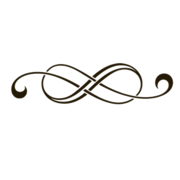
**Mobile Crisis THINK TANK Notes and Themes**

*From Wednesday, June 13, 2018*



**Design a Mobile Crisis System for Vermont**

**Things to Consider:**

* Who is the population?
* What is provided?
* How is it structured?
* How is it provided?
* How does it link with other parts of the system of care? Are there efforts already occurring that could be combined?
* What’s working that we can build upon?
* Were there components from other state models that you want to incorporate?
* Is it consistent with our **System of Care values**?
* Child-Centered, Family-Focused
* Collaboration Between and Among Families, Agencies and Community
* Individualized
* Family-Driven
* Strength-Based
* Culturally Competent
* Community-Based

**Instructions for Small Group Discussion**

1. What are the most promising themes you heard?
2. What, if anything, would you shift about your model based on the other systems you heard about?
3. What are the top two essential elements you think any mobile crisis for Vermont should include?

| **WHAT’S CURRENTLY WORKING WELL?** | **GAPS** |
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| * Upstream preventative supports – outreach * Connections with schools – preventative referrals * Pediatricians – social workers in offices * Proactive emergency plan – for individuals in contracts with hospitals. * Designated Agency (DA) crisis teams on call. Dev. Services eligible participants * Single point of entry for children – triage to correct service providers. * Telehealth with psychiatry staff. * Infiltration into schools and Primary Care Provider offices * Alliances with DA Clinical * Clara Martin Center (CMC) – outreach to prevent crisis.   + Work in schools – school can call CMC for assistance.   + Working with local pediatrician’s offices.   + Embedded social workers in police departments * Rapid response in Rutland * Post crisis response (up to 8 weeks) * Establish relationship with kid and family * Participate in community meetings * Follow-up programs * Each DA has after-hours response * Other social service agencies have own response * Centralized Intake Emergency Services (CIES/DCF-Family Services) called for permission to treat * Collaborative response between DCF-Family Services and DA * Different county to county * Staffing high risk DCF/community-based kids | * Not enough beds * Training for respite providers to support workforce – retention * Family managed respite utilization * Crisis responders – foundational training * Danger/safety - protection * Clinicians outside DA making referrals * Rate of pay and paper regulations * Soft transition home from crisis beds. * Access to crisis beds for those with developmental disabilities. * Access to psychiatry * Not enough local resources * Not enough psychiatrists * Respite providers need training * Emergency Department (ED) becomes default * Workforce issues-find the staff and then retaining them * Licensed clinicians leave for private practice. * Access to crisis beds then support to transition home – ongoing support for family * Who will do it? Workforce issues all over VT. * Geography * Personnel * When at ED and then discharged then priority or eligibility changes * Triage * Education |

| **POSSIBLITIES/NEEDS** | |
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| * Safe team limited to DA’s clients * Menu of services/activities children/families can access to increase resiliency * If safe, provided in home * Just go! * Utilize law enforcement if needed * Rapid response team * Non-law enforcement responder to access situation * Support to foster parents face to face * Response within one hour * Follow up who and for how long * Orienting providers to mental health issues/behaviors in a different way (MH train) * Trauma informed response * Expand telehealth * Skilled respite training. * De-stigmatizing perception – public education * Addressing workforce payment/reimbursement for crisis and respite beds. * Pediatricians collaborative with DA * Workforce relationships and follow up services * Local beds for kids so they can go to school * After hours crisis 800 number * Local crisis beds for adults   + Minimize travel   + Maintain continuity * Contracting with local ER w/ DA * Creating incentives * Shared savings * Crisis response beds for siblings * Crisis should be defined by the caller * Alternative sites for response (other than the hospital) * Families don’t generally want crisis work in the home. * ER setting – leads to outcome some parents are looking for. * Neutral, non-medical setting may be helpful “23-hour” setting, living room feel. * Not common crisis response state wide. Could be helpful to have baseline language/expectations. * Combined children and adult crisis – helps with staffing, costs, what’s the sweet spot in terms of local, regional, state? * Peer support, supervision, break, connection. Could these “wraps” be created around children/family beyond the immediate screening. * Funding model that is vastly different. * Aftercare/stabilization services – in the moment response – in location * Mobile Crisis – late in the game, can we connect sooner? * CIES – could we build upon this? * Consistency (across regions/state) * Love the Just Go! Response * Meet families where there are- physically and definition of crisis. * Acuity triage * Family focused – so can respond to adult needs as well as child. * Crisis respite – especially in younger (>12 y/o)   + Broader menu of safe holding settings * Disparity regarding 3rd party covered services   + Want in home/community-based services covered by 3rd party. * Licensing regulations – allow to staff a foster home build up support to foster home to take kids with higher acuity. * BA Level interventionist to reach out when MA level assessment isn’t necessary. Crisis credential to incentivize retention. * Back up structure to tap resources from other parts of the system. * Call Center:   + Phone response.   + Screening in person.   + Mobile team * Follow-up post crisis * Triage of kids for BR admissions doesn’t distinguish location of waiting. * Mobile crisis team – clinical and BH specialist plus APRN * Training re: tolerance of risk for crisis intervention, families, schools, mental health providers, FSD, etc. * Supports for foster home (to increase tolerance/stability), $, service wrap * Centralized call center   + Pros:     - May address workforce challenges     - One number     - Link with other crisis numbers (suicide lifeline, ESD)   + Cons:     - Cost and complexity of EHR     - Knowledge of local resources (when handed off to regional team) * Planful discharges * Discharge meetings – include DA, DCF (if involved), parents, schools * Crisis Beds * Training for ER staff * Data – kids waiting volume | * Redefining crisis doesn’t have to be baseline language across the state * Cultural work to merge DS/MH * Shared savings funding stream is not driven by utilization * Peer support models – parents * Range of response * Universal EHR and releases to work with providers * Flow of communication * Local CORE Team Meetings * DS crisis team on call. Adults and kids. * Crisis team support in ED. * Single point of entry for all kids @ DA. * Pro-active emergency plan with every person enrolled in services. * Provide support for people who show up in ED. * Network of skilled providers * Dedicated workforce to local crisis response that would also be available for outreach and prevention. * Meet families where they’re at. * Partnership with hospitals * Multidimensional local teams * Workforce training/skill building for families. * Flexibility/mobility * Education/Prevention * Fund for capacity * Access to information (EMR) * Support in the moment to deescalate, refer, process * Environment that is more trauma informed * Create respite/time out placements * Screening where child/family are located. * Educate parents/guardians about who/what/why process works for family * More hospital diversion type beds? Kids seem to be waiting * Advocate with hospitals for funding sources with system of care partners * Crisis plans shared with mobile crisis * Hospitals creating a calmer space outside of the ER for kids. * Beef up private clinician crisis plans, empower families to use the plan developed. * Youth center approach environments * Concurrent planning beyond mobile crisis. * Follow up time with family and determining who is the lead in follow up * System of pro-active crisis planning * Access to everyone * Preventative in Response * 24/7 * Just Go * Aware of population and special needs * In person response within one hour * Ability to triage need ie: crisis planning – hospitalization * Ability to access EMR for family history * Simple documentation * Ability to share information with a universal release * Safety consideration for those who are responding and where responding to * Sharing information of ‘at-risk’ or EMR high risk youth across agencies * Consider integration of peer-peer support [youth-youth, parent-parent] * Ready access – Respite * Cool places – be while waiting for bed * Different levels that would involve in home wrap around services (respite), to out of home with wrap around * Community cares home * Do not want patients being sent to a wing at the correctional facility * More public education on early intervention, coping skills * More links with schools and law enforcement, first responders, police social workers, PCP (standardized screening) (CAMS) (ACES) (PHQ) * Centralized EMR – with access by crisis workers. * Build relationships with local PD’s * RV idea great idea “outside the box” * Just go response – Get there! * Response time one hour or less * Most skilled staff should be on the front end. * Kid-friendly sensory spaces – accessible to anyone and place to meet. * State wide training for direct responders and triage |

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| **Themes** *(items that came up in multiple groups)*   * Meeting families where they’re at – both literally and figuratively * Need more peer to peer support * Follow up supports after crisis * Shared savings from reducing spending at higher levels of care and systems efficiencies * Caller defines the crisis * Focus on education/prevention to others who interact with children and families-hospital staff, law enforcement, schools * Use a common language when talking to families in crisis (and de-escalation techniques) * More partnership with local law enforcement * Need more resources-financial, staff, settings * Workforce challenges-recruiting and retaining staff is difficult * Integrated Crisis teams to serve children with any challenge (MH, DD) * Find existing family friendly space in the community and develop agreements for use of the space rather than having to meet families at the ED for a crisis response |

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| **What are the Essential Elements for Mobile Crisis in Vermont?**  *(This list is not in priority order. These represent the ideas from the small work groups and may have overlapping themes)*   1. Multidisciplinary crisis teams    1. Assessment clinicians    2. APRN Nurse    3. Bachelors level interventionist    4. Peer parent support or young adult peer support 2. Provide training to those who interact with children and families    1. Intervention and de-escalation safety and planning 3. Informed and nonjudgmental person that answers call, and the caller defines the crisis 4. Make crisis positions attractive for candidates – tuition forgiveness, training, adequate compensation, flexible schedule 5. Centralized Call Center – 24 hours    1. With trained staff/clinicians       1. Triage calls – determine if behavioral crisis or mental health crisis       2. Offer supportive counseling       3. Reports to DA’s in the morning    2. State wide call center – connections at the local level       1. To have trained staff, must make position in Mobile crisis attractive       2. Local crisis placement options       3. Pros and cons of centralized call center. Much more efficient. Will learn local system but EMR challenges. Pros are:          1. For support          2. Initial screening          3. Triaging 6. Need adequate capacity for in-person response that is:    1. Timely    2. In the most appropriate setting possible    3. Adequate capacity for safety planning and emergency supports in the community    4. Staff with expertise on both children, family dynamics, and adults 7. Community based training for partners    1. Staff would need to be clear on division of counties and providers |