilities and LGBTQIA+ individuals, sexual assault or intimate partner violence, poverty or economic hardship preventing access to basic needs, natural disasters like floods and earthquakes, involvement with the legal system and incarceration, war, armed conflicts, and man-made disasters, as well as serious physical illness.

Children who experience multiple traumatic events are more likely to face increased trauma as adults, which can lead to additional physical and emotional health issues.

Impact of Trauma on Individuals:

- **Emotional:** difficulty regulating emotions, depression and anxiety, PTSD
- **Behavioral:** substance use, self-destructive behaviors, avoidance
- **Physical:** high blood pressure, headaches, fatigue, insomnia, muscle tension resulting from emotional distress

[6] SAMHSA. (2023). *Practical Guide for Implementing a Trauma-Informed Approach*. https://store.samhsa.gov/sites/default/files/pep23-06-05-005.pdf
[7] *Ibid.*

- **Developmental:** changes in brain development, children at high risk
- **Cognitive:** decreased focus or concentration, alienation, dissociation
- **Interpersonal:** withdraw from others, lack of trust
- **Spiritual:** feelings of abandonment and loss of faith

Ways to become more trauma-informed:

Minimize the risk of re-traumatization: Help the person feel empowered, in control, in a good space (not trapped), and free of judgement. Avoid situations where the person may feel unsafe and do not challenge or push a person to recall traumatic events.

Create a safe environment. Strive to create a sense of physical and emotional safety by being consistent, dependable, and compassionate. Allow space for vulnerability and respect the person's experience. Lead with empathy, recognizing that the person may be trying to meet an unspoken need. This may involve moving the person to a different or alternative physical space.

Recognize trauma through a cultural lens. Culture affects the person's interpretation of traumatic events, how they take responsibility for the trauma, and the meaning of help-seeking behaviors as well as support.

Build on strengths. Shift from the perspective of "What is wrong with you?" to "What happened to you?" Try to redefine the presenting problems by using a strengths-based perspective.

Use person-first language. Do not refer to someone as "an addict" or "a schizophrenic." Think of them in terms of people you support, such as someone with a substance use condition, or a person who lives with schizophrenia.

Provide stability. Discomfort is not a signal to retreat. It is a signal to engage and that behavioral and emotional responses to triggers are normal and part of the recovery process. Sometimes stability means giving a person more space.

Help build resilience. Help people identify personal or community connections. Encourage empowerment and for the person to advocate for themselves. Let the person make informed decisions about their treatment. The individual should be driving the bus while we can offer directions.

De-Escalation Techniques[8]

Be Empathetic and Non-Judgmental. When someone says or does something that you perceive as weird or irrational, try not to judge or discount their feelings. Keep in mind that whatever the person is going through is the most important thing in their life at the moment.

Respect Personal Space. Stand at least 1.5 to three feet away or more from a person who is escalating. If you must enter someone's personal space, explain your actions so the person feels less frightened and confused.

Use Non-Threatening Nonverbals. The more a person loses control, the less they hear your words—and the more they react to your nonverbal communication. Be mindful of your gestures, facial expressions, movements, and tone of voice. Stand at an angle towards them, but not face to face and avoid crossing your arms.

Maintain your calm demeanor. Remain calm, rational, and professional. While you cannot control the person's behavior, how you respond to their behavior will have a direct effect on whether the situation escalates or defuses. Remember that you can control your behavior and how you respond to them during a crisis.

Focus on Feelings. How a person feels is the heart of the matter. Some people have trouble identifying how they feel about what is happening to them. Watch and listen for the person's real message. Try saying something like, "That must be really scary." Supportive words can let the person know that you are trying to understand.

Ignore Challenging Questions. When a person challenges your authority, redirect their attention to the issue at hand. Answering challenging questions often results in a power struggle.

Set Limits. If a person's behavior is belligerent, defensive, or disruptive, give them clear, simple, and enforceable limits. Be concise and respectful.

Choose Wisely What You Insist Upon. It is important to be thoughtful in deciding which rules are negotiable and which are not. If you can offer a person options and flexibility, you may be able to avoid a challenging situation.

Allow Silence for Reflection. It can give a person a chance to reflect on what is happening, and how they need to proceed.

Allow Time for Decisions. When a person is upset, they may not be able to think clearly. Give them a few moments to think through what you have said. Allow them space.

[8] Crisis Prevention Institute. (2023). *Top 10 De-Escalation Tips*. https://institute.crisisprevention.com/Refresh-De-Escalation-Tips.html/.

Motivational Interviewing has Core Skills of OARS[9]

Open questions draw out and explore the person's experiences, perspectives, and ideas.

- What was your relationship like with your parents?
- What do you want to do next?
- How can I help you with ____?

Affirmation of strengths, efforts, and past successes help to build the person's hope and confidence in their ability to change.

- I appreciate that you are willing to meet with me today.
- You are clearly a very resourceful person.
- You handled yourself really well in that situation.
- That's a good suggestion.

Reflections are based on careful listening and trying to understand what the person is saying, by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate. This is a foundational skill of motivational interviewing and how we express empathy.

- So it sounds like you feel…
- Is…what you meant when you said…
- You're wondering if…

Summarizing ensures shared understanding and reinforces key points made by the individual.

- Let me see if I understand so far…
- On the one hand…, on the other hand…

[9] MINT. (2017). *Understanding Motivational Interviewing*. https://motivationalinterviewing.org/understanding-motivational-interviewing.

The Role of 988, Mobile Crisis, and the Designated Agencies in Crisis Response

988 is the National Suicide and Crisis Lifeline that an individual can call, text, or chat with 24/7. When they contact 988, they will be connected directly to a crisis counselor. If immediate support is needed, 988 can reach out to the caller's Mobile Crisis Team (MCT) with the caller's consent.. The MCT can then go to the location to assess the situation, and in most cases, resolve the crisis without further intervention. More than 99% of all 988 calls do not require police or emergency intervention.

988 is more than just a crisis response. It is a resource for Vermonters to have a safe space to talk about their concerns and have an objective ear to help them process some of life's more challenging moments. It can be used for problems related to mental health, substance use or addiction, interpersonal relationships, grief and loss, and a host of other situations where the caller may feel like they have nowhere else to go and seek support.

If individuals feel that a higher level of care is necessary or need a more comprehensive response, they can request a MCT response. The local MCT may then be sent to help them with the situation. The MCT typically consists of a two-person team, ideally including a trained mental health clinician and a peer specialist who has personal experience with the mental health system. At times, a member of the MCT may participate remotely via telehealth. The clinician may assess the individual for safety and provide supportive counseling, while the peer support provider may offer empathy, validation, and resources to help manage the crisis situation.

In life-threatening circumstances, there may be a need to conduct an Emergency Examination (EE), which could result in someone being involuntarily hospitalized or the issuance of a mental health warrant, allowing for the individual to be taken to the closest Emergency Department (ED) for assessment by a medical professional. These occurrences are uncommon. Moreover, the involvement of law enforcement or first responders in a situation is also infrequent. In all cases, the MCT will attempt to resolve the individual's crisis without involving external entities such as emergency medical services (EMS), law enforcement, or fire response. Depending on the crisis, the MCT can take the lead in responding to the crisis.

Keeping in line with the "Someone to Talk To, Someone to Respond, and A Place to Go" model that the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies as best practice, there are several new Alternatives to the ED that have been formed around the state of Vermont. These are programs that individuals can utilize to talk to a counselor and a peer specialist about their challenges and stay in a "living room" environment where they can feel safe, supported, and find resolution to their crisis.

Alternative to ED programs across VT includes: the Access Hub (Washington County Mental Health), Interlude (Counseling Services of Addison County), Front Porch (Northeast Kingdom Human Services), and Mental Health Urgent Care (Howard Center). There are programs for children and youth such as the Emergent Psychiatric Intervention for Children (EPIC) program (Lamoille County Mental Health Services) and Psychiatric Urgent Care for Kids (PUCK) (United Counseling Services). These programs offer a space for people to go without having to go to their local ED to utilize crisis services. More information about the Alternative to ED programs in Vermont is available in the Resources section at the end of this document.

Several agencies also have after-hours on-call crisis resources specific to supporting people who receive Developmental Services. Talk to your local Designated Agency about these resources. Contact information for your local Designated Agency is available in the Resources section at the end of this document.

Frequently Asked Questions

When would someone call 911 and when would they call 988?

911 is for immediate medical or police intervention in cases of imminent risk to life or danger to a person, injuries requiring medical attention, law enforcement response, or fires. However, it should not be used for emotional struggles or general conversation.

988 is for mental health crises, providing a telephonic response and support from trained crisis counselors. It is for processing emotional crises or seeking support to resolve personal issues. If someone is considering calling 988, please encourage them to do so – we want to support them through their experience.

If an MCT responds, what can someone expect to happen?

When a crisis occurs, a team comprising a trained crisis clinician or mental health professional, and a co-responder will be dispatched to respond. The clinician will conduct a thorough assessment of the individual's risk level, safety, and needs, which may include alternatives to hospital emergency department visits, outpatient treatment, and more. Additionally, the clinician aims to understand the individual's current state and determine the type of support required to effectively communicate their desires, emotions, and needs.

In an ideal scenario, which is the goal of MCTs, the response team will include a co-responder who is a peer support worker with lived experience in the mental health system. The peer support worker can assist the individual in managing their emotions, understanding the situation, and offer guidance on available resources. The co-responder may also be a case manager, family support worker, or another trained professional.

When would law enforcement or EMS be used?

Law enforcement (LE) and EMS would only be used as a last resort or if all other interventions fail to keep the person safe. The crisis clinician may need to involve LE for safety reasons if the person has a weapon or if the person escalates into violence. EMS may be used to safely transport the person to the hospital if the person needs a higher level of care. In cases where LE is called in, the MCT (or person with the best rapport with the individual in crisis) should take the lead unless there is a threat to safety; the LE can take the lead if they are dealing with a life-threatening situation.

When would a crisis team do an Emergency Evaluation (EE) or issue a Mental Health Warrant?

If a person is in immediate danger of death or their safety is severely compromised and they refuse care, a crisis clinician may consider involuntary hospitalization through a process known as an EE (18 V.S.A. § 7101; 18 V.S.A. § 7504). If the person needs evaluation at the emergency department (ED), the clinician can request a warrant (18 V.S.A. § 7505), which allows LE to transport the person to the ED for evaluation by a physician and psychiatrist to determine if hospitalization is necessary.

What if the person in crisis is or appears to be intoxicated/under the influence of a substance?

The MCT can still respond to the person whether or not the person is under the influence of a substance. MCT will take all calls seriously and can give their best clinical opinion to determine whether a person could have taken a substance. In some cases, the person can be allowed to have a period of time to let the substance leave their system in which case the crisis might resolve itself.

What if someone is not in imminent danger and does not want help?

This situation is difficult, but it is important to respect the person's autonomy. If there is no threat to safety, responders can step away. Responders can offer resources such as 988, connection to Mobile Crisis Team, and other community resources like local designated agencies, community centers, NAMI Vermont and other peer-run organizations such as Another Way or Pathways VT, and faith communities. The person may choose to accept or not, and we can gracefully step out of the picture. Not everyone is ready or willing to seek help for their mental health issues. If they are not a risk to themselves or others, allowing them space to come to a place of help seeking on their own.

Where can someone go when they do not want to go to the Emergency Room, but they feel like they are in crisis?

Vermont has several alternatives to the Emergency Room or Emergency Department (ED) that are up and running in Vermont. They are:

- Interlude in Addison County
- Front Porch in the Northeast Kingdom
- Access Hub in Washinton County
- Mental Health Urgent Care in Chittenden County
- PUCK in Bennington
- EPIC in Morristown

All these sites offer a flexible and home-like environment which is trauma-informed, voluntary, and sensitive to the needs of people who might be going through crisis. Guests to these programs can go there during day/evening hours and benefit from counseling, assessment of needs, peer support, de-escalation, safety planning, and if needed, connection to psychiatric supports.
The individual in crisis can go directly to the program on their own or if first responders have already been involved, the officer can provide a warm hand off to any of the Alternatives to the ED programs.

What if someone is not responding to intervention techniques or requests?

The individual may require more time to respond or may have other issues that prevent them from understanding what is being asked of them. For instance, someone whose first language is not English may struggle to comprehend the request. Similarly, an individual with an intellectual or developmental disability might be non-verbal or have difficulty comprehending complex tasks. Always ensure that the person understands.

Can they nod their head? Is there another non-verbal form of communication that could be used to assist the person? When trying to communicate with someone in a challenging situation, can you use short, one-step commands? For example, "Raise your hand if you understand." It is important to remember that not everyone has the same capacity to listen, respond, and understand.

Resources

988: Suicide and Crisis Lifeline (call, chat, or text)

1-833-VT-TALKS/1-888-604-6412: VT Support Line and Warm Line (call or text)

Local designated agency 24/7 crisis teams

Designated Agency (DA)	Phone Number	County
Counseling Service of Addison County (CSAC)	802-388-7641	Addison
United Counseling Service (UCS)	802-442-5491	Bennington
Howard Center (HC)	802-488-7777	Chittenden
Lamoille County Mental Health Services (LCMHS)	802-888-5026	Lamoille
Northeast Kingdom Human Services (NKHS)	802-334-6744	Orleans, Essex, and Caledonia
Northwestern Counseling and Support Services (NCSS)	802-524-6554	Grand Isle and Franklin
Clara Martin Center (CMC)	800-639-6360	Orange
Rutland Mental Health Services (RMHS)	800-775-1000	Rutland
Healthcare and Rehabilitation Services (HCRS)	800-622-4235	Windsor and Windham
Washington County Mental Health Services (WCMHS)	802-229-0591	Washington

Alternatives to Emergency Departments

Alternatives to ED Programs	Address	Hours	Phone Contact
Interlude (CSAC) **Adults 18+**	99 Maple Street, Suite 16 in the Maple Works Complex, Middlebury, VT	Monday – Friday, 10am-6pm	802-458-8219
Front Porch (NKHS) **All ages**	235 Lakemont Road, Newport, VT	24/7/365	802-624-4016
Access Hub (WCMHS) **Adults 18+**	34 Barre Street, Montpelier, VT	Monday – Thursday 7am-7pm; Friday 7am-4pm	802-301-3200
Mental Health Urgent Care (HC) **Adults 18+**	1 South Prospect St, Arnold Building, Burlington, VT	Monday – Friday 9am-5pm	802-488-6482
Psychiatric Urgent Care for Kids (UCS) **Youth ages 3-18**	314 Dewey St, Bennington, VT	Monday – Friday 8am-5pm; Saturday 9am-12pm	802-442-5491
Emergent Psychiatric Intervention for Children (LCMHS) **All youth ages**	72 Harrel St, Morristown, VT	Monday – Friday 9am-4pm	802-888-5026