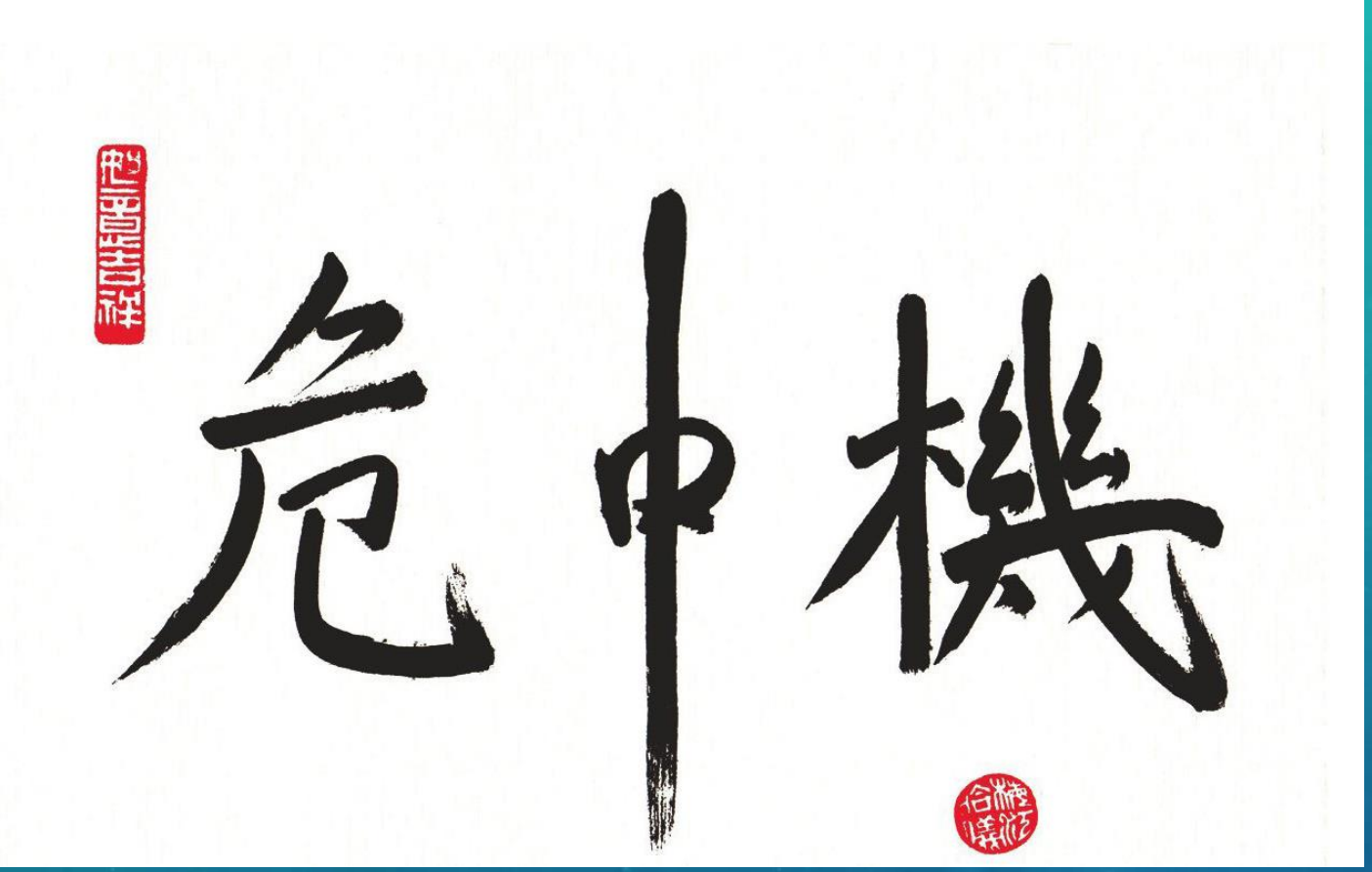
MOBILE CRISIS THINK TANK: FROM REACTIVE TO RESPONSIVE

DATE: WEDNESDAY, JUNE 13, 2018

LOCATION: WATERBURY STATE OFFICE COMPLEX, SALLY FOX CONFERENCE CENTER

TIME: 12:45-4:30

This event has been organized by a team from the Department of Mental Health, the Department for Children and Families ~ Family Services Division and the Department of Disabilities, Aging and Independent Living ~ Developmental Disabilities Services Division



“The Chinese use two characters to write the word 'crisis.' One character stands for danger; the other for opportunity.

AGENDA

12:45-1:00	**Welcome and Introductions**
1:00 – 1:45	**Context and History**

- Problem we are trying to solve and our goal for today
- What is the current Vermont data telling us?
- Promising Practices/Models in Other States

1:45-2:00	**Break**
2:00 – 3:00	**Small Group Work-Design a Mobile Crisis System**
3:00 – 3:45	**Large Group Report Out**
3:45 – 4:15	**Small Group Discussion**

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

4:15 – 4:30	**Next Steps and Wrap-Up**

WHAT'S OUR OPPORTUNITY AND WHY ARE WE HERE TODAY?

PROBLEM:

- There has been an increase in children/youth (0-17) who are coming to Emergency Departments in crisis.
- Currently, Designated Agencies emergency services are structured around crisis screening for inpatient admissions. Families and providers see a need for responsive, in-home community supports beyond this screening.

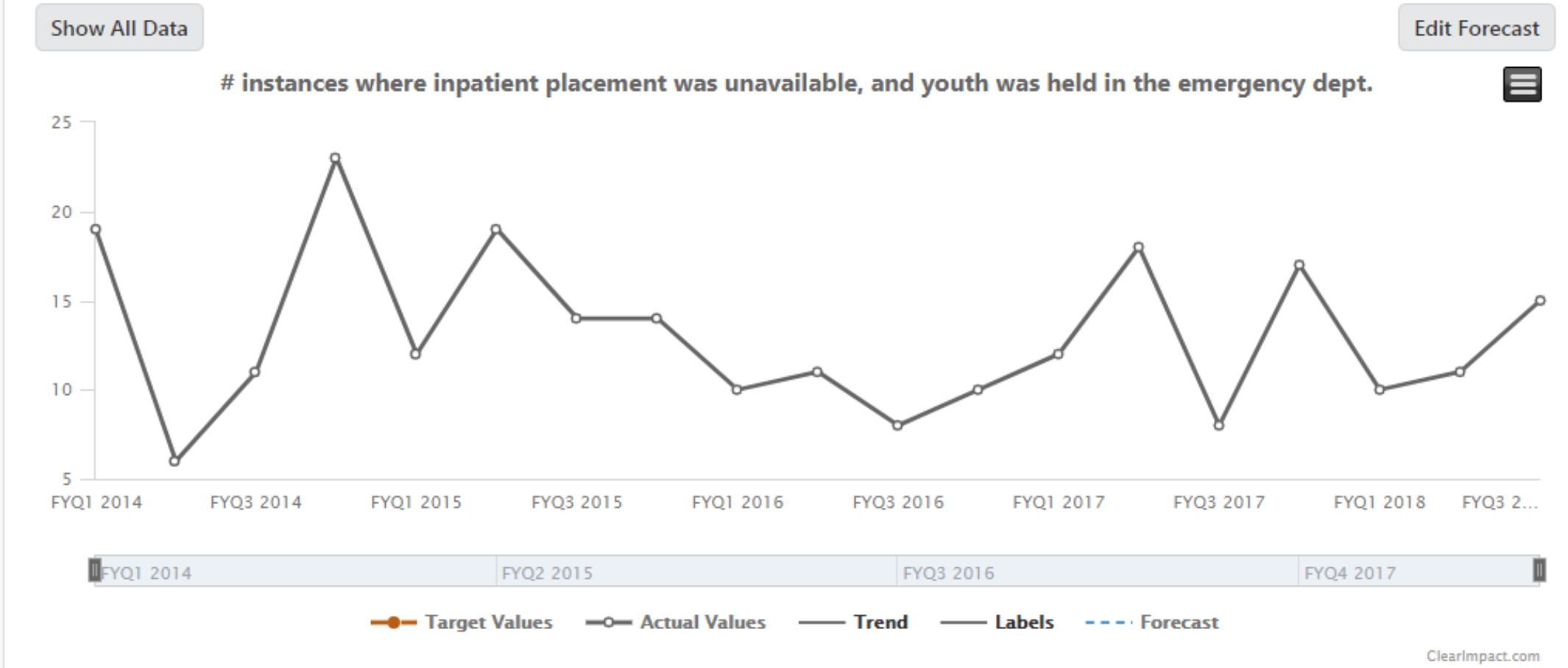
GOAL: We want to:

- help families in distress in a timely way.
- provide support to prevent higher levels of care.
- prevent out of home placements.
- provide services in the home or community whenever possible.
- provide services to ensure stability and safety.
- improve the health and well-being of children, youth and families.

VERMONT DATA

CHILDREN WAITING IN VT EMERGENCY DEPARTMENTS – INVOLUNTARY STATUS

PM Snapshot # instances where inpatient placement was unavailable, and youth was held in the emergency dept.



CHILDREN WAITING FOR PLACEMENT IN ED - INVOLUNTARY

Children - Emergency Exams and Warrants
Wait Times in Hours for Involuntary Inpatient Admission
FY 2018

Wait time	Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
No wait time	0	0%	1	17%	0	0%	1	13%	0	0%	0	0%	1	25%	0	0%	0	0%
1-8 hours	0	0%	0	0%	0	0%	1	13%	1	20%	0	0%	0	0%	0	0%	0	0%
9-16 hours	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
17-24 hours	1	33%	2	33%	1	50%	0	0%	0	0%	0	0%	1	25%	1	20%	1	14%
more than 24 hours	2	67%	3	50%	1	50%	6	75%	4	80%	0	0%	2	50%	4	80%	6	86%
Total	3		6		2		8		5		0		4		5		7	

Wait Time in Hours		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Youth	Mean	25	32	22	44	123	-	29	69	65
	Median	26	25	22	45	50	-	23	49	51

Data about Family Services Division youth waiting in emergency departments from April 2017 – March 2018

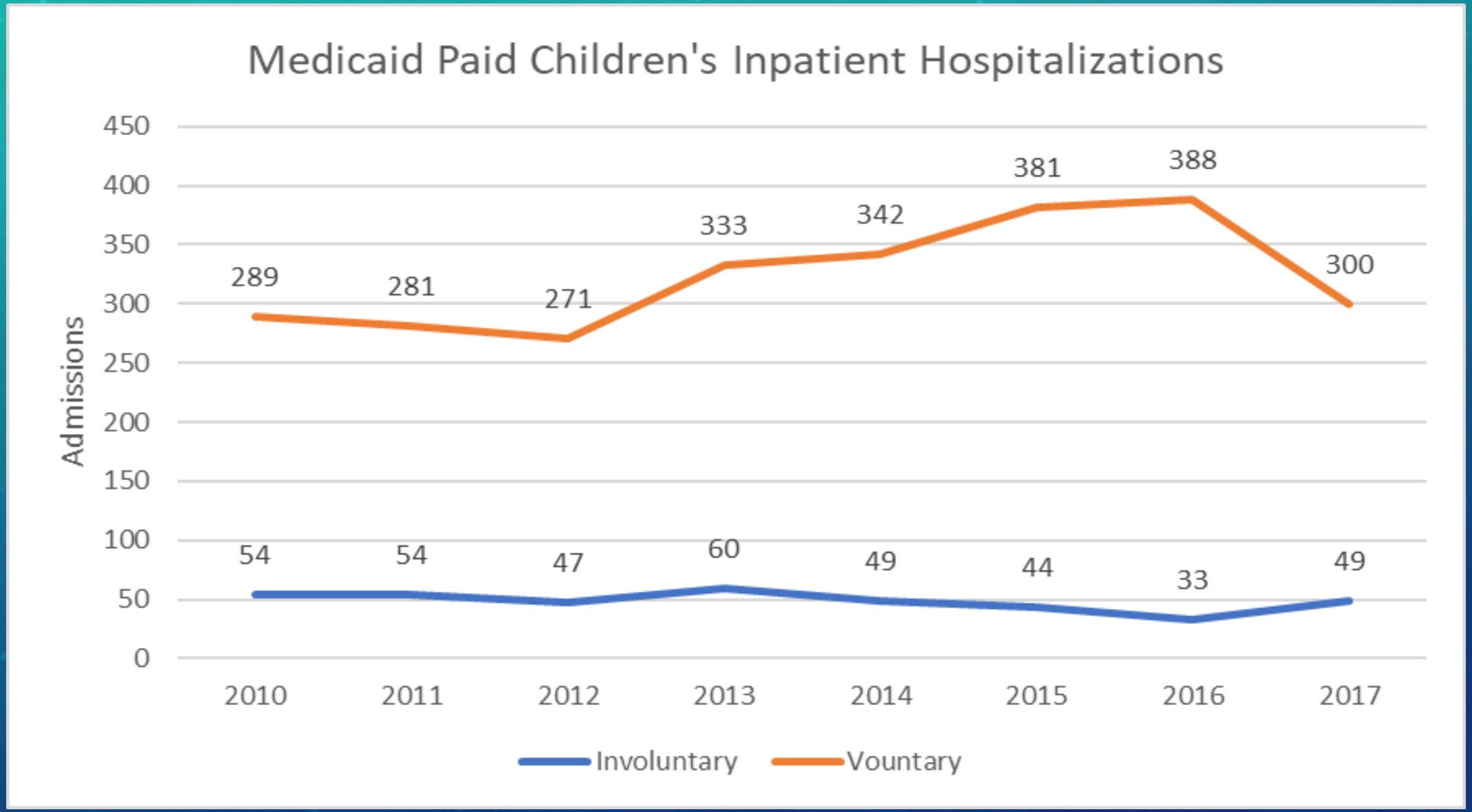
*$20 an hour for foster parents
**$25.60 step 2 for new family services worker

Age	Episodes	Individuals	Days	Hours	Low respite cost	Low worker cost
8 years	2	2				
10 years	2	1				
11 years	2	2				
13 years	6	5				
15 years	8	6				
16 years	5	5				
17 years	7	6				
No age	6	6				
Total	38	33	116	2,784	$55,680*	$71,270**

DAIL'S VERMONT CRISIS INTERVENTION NETWORK BED DAYS FOR CHILDREN FY15, FY16, FY17

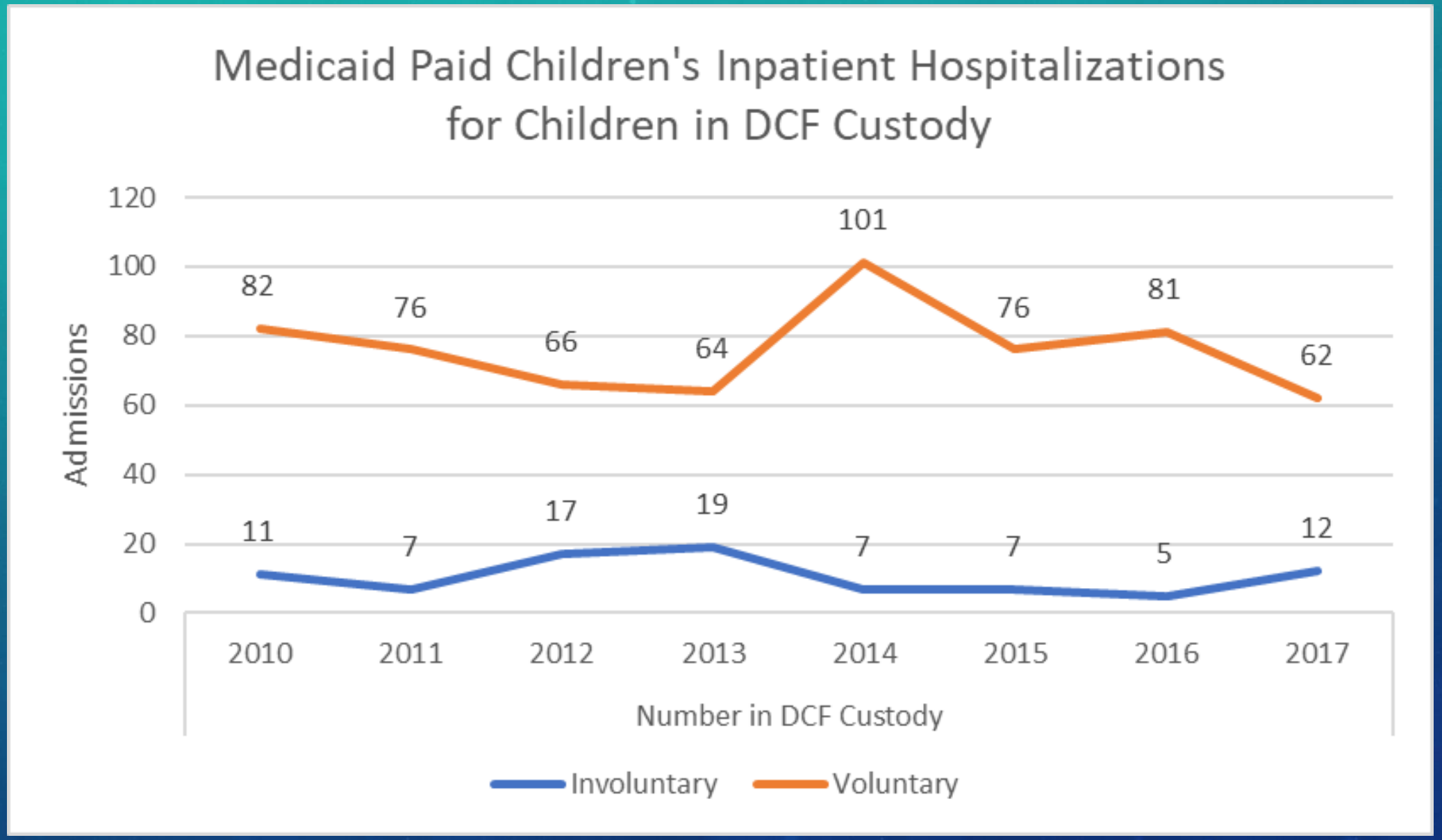
Fiscal Year	% of bed days utilized by children	Total Bed Days (children)	% of individuals served in VCIN beds who were children
2015	18%	95 days	20%
2016	12%	108 days	9.5%
2017	16%	91 days	10%

INPATIENT ADMISSIONS



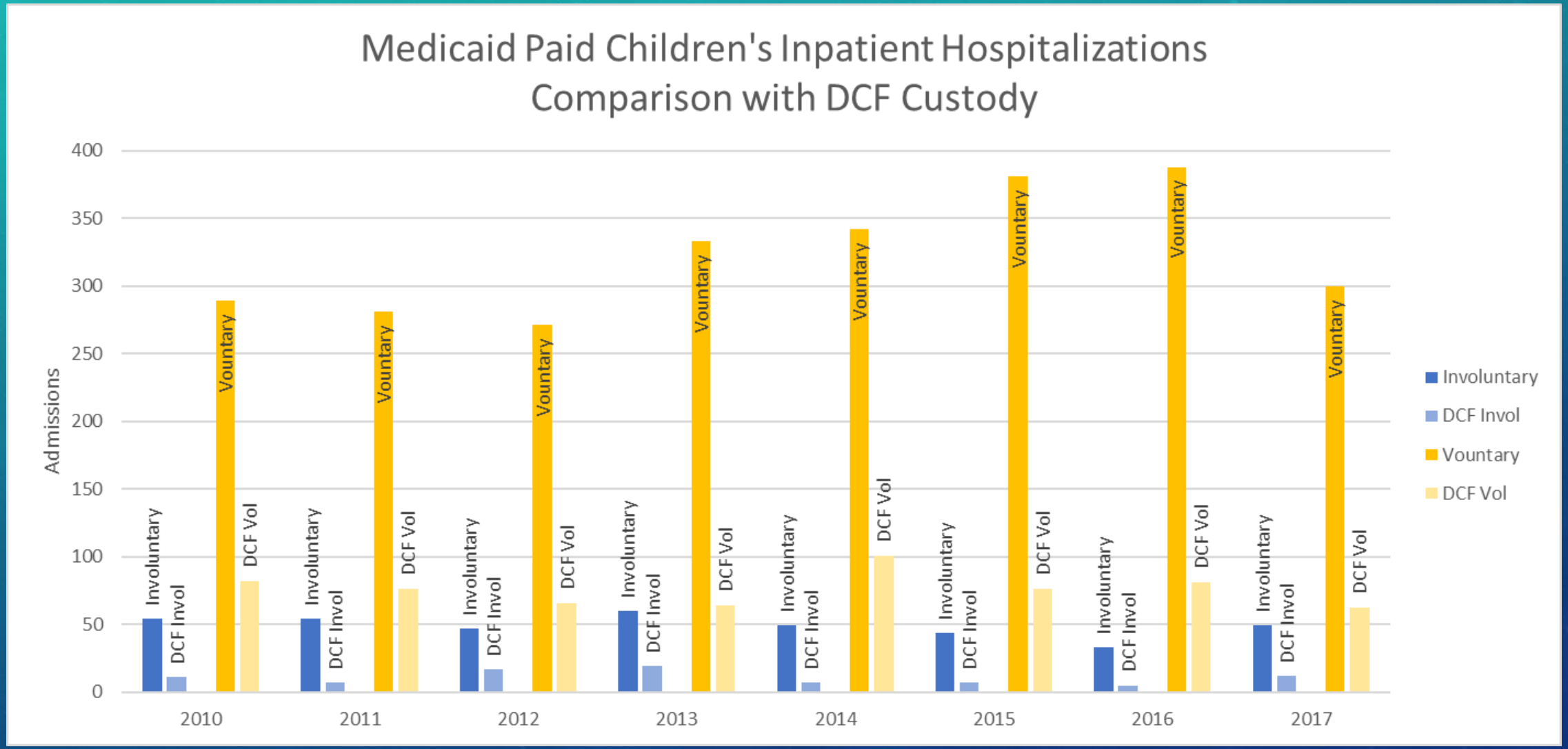
Source: Vermont Department of Mental Health Children's Inpatient End of Year Report

INPATIENT ADMISSIONS: DCF CUSTODY



Source: Vermont Department of Mental Health Children's Inpatient End of Year Report

INPATIENT ADMISSIONS: COMPARISON WITH DCF CUSTODY



Source: Vermont Department of Mental Health Children's Inpatient End of Year Report

DESIGNATED AGENCY CRISIS SERVICES

TABLE 2A-8a Youth ages 0-17 only

EMERGENCY/CRISIS ASSESSMENT, SUPPORT AND REFERRAL

Fiscal Year 2017

	Total	All Programs of Service		Children's Services		Emergency Services	
	Clients	Number	Services	Number	Services	Number	Services
OVERALL	10,480	1,807	5,120	1,120	2,476	821	2,582

TABLE 2A-8a Youth ages 0-17 only

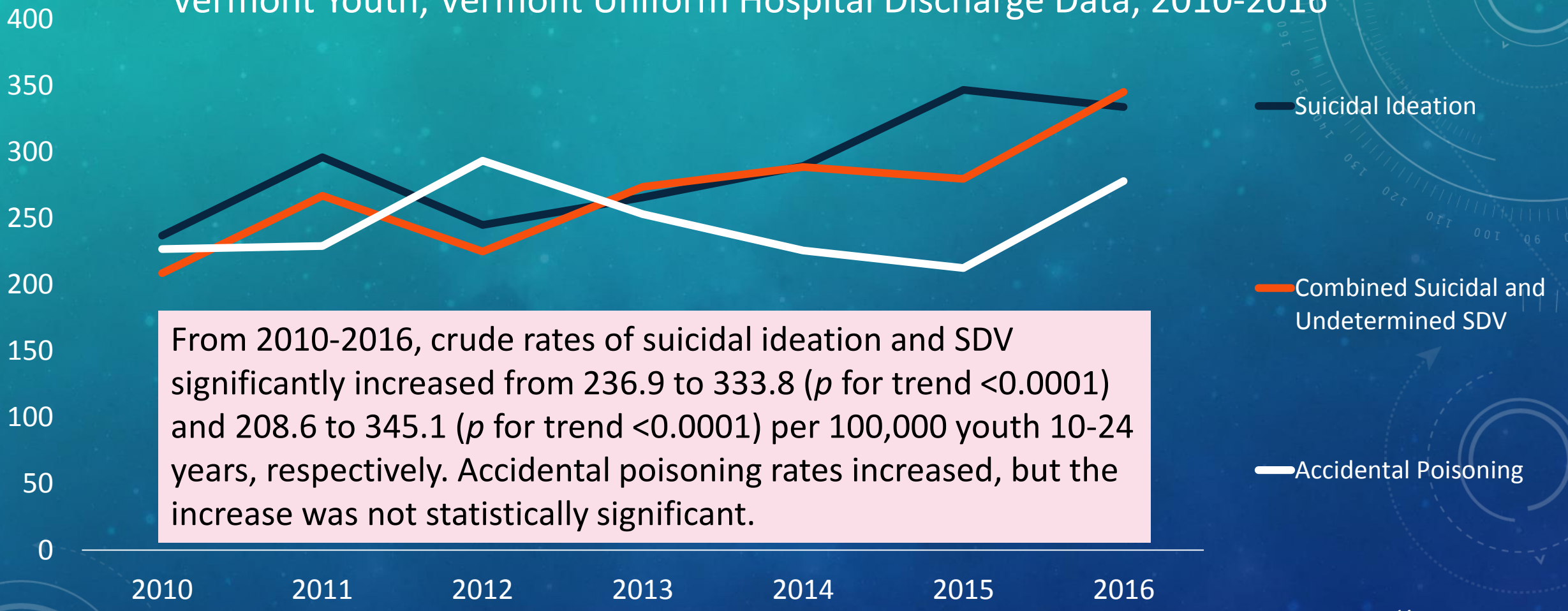
EMERGENCY/CRISIS ASSESSMENT, SUPPORT AND REFERRAL

Fiscal Year 2016

	Total	All Programs of Service		Children's Services		Emergency Services	
	Clients	Number	Services	Number	Services	Number	Services
OVERALL	10,527	1,910	5,995	1,483	4,723	531	1,192

DMH Monthly Service Report extract. Coding of emergency/crisis services to *Primary Program of Service* appears to have changed between 2016 and 2017.

Crude Rates of Suicidal Ideation, Self-Directed Violence (SDV), and Accidental Poisoning (per 100,000 Vermont Resident Youth 10-24 Years of Age) among Vermont Youth, Vermont Uniform Hospital Discharge Data, 2010-2016



From 2010-2016, crude rates of suicidal ideation and SDV significantly increased from 236.9 to 333.8 (*p* for trend <0.0001) and 208.6 to 345.1 (*p* for trend <0.0001) per 100,000 youth 10-24 years, respectively. Accidental poisoning rates increased, but the increase was not statistically significant.

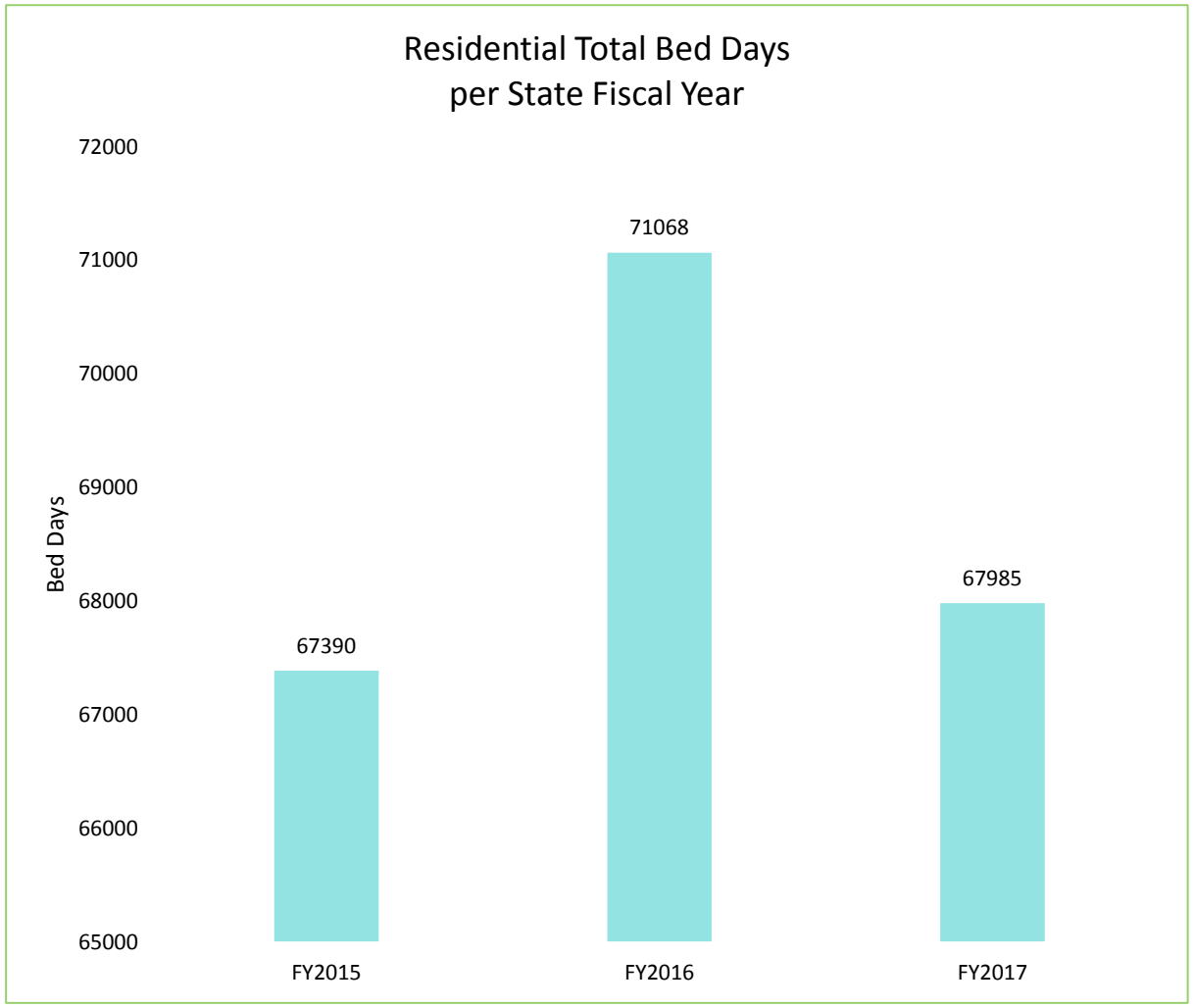
Kasehagen, L. 2017

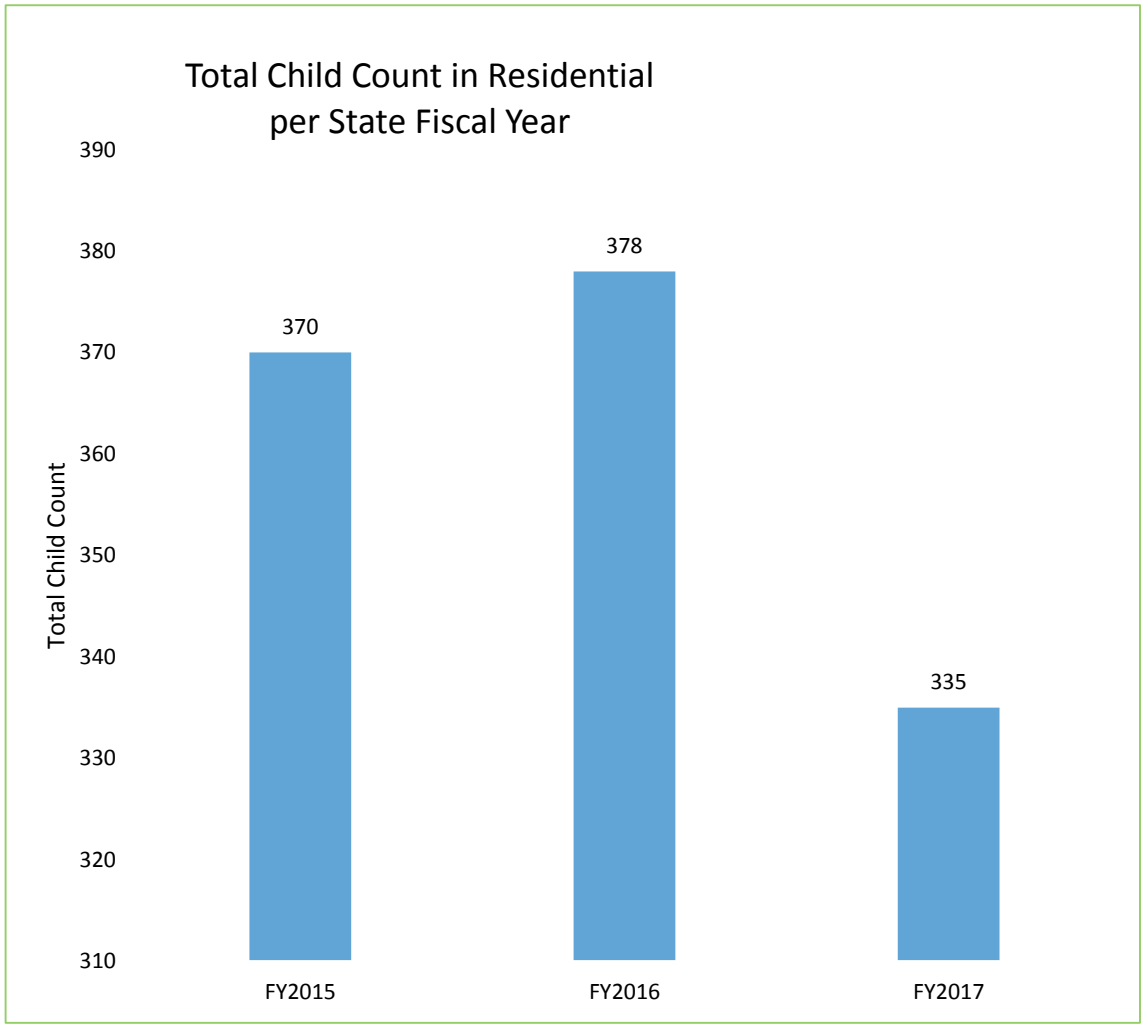
Number of Episodes and Crude Rates of Suicidal Ideation, Self-Directed Violence (SDV), and Accidental Poisoning (per 100,000 Vermont Resident Youth) by Age Group, Vermont Uniform Hospital Discharge Data, 2010-2016						
Episode Types		All Youth				
		10-12 years	13-15 years	16-18 years	19-21 years	22-24 years
Suicidal Ideation Only	crude rate / 100,000 youth	77.6	283.7	351.7	311.9	372.5
Combined Suicidal SDV & Undetermined SDV Only	crude rate / 100,000 youth	61.4	364.9	380.8	271.1	243.5
Accidental Poisoning Only	crude rate / 100,000 youth	189.6	171.5	223.3	265.8	356.7
Any 2 or All 3 Episode Types	crude rate / 100,000 youth	26.3	298.5	328.9	225.9	268.7
Total Number of Episodes	crude rate / 100,000 youth	354.9	1118.6	1284.7	1074.7	1241.3

Kasehagen, L. 2017

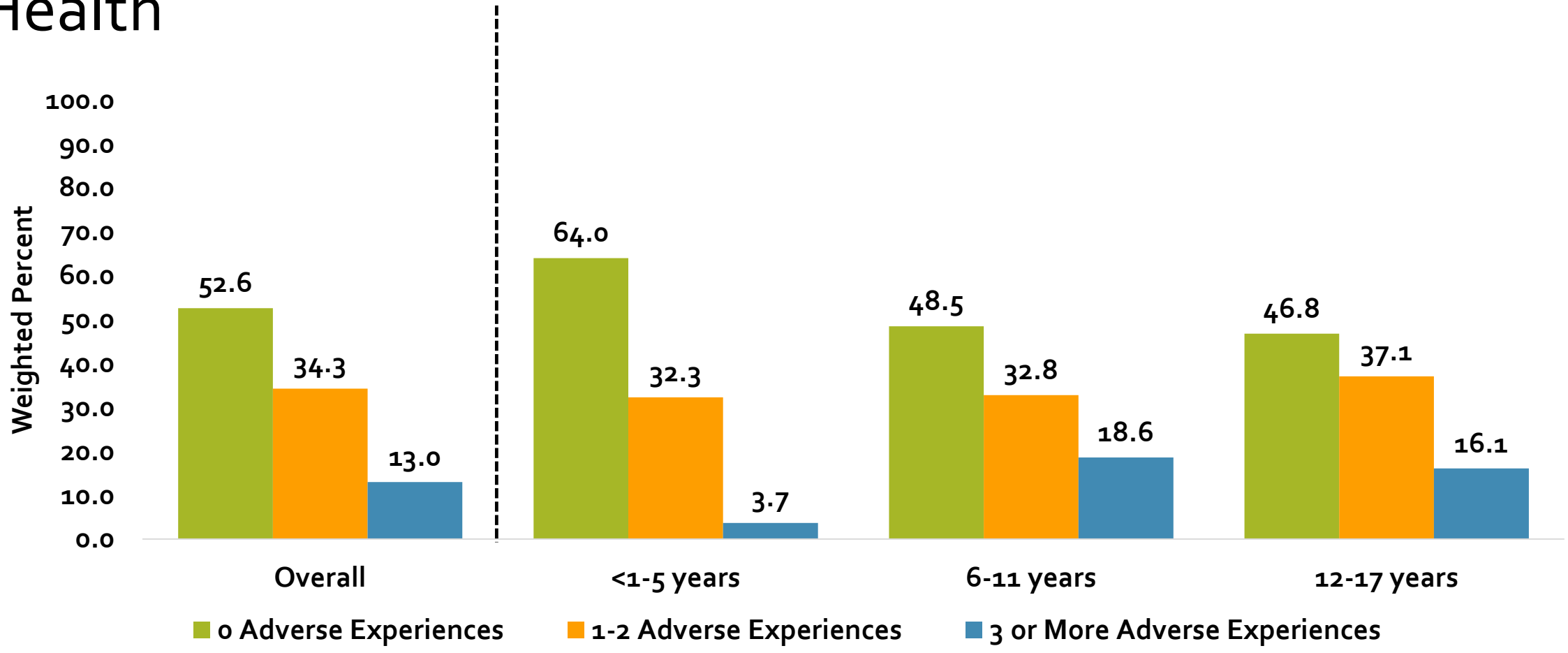
CHILDREN AND YOUTH IN RESIDENTIAL CARE: BED DAYS AND TOTAL CHILD COUNT

DATA COMPILED BY DEPARTMENT OF MENTAL HEALTH



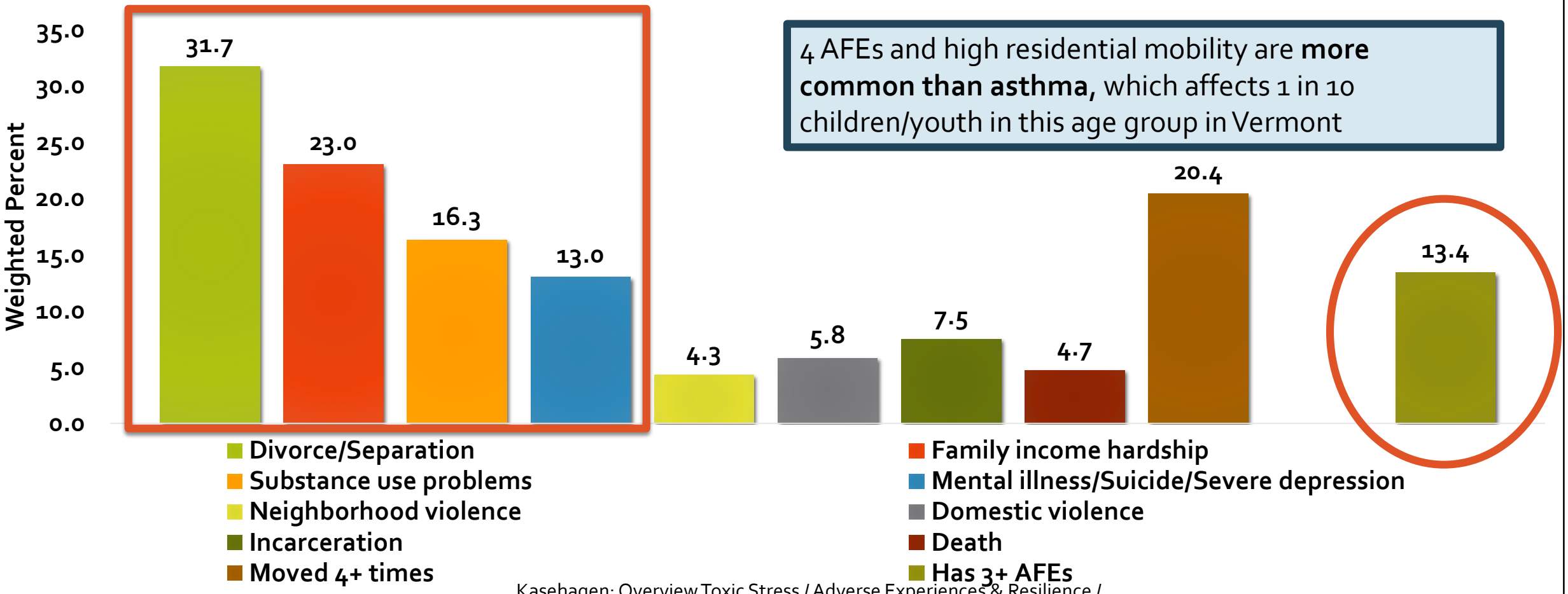


Prevalence of Adverse Family Experiences among Vermont Children, <1-17 years, 2016 National Survey of Children's Health



Burden of Adverse Family Experiences and Residential Mobility among Vermont Children & Youth 6-17 years, 2016 National Survey of Children's Health

AFEs are risk factors, e.g., some children live with a parent with a MH issue and MH issue is treated and not impactful to the child in a negative way



4 AFEs and high residential mobility are **more common than asthma,** which affects 1 in 10 children/youth in this age group in Vermont

PROMISING PRACTICES/MODELS IN OTHER STATES- NEW JERSEY

- Centralized call center 24/7
  - BA-level call center staff with access to clinician and child welfare expert
  - Triage & warm hand-off to local mobile response service system (MRSS)
  - Electronic case record accessible by mobile response team
- Verbal consent; presumptive eligibility
- Local mobile response service system (MRSS)
  - 72 hr intervention
  - De-escalation, assessment & planning
  - Crisis Assessment Tool (short version of CANS)
  - Service contracts through RFP and are all embedded in either a community mental health center or hospitals
- Follow up stabilization services for up to 8 weeks (56 days)
- Child Welfare policy that within 24 hours of a foster placement, mobile crisis goes to home regardless of the reason child entered care

PROMISING PRACTICES/MODELS IN OTHER STATES - CONNECTICUT

- Centralized call center 24/7
  - Triage & warm hand-off to local mobile response service Local mobile response services
- Local Mobile crisis to homes, schools, Emergency Departments, community
  - Crisis stabilization
  - Diversion from ED/inpatient
  - Clinical assessment using standardized instrument
  - Access to psychiatric evaluation & medication management
  - Collaboration with families, schools, hospitals, other providers
  - Referral and linkage to ongoing care as needed
- Follow up services for up to 45 days
- Standardized training of workforce (have examples of topics)

COMMON COMPONENTS FROM NJ & CT

- Crisis defined by the caller – **Just Go!**
- Time response expectation (NJ 1 hr; CT 45 min)
- Robust staffing
- Clear annual workforce development & standardized training
- Core intervention skills
- Routine data reporting, data analysis, ongoing quality improvement

SMALL WORK GROUP

Design a mobile crisis system

Things to Consider in your discussion

- Who is the population?
- What is provided?
- How is 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?

VALUES FOR VERMONT'S SYSTEM OF CARE

- Child-Centered, Family-Focused
- Collaboration Between and Among Families, Agencies and Community
- Individualized
- Family-Driven
- Strength-Based
- Culturally Competent
- Community-Based

LARGE GROUP REPORT OUT

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?

THANK YOU FOR COMING!

Turn your face to the sun and the shadows fall behind you.

- *~Maori Proverb*

For questions please contact any of the following individuals:

- Diane Bugbee, Department of Disabilities, Aging and Independent Living at Diane.Bugbee@Vermont.gov
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