REPORT ON THE SYSTEM OF CRISIS CARE FOR PEOPLE IN RECOVERY

A Project of the North Central Regional Mental Health Board

Site Visits Conducted July 2014 – 2015

Respectfully Submitted:

Marcia DuFore, Executive Director
Quyen Truong, Review & Evaluation Staff
Susan Coogan, Review & Evaluation Chair

North Central Regional Mental Health Board
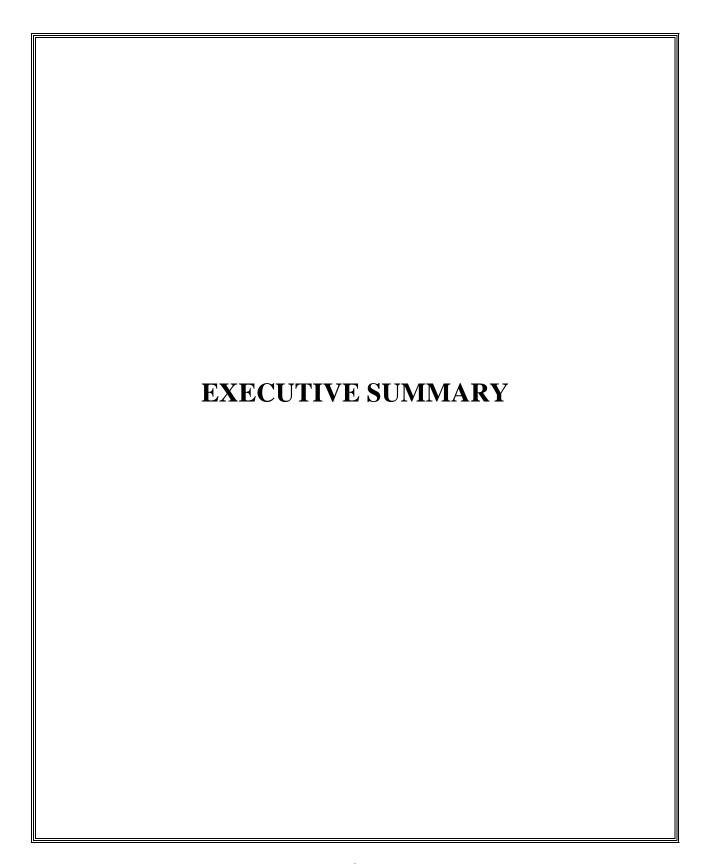367 Russell Road
Newington CT 06111
860-667-6388

Final Report – August 2015

Report on the System of Crisis Care for People in Recovery

North Central Regional Mental Health Board
August 2015

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Report on the System of Crisis Care for People in Recovery

North Central Regional Mental Health Board
August 2015

Members of North Central Regional Mental Health Board wish to thank its six Catchment Area Councils (CACs), the Local Mental Health Authorities (LMHAs) in Region IV, agencies providing mobile crisis services, their staff, and persons in recovery who participated in the discussions held during this review. We hope that all the participants see this report as their opportunity to convey to the Department of Mental Health and Addiction Services their perceptions and recommendations.

In FY 2014-15, the North Central Regional Mental Health Board (NCRMHB) conducted a review of DMHAS funded mobile crisis programs and community supports in Region IV to achieve the following objectives:

1. Understand the particular crisis care models and outpatient crisis management currently available in the region
2. Document how mobile crisis care has been implemented; and
3. Assess the effectiveness of crisis care programs in creating recovery pathways for people in crisis.

To do this work, NCRMHB conducted a series of reviews with agencies in Region IV that offer **mobile crisis support** programs. Additional site visits were scheduled with Town Social Services staff, police departments, families, clinicians, mental health professionals, and people in recovery. Finally, NCRMHB facilitated Catchment Area Council (CAC) discussions in order to gain a full picture of how crisis care programs impact people in Region IV. We looked at the role they play in helping people in crisis recover from triggered situations.

This report focuses on issues that arose from crisis program visits and interviews with persons in recovery, families, and key stakeholders as indicated above in each of the CACs in our region throughout FY 2014-15:

A total of **14 NCRMHB volunteers participated in the reviews as interviewers**. Review teams were comprised of NCRMHB staff, NCRMHB Review and Evaluation Committee members, and CAC members that included persons in recovery, family members, provider members, and concerned citizens.

We hope that our review efforts will stimulate further discussion among the region's mobile crisis programs, the agencies that provide inpatient and outpatient services, DMHAS, and our various community partners, so that system-wide and cross sector improvements can be made to broaden the impact and increase the effectiveness of crisis response and care in our region.

OVERVIEW

In Region IV, mobile crisis services are available under DMHAS contract to offer mobile, readily accessible, rapid response, short term services for adults (18 and over) experiencing episodes of acute behavioral health crises.

Mobile crisis services focus on evaluation and stabilization activities. These include assessment and evaluation, diagnosis, hospital pre-screening, medication evaluation and prescribing, targeted interventions and arrangement for further care and assistance as required. Mobile crisis services should be provided in person following a telephone screening when an individual is experiencing sudden, incapacitating emotional distress or other symptoms. **Mobile emergency crisis clinicians shall assist and collaborate with local police officers** to de-escalate and divert crises.

Mobile crisis services are evaluated by DMHAS on 5 measures. They are as follows:
1) Contractor will meet reporting requirements no later than the 15th day of each month.
2) Contractor will meet at least 90% utilization rate.
3) At least 75% of individuals requiring a face-to-face evaluation will be evaluated within 1.5 hours of initial request.
4) At least 80% of all mobile crisis evaluations will be conducted in the community (person's own community settings - outside of clinical care, within neighborhoods, people's residences, schools, parks, etc.).
5) At least 90% of individuals evaluated by mobile crisis will have at least one other service within 48 hours.

However, it should be noted that mobile crisis services are not evaluated on measures involving people's experiences, nor on diversion from emergency room, from hospitalization, or from incarceration. These are measures that can indicate success but that are not currently considered.

REGION IV MOBILE EMERGENCY CRISIS SERVICES LOCATIONS

CAC 15 & 17:
Community Health Resources (CHR) – Enfield & Manchester Crisis Services
995 Day Hill Rd., Windsor, CT 06095

CAC 16:
InterCommunity (IC) – Crisis Services
281 Main St., East Hartford, CT 06118

CAC 18 & 23
Capital Region Mental Health Center (CRMHC) – Mobile Crisis
500 Vine St., Hartford, CT 06112

CAC 19:
Wheeler Community Response Team (CRT) – CMHA
91 Northwest Dr., Plainville, CT 06062

- **Community Health Resources (CHR)** has **2** staff plus the mobile crisis director weekdays from **9am-9pm**, and weekends **10am-8pm**. All calls go through the CHR Assessment Center. After-hours calls roll over to the Institute of Living (IOL). The IOL Assessment Center pages the MCRT on-call clinician after hours to manage CAC 15 and CAC 17 area crises. The MCRT on-call clinician determines how to manage the crisis and develops a crisis plan: if in an imminent crisis, the IOL Assessment Center and/or MCRT on-call MCRT Clinician will contact the appropriate police department for intervention; other dispositions include telephone contact with the consumer/family/provider to provide support and to arrange a crisis assessment the next morning. CHR is a provider for **Emergency Mobile Psychiatric Services (EMPS)** for children and adolescents who are experiencing psychiatric or behavioral health crises.

- **InterCommunity (IC)** mobile crisis unit has **3** full time LCSW clinicians, and **1** non-licensed therapist. In addition, 3 other staff are on-call to respond to after hour emergencies. Calls roll over to IOL at **4:30pm**, and mobile crisis is available until **11pm.** There has been a reduction of mobile crisis calls from previous years partly due to the availability of walk-in same day access. IC has EMPS for a six town catchment area: East Hartford, Wethersfield, Marlborough, Rocky Hill, Newington and Wethersfield. IC's Addiction Services division (formerly ADRC) has a detoxification center and the SATEP access line number is contracted through Advanced Behavioral Health.

- **Capital Region Mental Health Center (CRMHC)** offers mobile crisis and intake services from the same unit. The intake team is staffed by 2 people with availability of psychiatrists and APRNs. Daytime mobile teams have **5** people, and evening teams have **3** people covering a shift from **4pm - 12:30am**. Generally, 3-4 mobile crisis visits occur per day. All mobile crisis staff are Crisis Intervention Team (CIT) trained.

- **Wheeler Community Response Team (CRT)** provides mobile crisis services under contract with CMHA. Wheeler operates 2 shifts with a part-time therapist and **2** clinicians each offering face-to-face service **until 10pm**. Outreach is done in pairs. On weekends, the office operates **9am-5pm** with non-licensed staff. There is telephone support 24/7, and 3 shifts with a licensed clinician on call. Wheeler also provides **2-1-1** back up for the whole state. Mobile crisis staff may provide short-term case management as a bridge service if there is a waiting list for case management through CMHA. Wheeler is a provider for national suicide hotline and is also a provider for **EMPS**. Wheeler also offers Helpline, which includes an Access Line for entrance to detox.

RELATED CRISIS CARE PROGRAMS

The state of Connecticut (CT) has made a significant investment in specialized training in the **Crisis Intervention Team (CIT)** model to respond to the needs of adults with emerging mental health and substance use disorders. The goal of the CIT model, described as a best-practice model by the Police Executive Research Forum, is safety: for the community, the law enforcement officer, and the person in crisis. Not only does the program promote safety for all involved, it also

links the person in crisis to services in the community whenever possible. CIT is specially designed for the patrol officer – the first responder. The training is one forty-hour week, and involves safe de-escalation techniques, suicide risk assessment and prevention, mental health and trauma, and real life individual and family perspectives on living with mental illness. After the one-week training officers receive periodic updates and annual advanced training. The training is fully funded by DMHAS and comes at no charge to federal state or local public safety agencies in CT. As the Director of the Memphis Police Department states, "CIT promotes education, sensitivity, understanding and the building of community partnerships."[1] As of August 2013, over 1700 police officers in 88 state, federal and local public safety agencies and their community mental health partners have received Crisis Intervention Team Training from the Connecticut Alliance to Benefit Law Enforcement (CABLE).[2]

In addition, **Specialized Crisis Intervention for Young Adults (SCYA)** is a unique partnership between DMHAS, Advanced Behavioral Health (ABH), CABLE, and the National Alliance for Mental Illness (NAMI). SCYA is being evaluated by researchers from UConn to track its impact on reducing treatment barriers and diverting young adults from the criminal justice system. The goals of SCYA include 1) engaging and linking young adults to treatment and support services, 2) providing training and ongoing consultation to CITs on engaging young adults in treatment or support services, 3) recognizing early psychosis, 4) identifying a statewide network of treatment providers and other resources for young adults, and 5) implementing young adult peer support groups statewide and networking through social media.

Finally, several new **Community Care Teams (CCT)** have been initiated in the Greater Hartford area following a model piloted by Middlesex Hospital. Currently, St. Francis and Hartford Hospital have a combined team, and Bristol Hospital has a team. There is one developing in Manchester. The Community Care Team model was developed to provide patient centered care and improve outcomes by developing wrap around services through multi-agency partnership and care planning. These teams are usually comprised of local community providers and agencies that deliver services. Medicaid Members who have complex, high risk factors and have been identified as "frequent Visitors" of the Emergency Department and Inpatient services are typically the targeted cohort. The desired outcome is that the pattern of ED utilization and other higher level of care services will be interrupted by the customized care efforts of the local CCT. These teams can also be instrumental in creating innovative interventions that result in expediting referral response time, promoting connect to care initiatives, exploring housing alternatives and decreasing readmission rates for inpatient levels of care. Value Options is supporting 5 Community Care Teams in CT. Each team has been assigned one Value Options Intensive Case Manager (ICM) and 1 Peer Specialist (Peer), who work with identified individuals to assist with connections to care and wraparound services.[3]

---

[1] CABLE website, 2013 Connecticut Alliance To Benefit Law Enforcement

[2] NAMI Connecticut and CABLE informational flier

[3] Dan Langless, ValueOptions Regional Network Manager - Letter to the Community, Connecticut BHP, September 2014.

R&E MEMBERS' QUESTIONS

During our crisis care review, our R&E members asked, "Do we have a good system of care that needs to be tweaked, or do we have the wrong system?" The R&E team wondered, "What gaps exist and what collaboration is needed among all the key players in a crisis to de-escalate or to prevent future crises?" Another question that frequently arose was, "Is it a matter of geography?" Why does the crisis care system work better in some towns than others? Is people's quality of care dependent on where they live? The variables of geography and resources of different CACs may contribute to an uneven system of care.

Overall, the R&E team concluded that a large number of police and emergency responders still **need CIT training**, that hospital care and discharge are problematic, and there is widespread fragmentation and gaps within the continuum of care in the mental health system. People considered it unfortunate that the "CIT training is a voluntary program and many first responders lack the awareness and skills necessary to deal with mental health crises." The team believed that "Crisis is a make-or-break moment when these skills and understanding are of utmost importance." However, people agreed that other parts of the response system need to be shored up as well in order to resolve crises.

A **current challenge** facing crisis care is the **waitlist**. According to some service providers, even if the agency offers same-day access, people in crisis still cannot see a psychiatrist right away. If **access to psychiatric services is not available promptly, crises are likely to persist** and even escalate. A mobile crisis director shared that approximately 40-50% of clients seen in Region IV are unknown to the evaluating crisis team. This means more people are having crises and people do not have enough access to care. Moreover, calls directly from individuals (rather than from clinicians or mental health or addiction centers) have increased – which poses particular challenges when mobile crisis staff are unable to refer to people's previous history. Staff must grapple with whether behaviors or symptoms are attributable to substance use rather than mental health, whether the individual has a history of violence, or homicidal or suicidal ideation.

Some new options are available to alleviate crisis thanks to the passage of recent legislation. For example, the **increased availability and use of Narcan,** an opioid overdose reversal drug, helps avert drug-induced crisis. According to the Hartford Dispensary, Narcan can be prescribed to family members, agencies can buy Narcan for community health workers, and police and other emergency responders can carry and dispense Narcan in emergencies they encounter. Legislation was recently passed to allow a pharmacist to provide Narcan following provision of a brief educational session but this is rolling out in October 2015; it has not started yet. Narcan will also be able to be dispensed directly by trained and certified pharmacists without a physician's order. The inhaler application is easy to use and as inexpensive as the injectable form. Additionally, the price of Narcan has gone down, making it more accessible to more people.

OVERALL STRENGTHS

Region IV's mobile crisis teams are strong in these key ways:

1) **Low Staff Turnover**: Most crisis teams have low staff turnover, which means staff know and understand individuals in crisis as well as the communities they live in. This leads to more effective and efficient responses to crisis situations.

2) **Strong Integration within the Local Mental Health Authorities (LMHAs)**: Mobile crisis teams work well within their LMHAs. They go to debrief meetings, share pertinent information daily, and actively work with clinicians and mental health agency staff as part of a team to address crisis issues. Mobile crisis teams are a valued part of LMHAs. With the exception of CMHA, who outsources to Wheeler, Region IV's LMHAs have integrated mobile crisis units. Even with CMHA, Wheeler's mobile crisis staff are improving at communications and meet weekly with CMHA about people at highest risk.

3) Social services staff report that **mental health crisis responders are very good at assessing a situation quickly** and taking charge of an often chaotic environment. Crisis responders in general are well informed on the community resources, wait lists and referral procedures that often expedite treatment and keep insurance costs down by avoiding a hospital visit if unnecessary.

4) Mental health crisis responders do a good job of **providing crisis debriefing, psychological first aid, post-traumatic stress management and providing resources**. They will do whatever is needed and are community involved. They do need more and improved training especially for universal screenings and suicide prevention.

5) LMHAs that operate **Enhanced Care Clinics (ECC)** offer an important treatment resource for people in crisis**.** These clinics have a higher Medicaid rate and they must provide certain services in a critical timeframe to respond to crisis care needs. ECCs in LMHAS make it easier for ERs to discharge people into community. Wheeler, CHR and InterCommunity operate ECCs.

6) The **longevity of Crisis Team staff** in all locations speaks to the strength and knowledgeable nature of these mobile crisis teams. They are truly an asset to crisis care.

OVERALL RECOMMENDATIONS

Recommendation #1: Increase Collaboration and Communication between Region IV Crisis Care Professionals (mobile crisis, emergency and inpatient psychiatric settings, town social services, police, shelter programs, etc.)

Effectively triaging and connecting people in crisis to appropriate services is greatly enhanced when a strong collaborative relationship exists between mobile crisis, hospital staff, town social services, police, and shelter programs. Our review team observed that mobile crisis teams that regularly met with police, town social services, and homeless shelter directors were able to establish relationships and **create a network of support for people in crisis, thus reducing**

churn and aiding with recovery efforts. This is especially important for towns at the edges of the catchment area. Because these towns are at the periphery and may have smaller segments of the population, they may be harder to reach in time and as a result, may rely more on good police response. Mobile crisis staff from various catchment areas can also meet to learn from one another. Identifying best practices among and between towns in our region will only strengthen their work.

Another barrier to good patient care during crisis is the **reach of coordination** on the part of discharge planners on inpatient units. High-risk people stabilize to the point of discharge to the community, but community providers aren't included in discharge plans and sometimes aren't notified of the discharge before it happens, even though providers make attempts to communicate with inpatient staff. Part of this stems from the confusion around HIPAA laws. CMHA has a written contract that meets HIPAA standards, but the police are not invited to crisis meetings due to HIPAA restrictions. In contrast, CHR's interpretation of HIPAA is that it is **okay to share information in an emergency,** so there can be information sharing with police and other first responders. CHR staff believe that **under continuity of care, responders can share information in compliance with HIPAA**. CHR's interpretation of HIPAA enables sharing information with the police and other clinicians and community supports, as needed. Regardless of whose interpretation is more accurate, there needs to be clarification around HIPAA and how to make information less restricted to help people in crisis.

Improvement is needed in the areas of communication and collaboration with community providers and stakeholders. Often when mental health providers make referrals such as to DCF, DSS, or APS, no follow up takes place. This leaves the referral source with questions regarding responsibility about follow up. **Improved communication and collaboration is needed** for continuity of care. The transition from hospital to community needs to be a group effort. Communication regarding the discharge plan needs to be communicated to the providers who will be resuming or beginning treatment as well as to a social worker/case manager to ensure that discharge planning, referrals, and paperwork were completed. One therapist said it is important to have an open dialogue – where everyone involved in a person's life is invited to the table to talk about different perspectives and plan for averting crises together.

Recommendation #2: Focus on Training Police
Many issues arise from lack of understanding and knowledge about how to approach people in crisis from mental health or addiction issues. Numerous personal accounts and studies confirm that police with CIT or Mental Health First Aid training more successfully avert and/or respond to crises than their untrained counterparts. Additionally, it is important to expand training to EMTs. Also, communication is very important between mental health providers and local police.

Recommendation #3: Develop alternatives to hospital psychiatric settings for people experiencing mental health crises.
Develop alternatives along the continuum of care for people who are able to step down from inpatient care but need higher levels of support for safe discharge back into the community. Some useful programs that could be expanded include: respite, more step down beds, more ACT teams, detox and substance abuse treatment for people who are actively using but not yet in crisis, visiting

nurses for disabled or older adults, more options for structured programming during the day, meaningful substance use treatment for young adults, assisted living for people with co-morbid conditions, dementia, diminished cognition, or medical complications from the psychiatric medications they are taking,

Access to care for people who need more structure and support is lacking for youth and adults. If a person needs help filling out forms, applications or paying bills, and has no family or other support, they will lack consistent care and may end up homeless or worse. The consequence of not accessing appropriate levels of care is crisis. It is frustrating to see people get into chronic life situations when it could be prevented.

One therapist said there should be more variety and homey relationship-based crisis centers with respite programs. "There should be opportunities for learning and lifestyle changes, instruction on nutrition, yoga, and a clinical team comprised of peers, a shelter without expectations. There should be a **variety of places of care to choose from**: EDs, inpatient care with medication management and crowd control, and peer respite programs."

Access to care for people who need more structure and support is limited. **More group homes** are needed. The barriers to each point in the continuum of care could be ameliorated with a coach to help individuals find and apply for resources. The consequences of not accessing appropriate levels of care are 1) readmission to the hospital, 2) not being able to integrate back into the community, and 3) frustration, challenges for people, and feeling like they are alone and on their own.

More resources are needed for existing services to **provide longer periods of service**. This insures that people are stabilized before release into the community, and that once there, they have the supports needed to maintain stability. Another frustration is that mobile crisis staff and clinicians cannot place someone into Intermediate Care beds if they are homeless; the person must have an identified place to go to as part of their disposition. To create proper transitions from hospital to community, **more structured community support services** are needed.

Recommendation #4: Monitor and Improve 2-1-1 and the Coordinated Access System for Housing or Shelter Referrals
Many people commented about difficulties experienced with the transition to the new Coordinated Access System for housing or shelter referrals (all referrals and appointments for priority designation must now go through 2-1-1). Since 2-1-1 is now a clearinghouse for shelters, the service is inundated with calls and the wait time is problematic. Return calls from the service are also unreliable. Phone wait times are a particular challenge to individuals who are homeless and without a cell phone or on a cell phone with limited minutes. Referral for housing is now a two-step process, with the second step being the assessment for priority designation (using the Vulnerability Index – Services Prioritization Decision Assistance Tool, or the VI SPDAT) Wait times, although improving, are also problematic for this step. There is a lot of work to be done to make 2-1-1 and the Coordinated Access Network a dependable referral system for people who are homeless.

Recommendation #5: Education at the Community Level
Educate the broader public on mental health and addiction issues. Educate employers. Create a community where people in recovery can be welcomed to live and work via advocacy and education efforts.

There is a misunderstanding about what EDs can reasonably do for people. People are disappointed to find that insurance does not fund detox. There should be an emphasis on community-based treatment – hospitalization should not be the first course of action; we must ensure that all other least restrictive settings have been considered. There also should be education of families and community referrals on the role of mobile crisis, assessment versus hospitalization, and the use of Emergency Certificates (EC), in which an M.D. must assess someone within 24 hours.

A woman from another part of the state shared that she was arrested during crisis. The friend who called mobile crisis for the woman was concerned for her well-being. They called 2-1-1 and could not connect even though it was at the middle of the day on a Friday. They had to call 9-1-1 so police came, but she was seeking psychiatric help. Police involvement was a result of a breakdown in communication. She said that mobile crisis responders eventually came but by this time she was deep in crisis and she did not feel heard. Her situation was not treated appropriately, there was no follow-up, and she tried to articulate that she needed help as things were spiraling, but she was arrested instead of treated. Her friend noted that people outside of the mental health system do not have the language to discuss their situation. This lack of understanding stems from the **need for more education at the community level**. The woman in crisis would have benefited from knowing what to say or how to behave in these trying circumstances, and police would have benefited from knowing how to better de-escalate the situation.

Recommendation #6: Review DMHAS Quality Standards and Measures Tracked for Monitoring Performance
While we are trying to improve mobile crisis programs, it is important to be clear about quality standards for DMHAS and measures used for tracking performance on the DMHAS Provider Quality Report. One of the quality standards requires providers to provide assessments "in community locations" 80% of the time. However, there are varying interpretations of "community locations" among providers. IC included their clinic setting as a "community" location, but CHR and CRMHC staff feel strongly that crisis assessment should be conducted in the person's home environment or natural setting where crisis is occurring. Due to these differing interpretations, it is difficult to measure adherence to the "community" standard. Additionally, the 48-hour measure is problematic because the client must touch another DMHAS organization in the 48 hours to count as a follow up. This measure doesn't gauge all follow up, it only acknowledges DMHAS touches as follow up. It does not even include mobile crisis follow-up. The 48-hour measure therefore does not accurately assess follow up outside of DMHAS. And very importantly, there are no standards or measures that reflect outcomes for the person in crisis - the quality of the individuals' experience or diversion from hospital or incarceration.

Recommendation #7: Promote the Use of Community Care Teams, Gridlock Committee and Central Access Networks (CANs)
One person from CAC 23 noted, "ERs are Band-Aids that treat symptoms and then let them go." To address complex medical conditions, people need teams of clinicians and healthcare providers to help them manage their health. We need to promote these essential services as a means of enhancing care, improving discharge planning and follow-up, and ameliorating outcomes for people for whom crisis response results in emergency or inpatient hospitalization. Community Care Teams can help address the need for a warm hand-off and work with ERs on releasing people before they are stabilized. Community Care Teams (CCT), the Gridlock Committee, and Central Access Networks (CAN) all serve to address complex cases, to resolve gridlock issues in hospitals, and coordinate to better triage people in crisis.

The Camden Coalition (CC) in New Jersey is an example of how we can continue to address complex medical cases and help the high utilizers of EDs and hospitals. Camden Coalition members share information through the **Camden Health Information Exchange** (Camden HIE). With relevant, real-time data, CC's cross-disciplinary **care teams** connect quickly with people who have high rates of hospitalization and emergency room use, and help them address their complex needs. Since 2002, CC has been demonstrating that human-centered, coordinated care, combined with the smart use of data, can improve patients' quality of care and reduce expensive, ineffective inpatient stays and emergency room visits. The Coalition holds a **monthly Care Management Committee meetin**g that rotates between the hospitals and is attended by social workers and other supportive services providers from across the city. This committee helped to oversee the development of the high utilizer team and continues to advise the Care Management Program.

Through the Coalition's work with high utilizers the staff has built close relationships with emergency room physicians, hospitalists, specialists, social workers, and nurse discharge planners across the city. These relationships are crucial to the team's success and ensure good discharge planning and care coordination upon discharge.

Recommendation #8: Develop Cultural Competency
Diversity of staff should be improved in mobile crisis care. Increased clinical trainings and better relationships with diverse communities also helps. Clinicians need more time and training devoted to multicultural issues. Clinicians-in-training need a field placement requirement for at least one semester so they can see exactly what's going on. According to hospital staff, "language lines" don't work well. Additionally, they admit "we have a difficult time working with deaf patients. Sign language interpreters are expensive (must reserve for a minimum of two hours). And you have to call ahead so it doesn't work for crisis!" Clinicians must learn to work with people across cultural and language barriers.

Mental health services are geared towards Caucasians. In many minority cultures, it is not acceptable to talk about mental health issues. The shame and stigma around mental health and addiction can exacerbate issues. At Asian Family Services – Asians are able to accept help for mental health issues because the organization takes the time to talk about physical ailments and build up trust and relationships. However, mainstream health providers do not make the time nor

allocate resources for this. Sometimes sessions for minorities may take longer because they need time to gain trust. Our system must do a better job at understanding culture. It is also important to help gear people towards a positive, change-maker role. Clinicians need to do a better job of listening actively and reading non-verbal cues.

Recommendation #9: Increase Number of Staff Working in the Mobile Crisis Units.
Every LMHA lauded the work of mobile crisis units. LMHA staff often stated that issues could be averted or improved if they called mobile crisis sooner and more often. However, at least four of our catchment areas talked about concern over the small number of staff working in the mobile crisis units. Many people wondered whether that is sufficient to meet the need.
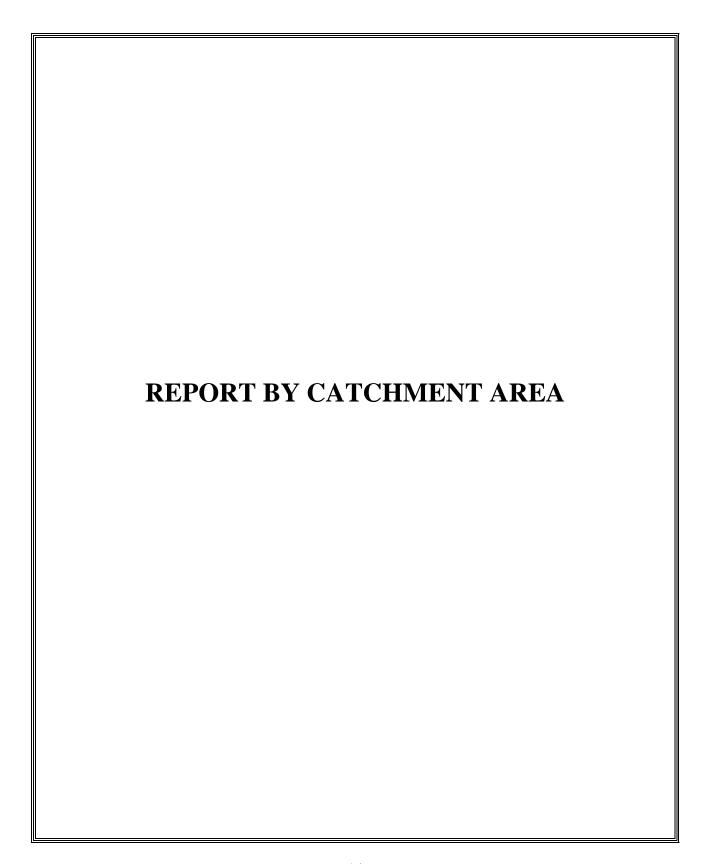
CONCLUSION

This report aims to provide an opportunity for a rich **exchange of ideas** among all the people in crisis care management, from mobile crisis and town social services to police, clinicians, case managers, families, and people struggling to maintain stability. Throughout the review and evaluation process, all the mobile crisis programs provided evidence of **thoughtful crisis management efforts, continuing efforts to improve practices, and a committed dedication to support recovery.**

Methods of Collecting Information:
The review teams surveyed police, town social services folks, family and individuals, clinicians, hospital staff who provide crisis care, staff from DMHAS-funded community health centers, and mobile crisis teams. They also attended NAMI meetings, interagency meetings, and attended CAC meetings. The notes drawn from these interviews inform the analysis of mobile crisis for the sections that follow and help us highlight some best practices.

The report is organized by Catchment Area Councils (CACs) and then subdivided into categories including mobile crisis programs, staff from DMHAS-funded community health centers, and issues raised by CACs. In the Appendix are interviews with police, town social services, families and individuals in recovery, and clinicians. Also included in the Appendix are innovative programs and questionnaires used by the committee.

REPORT BY CATCHMENT AREA

CAC 15
CHR – Mobile Crisis Response Team (MCRT)

The MCRT serves CAC 15 and CAC 17 to address crisis situations. MCRT is targeted to individuals aged 18 years and older with a diagnosis of a severe persistent mental illness (SPMI), or with a psychiatric disorder of sufficient severity to cause a current role disturbance in their occupation, maintaining social relations, self-care, ability to manage tasks of daily living, impulse control, exhibiting high risk behaviors, and are at risk of harm to self or others.

MCRT is responsible for timely Crisis Assessments in the community, crisis intervention, pre-admission screening and triaging, behavioral consultation, referral to respite and step-down services, family consultation, disaster crisis counseling, and critical incident stress management debriefing. MCRT is the gatekeeper and coordinator for all CAC 15 and CAC 17 Connecticut Valley Hospital (CVH) and Community Health Resources Respite services. Requests for admission to these service programs result in an Outpatient or MCRT Crisis Assessment.

After a crisis, MCRT contacts hospital staff, provides a clinical update, and learns why the police are involved. They keep in touch with hospital staff until there is a disposition, inform and update the CHR treatment team, and act as a go-between communicator until the situation is resolved.

Behavioral Health Specialist Patrick Tuckey from the Commissioner's office handles the community call line and sometimes outreaches to a mobile crisis team to conduct a wellness check. Data is tracked for all people who call in, and all staff manage their own caseload.

HIGHLIGHTS:
MCRT is called upon by agency staff for 1) intervening in residential settings with people whose symptoms are beyond what staff can manage; 2) well checks when coming out of the hospital or no shows for appointments; 3) debriefing with staff and people in their programs after traumatic situations.

At the time of our site visit, MCRT's report card reflected that they had 238 unique clients, 271 admits, and 273 discharges. This year, MCRT had fewer unique clients (down 11%), admits (down 19%), and discharges (down 18%) than in fiscal year 2014. In keeping with DMHAS standards, they improved on their "evaluation within 1.5 hours of request" from 63% to 67% over the last year. But they reduced their "follow-up service within 48 hours" from 39% to 31%. They exceeded their goal on "community location evaluation" (100%).

Karen Hanley, director of the program, shared that sometimes the **team goes into the community with police** to respond to crisis. This helps de-escalate the situation and allows clinicians and police to work together toward offering care rather than criminalizing the person in crisis. Hanley meets monthly with the police officers in Manchester and in Windsor. In this meeting, they convene with people who work in shelters, in schools, and who deal with people in crisis so that they can talk about how to better coordinate services. The MCRT is highly regarded by the police in those communities.

CHR operates an **Enhanced Care Clinic (ECC)** at both Manchester and Enfield sites. At ECCs, people can see a clinician within 2 days of referral. However, there a very few people in crisis who present themselves to the clinic as walk-ins. MCRT staff are concerned that a waiting room is not an appropriate setting for a person in crisis, and that crisis assessments should be done in the community in people's natural setting(s). This allows for a more comprehensive and accurate assessment taking into account the physical environment and other people in the setting.

CONCERNS:
As is the case with several mobile crisis services in Region IV, MCRT's report card shows that the follow up service within 48 hours is at 31%. Region IV providers have expressed concern about the validity of this rating because only certain follow-up settings count as "follow-up" and follow-up by crisis staff is not considered as one of those settings. Other common settings not reflected in the data assessed include inpatient care and outpatient follow-up in non-DMHAS settings. Timely follow-up is an important standard, but the way this rating is being measured may not be giving us the information we need to fully understand the problem. Regardless, according to Hanley, the system is pretty stretched. She stated that within any 10-hour shift, there are only 2 clinicians and herself on staff.

Some other issues of concern expressed by CHR staff are: premature hospital discharges, wait times, and missing levels in the continuum of care that result in recidivism.

Manchester police officers shared the following concerns coming from their experiences with Emotionally Disturbed Person (EDP) calls they respond to. One issue is long term care of residents with significant mental illness. People with severe and persistent mental illness often suffer from a continuous cycle of hospital to police involvement. When patients return to the hospital for multiple treatment and assessments, there tends to be negative tension that develops between the patient and hospital staff that leads to issues. Moreover, officers perceive a negative attitude and conduct by emergency room staff toward people they bring to the hospital in response to EDP situations. Finally, there is a **lack of training for group homes** and congregate settings for people with mental health issues. There are questions about whether or not some of the situations police are called into should really be police matters.

RECOMMENDATIONS:
Karen Hanley recommended that the **system of care must become more flexible** and fluid with a **variety of options to meet peoples' needs after discharge** from the hospital. There is no one solution for everyone. She also believes that lack of long-term care after inpatient discharge leads to recidivism. She pointed out a need for more respite, intermediate hospital care, and structured residential settings for people who are coming out of the hospital and in need of intermediary care.

The following are suggested remedies from police officers. First, offer a **specialized mental health unit 24/7**. Second, offer training for ER staff for dealing with people with mental health problems. CIT exists for officers but what about **training for nurses and ER staff**? Third, create a conduct contract for people in residential or congregate settings so that clear expectations are established for people living there. Finally, develop training for staff for dealing with challenging

behavior more effectively and de-escalating situations before they get out of control. Have plans in place for situations that can be managed internally before calling the police. Having plans in place is key.

DMHAS-FUNDED COMMUNITY HEALTH CENTER STAFF: CHR-MANCHESTER

Staff at CHR-Manchester wanted to talk about Strickland House. This place houses 6 people who are acutely mentally ill and have transitioned out of the CT Valley Hospital (CVH). Strickland staff rely on MCRT (or mobile crisis) for help. Strickland staff were present at this meeting.

In situations that require crisis response, people from Strickland call mobile crisis when their residents deteriorate, when they feel 9-1-1 is not enough, when they need an assessment, and when they want to get someone to the ER. Strickland staff assert that MCRT is good at being in touch; one time MCRT helped the Strickland community cope with grieving when one of their residents died. MCRT is also very responsive and comes right away when needed.

Sometimes an individual is on the phone with a clinician, and mobile crisis can come to lay eyes on them. This helps ascertain whether the person needs more care. The MCRT communication with EMTs and police is excellent, according to CHR staff. One staff used to work in the ER and remembers how MCRT came in to help assess and de-escalate the situation. MCRT was in touch during and after discharge. One of the older adults was a super utilizer of the ER, so MCRT came out to chat with this person to get to know them better.

Staff also call crisis when people are suicidal or decompensating. Maybe they admit they are not taking their medication. Mobile crisis is willing to brainstorm before crisis to avert the situation. In tragedies, mobile crisis also comes out to help with grieving. Moreover, MCRT is present at treatment meetings, they help with transition plans, and they know staff and people served by CHR well. CHR staff are grateful for MCRT's involvement.

In regards to the role of police in crisis care – at Strickland, staff call the police when residents are violent, or when they need help. The police are aware of Strickland needs and are patient and understanding. At WISE – the police are aware of older adult clientele and can help with check-ins. Each officer's style and intervention is different, but community policing in Manchester is the "best in the state." When police know people they are more helpful – this has been the case especially in South Windsor and Vernon and Manchester. From the perspective of CHR staff, outside Manchester, police are quicker to "paper" clients, or write PEERs (Physician Emergency Evaluation Request) to get them to the hospital. In contrast, the Manchester police are more apt to work with the staff to determine whether a PEER is appropriate. In towns where the provider/police relationship is not as well worked out, staff are more likely to call mobile crisis to write an Emergency Committal (EC) order. Staff cannot write ECs outside of their program, but MCRT can write an EC for anyone in the community.

MCRT is very good with communication during and after crisis. They are patient and understanding with staff as well as empathetic to the people they serve. CHR and MCRT all access

17

the same system and read the same notes, so they can easily debrief about next steps. They are also good at provider relations, and they are thorough with every aspect of their work.

The follow up after crisis usually involves a debriefing. MCRT will email or call the families, or families will call the Assessment Center and MCRT helps them with information and support. The match-up between what is needed and the follow up care for MCRT is very good.

The frequency of people needing a crisis response varies. It depends on caseload size. There can be crises weekly or multiple times a day, depending on the program.

Mobile crisis does an excellent job of communication, commanding knowledge of the situation, and addressing questions. They are prompt and efficient: they address the problem and tell you how long it will take to get there. MCRT staff can be chatty and friendly but also exercise their authority when needed. MCRT has a low staff turnover, so the MCRT staff know most of the people served by CHR well. CHR staff have absolute trust in them.

CHR staff struggled to find something that MCRT could improve. CHR said "they're so good at responding to crisis care!" Strickland had many sticky situations that MCRT responded to well. CHR said they are getting better at calling MCRT sooner. People in CHR care don't see the crisis team as bad people – they lean on them for support.

As for successes or weaknesses in the system, people talked about how as CHR grows, expectations of the quality and responsiveness of grows. There is a limit to supporting individuals in the community. Moreover, CHR is expected to help a lot of people who do not actually reside in the area. CHR served 18,000 people last year! They shared a **need for more residential options like those at Strickland**. The respite facility is small, the MACC shelter is closed, and YAS uses a lot of respite care. Since different levels of board and care are not available, people are stuck at CVH. Hospitals can't discharge because the VNA can't serve people who are homeless. People are coming with a lot of medical conditions and those who need higher levels of care don't have community supports. They need 24-hour care and cannot live independently, but they also don't need the level of care at CVH. Many older adults have mental health waivers but if they are homebound, there are few medical services that come to them. They can't use Logisticare and if they can't get services, so they end up needing nursing home care, but it would be better for them to have the option of home visits. We **need different levels of residential care**.

Issues Raised by CAC 15 Members

In our Catchment Area Council (CAC) 15 meeting, people discussed "What is crisis to you?" The two main concerns raised by members were the older adults with disabilities including dementia, and people with co-occurring mental health and physical health needs.

Particular concern was reported for people in the 55-64 age group who are not eligible for protective services for older adults. They are often susceptible to virus infections and falls, and

with additional dementia, a discernable gap in coverage for mental health care exists. A provider discussed how, due to their physical disabilities some older adults are unable to leave the house to visit a psychiatrist, and they lack a relationship with a mental health counselor. Without a doctor to advocate for mental health home care services, people can languish. One provider was able to hire an APRN to visit patients with physical issues at home, but confirmed there are no similar models for psychiatric care.

Another member talked about lack of continuity of care for people returning from psychiatric hospitalization. He shared that if respite beds are full and the situation is not severe enough to go to the hospital, then there is no place to go. A paucity of options for people after hospitalization results in lack of stability.

A person in recovery was hospitalized for a broken ankle and heart issues that required she have a pacemaker. She went to the nursing home to recuperate, but when the medical provider saw that she was taking psychiatric medication, they concluded she was depressive instead of suffering from a physical ailment related to her heart. This resulted in a treatment that failed to address her physical issues.

A member described a participant at a NAMI Board meeting who was developmentally disabled but who also had mental health issues. When brought to the hospital, this person's symptoms were interpreted as behavioral issues and he was not treated.

One police officer shared a case in which a domestic violence protective order was issued for a young man with mental health issues who was living at home with and taking care of his mother. The officer who was called to the scene had a very difficult decision to make because arresting the young man for domestic violence resulted in a protective order that prevented him from returning home once he was stable. As a result his mother had no one to care for her. Legally, a police officer is required to make an arrest in a domestic violence situation, but these extenuating circumstances leave them somewhere between a rock and hard place when a psychiatric crisis has led up to the domestic violence for which they are called to the scene.

Jail-diversion clinicians can provide intervention at the time of the court hearing but would not be at the scene at the time of arrest. Others may contact jail diversion (parents, crisis teams, and public defenders) to give them a heads up and help them understand an individual's psychiatric needs.

A police Sargent talked about an officer who is very familiar with people in community and who understands when some individuals are outside their "normal" behavior. This kind of neighborhood watch is helpful. The sergeant also discussed Computer Aided Dispatch (CAD), which is information available electronically at the time of dispatch so officers can have context of an individual's behavior from prior crises. The CAD includes information from senior family adult services, MACC, the hospital, etc.

A CAC member shared that the presence of police in the initial response to a crisis may be difficult for some people, but if people have had good prior relationship interactions with police, if the police have talked to them outside of crisis, then there is a better chance of de-escalating a situation.

Recently passed legislation requires that all police officers must receive mental health training. However, the **mandate does not require CIT Training**. The CIT Curriculum is an intensive 40-hour training and is voluntary for police officers and police departments.

STRENGTHS

Here are the major strengths identified by the R&E team:
1) Collaboration with police: CHR notably **engages in police meetings** to create rapport and to teach police how to write a Psychiatric Emergency Evaluation Request (PEER) – the form that police officers complete when hospitalizing someone for psychiatric evaluation. These positive relationships help with recidivism and aid in de-escalating psychiatric or addiction crises.
2) Communication skills with all entities involved: CHR has a practice of **critical incident debriefings**. These are times when CHR crisis care staff convenes to discuss and consider incident reports that are of a critical nature.
3) Thorough, prompt, efficient, knowledgeable, "magical." People in crisis who need medication can set up emergency appointments at one of 3 clinics.
4) The **"open access"** at CHR reduces need for mobile crisis. Open access means that people in crisis can walk into the clinic and get help immediately.

RECOMMENDATIONS

Here are recommendations from the R&E team:
1) Develop a pilot study which tracks diversion from the hospital – note the techniques used, how it helps individuals in crisis and hospitals, and whether it is worth recommending these measures as standards of care to be utilized by the DMHAS Quality Management and Improvement Office.
2) Advocate for additional staffing to meet the need of the large demographic in CAC 15.
3) Continue to provide support to community and providers serving high-need people coming out of state hospitals.
4) Continue to work with police who respond to Emotionally Disturbed Persons (EDP) calls and initiatives in partnership with the Manchester EDP Task Force for de-escalation training with community providers.

PROVIDER COMMENT

CHR articulated their appreciation of NCRMHB's "incredibly thorough and thoughtful review of the Crisis System in Region IV." CHR's Mobile Crisis Program Director said she "truly appreciated learning the areas in which we are capable, but more importantly the areas in which

we need to expand our focus and outreach. This includes ensuring the community knows how to access MCRT and increasing efforts to work with town social services."

InterCommunity (IC) – Crisis Services

The IC Assessment Center is responsible for general intake as well as emergency and mobile crisis assessments. At the time of our visit there was one intake staff, one LCSW, one MSW and one soon-to-be MSW, as well as the director, Ms. Doutre, on the team. IC's Chief Operating Officer Tyler Booth and Director of the Outpatient Psychiatric Children's Clinic (OPCC) Rick Amaral serve as back-up to the mobile crisis team. The numbers of mobile crises are decreasing since 2013, because IC is able to fast track services to people. The theory is that if people are able to obtain immediate treatment, they may not need to go to the hospital. People can get medications within 1-2 days, and IC offers "Open Hours" walk-in services. There are an average of 10 walk-ins a day. All services via IC can be delivered within a week.

Data tracked includes adult and child intakes, mobile crises, and total incidents, among other information required by DMHAS. Data is entered into the DMHAS DDap, (which is the program quality dashboard system). The current report card (July 2014-March 2015 shows that they had 117 unique clients, 142 admits, and 137 discharges. They exceeded their goal for crisis evaluations within 1.5 hours of request (98%), conducting evaluations in a community location (93%), and follow-up service within 48 hours (95%). However, it must be noted that IC staff defined "community location" as inclusive of the IC outpatient clinic.

HIGHLIGHTS:
Director Ms. Doutre speaks highly of the **Open Access Program**, which is IC's version of the Enhanced Care Clinic. This program allows walk-ins for all services except for prescribers, which people can schedule 72 hours ahead of time. The Open Access model allows IC to schedule staffing based on peoples' needs. Previously when staffing was based on appointments, there were a lot of no-shows. Now they can actually serve more people.

As of July 2015, IC has a DMHAS-funded **Assertive Community Treatment (ACT)** Team. ACT is a highly effective team-based model of providing comprehensive and flexible treatment and support to individuals who live with serious mental illness. ACT is identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice that consistently demonstrates positive outcomes and is considered by experts as an essential treatment option.

IC reports a good relationship with the local hospitals with open communication after crisis. The majority of people go to the Institute of Living (IOL) and then discharge recommendations come to an IC clinician for assessment. Ms. Doutre receives many of those hospital discharge recommendations, and the hospitals can discharge people right to the door at IC for outpatient services.

IC staff report a strong relationship with the East Hartford Police, many of whom are CIT-trained. Other police departments in their catchment area include Glastonbury (with whom they report a good relationship – most calls are about hoarders), Wethersfield and Rocky Hill (decent

relationship), and Newington (less developed relationship). IC views a positive relationship with the police as important for insuring that people in need of services will be brought to IC.

The IC "Community Foundations" Supportive Housing staff deem it helpful to have mobile crisis intervene with residents when staff are no longer able to intervene effectively with them. Clinical staff also use mobile crisis to conduct wellness checks when people they are concerned about do not come in for appointments.

CONCERNS:
Ms. Doutre reported that she is unsure about what **impact of the Affordable Care Act** (ACA) will be on IC services. The cost of their prescribers is not adequately covered – Medicaid costs are not sufficient to pay APRNs and MDs at a competitive rate – so they must seek grant funding to supplement costs. The **ACA does not cover the gap that DMHAS grant funding** used to cover. IC reports they are losing money on prescribers every day. IC also serves people with private insurance. If those rates do not cover the cost of care, an increase in the number of people covered by 3rd party revenue may actually hurt their finances. Thus, the ACA may cause staff to be more anxious about budget cuts. The ACA ensures that more people are covered by some kind of insurance, but if reimbursement rates do not cover the cost of care, the result is providers like IC are losing money each time they provide services. DMHAS grant funding cannot be used to make up the cost difference.

Other issues of concern include **options for discharge** for people leaving the hospital with physical health challenges, co-occurring (mental health and addiction) disorders, and lack of housing. IC is struggling to meet care for some individuals they serve, especially those who are homeless. They operate some supervised apartments, Community Foundations, but some people need more structured settings or long-term hospitalization. About 5% who go to hospitals will come out homeless – and might also have co-occurring disorder issues. IC often relies the East Hartford shelter for temporary housing in these situations.

People coming from CVH who need a highly structured residential setting may not be able to find supports they need to transition back into the community in catchment area 16, so they are much more likely to relapse or will not be able to return to their home community. Programs currently available do not have a high enough level of support available for people.

RECOMMENDATIONS:
There is still a question of how to make accessibility to services as easy as possible. The Director of the IC mobile crisis program said, "Gridlock helps create a case for better services." By this, the Director meant that when people flood the system with unmet needs, there is a gridlock where people cannot find a way to access the flow of services they need. Instead, everyone is at a standstill, waiting for other people to move along and for issues to be resolved. Part of this is a lack of services. Part of this is that services need to be more efficient and effective. Gridlock shows a clear need to **create more efficient and effective services**.

DMHAS-FUNDED COMMUNITY HEALTH CENTER STAFF: INTERCOMMUNITY

CSP, Social Rehabilitation, Clinical, and Housing staff all participated in this review.

When asked about situations that require a crisis response, people responded that they vary. Sometimes this happens in a group, when someone self identifies as being in crisis. Perhaps a probation officer is concerned about a person on his/her caseload. Perhaps a person has had suicide attempts and seems withdrawn – in this case mobile crisis is asked to do a wellness check to avert crisis. IC's goal is to promote recovery in the community and avoid unnecessary hospitalizations.

The Assessment Team helps if the police come to address crisis. The team has a good relationship with police in the area. Someone mentioned that they've never heard of police getting physical with people. They are very responsive to urgent calls and they work with the Assessment Team to make sure they don't overwhelm the person in crisis. The police also choose to mingle or socialize with local clubhouses at certain events. IC organizes a 1st responder picnic annual event where they deliberately cultivate healthy relationships between the police, staff and people they serve. IC reports a great relationship with the East Hartford police specifically, and are currently working with Glastonbury police on CIT training. There are gaps and inconsistencies in the crisis response call system – one woman called Newington Police via 9-1-1 for crisis and she was diverted to CRMHC instead of IC.

In terms of the communication with crisis responders, clinicians find this very helpful. Crisis responders are great at following up; they stay involved; they triage over the phone; and they follow up with the IOL for assessment. In return, staff feel that the follow-up care is appropriate. After crisis, mobile crisis follows-up with staff regarding disposition. They stay in picture if necessary (especially with medication issues) and e-mail all people involved in case. There is care coordination. Mobile crisis will reach out to a hospital directly as needed.

According to IC staff, about 1 out of 17 people required a mobile crisis response from IC's housing program. These folks are living in Heritage Gardens, have case managers, and have a high level of care. Overall, fewer than 30% of clients required mobile crisis. The Common Ground Clubhouse calls mobile crisis about 5 times a month due to the number of people in the setting and out of concern for others in a close environment when one of the members is experiencing symptoms that are difficult to manage. IC tries to avoid hospitalization as a primary response to crisis and encourages stable housing and meaningful daily activity as preventive measures.

From the perspective of IC staff, one of the strengths in the CT system is the continued investment in supportive housing – previously many crises are precipitated by homelessness and now there seems to be more support for housing. Staff also cited the ACT Team, which was funded by DMHAS last year, as a strength.

From the perspective of IC staff, the mobile crisis team has many strengths. First, clinicians have been at IC for a number of years so they know many of the people. They are a huge source of support for the supported housing coordinator – who is newer. The team has good rapport with

people – even those with complex issues. The mobile crisis team does a good job with coordinating with case managers and helping determine red flags.

Staff expressed concern about individuals whose symptoms/behaviors have not reached the level of a crisis) The IOL seems to be getting better, but some on call staff are less skilled at assessing and de-escalating the situation, they call IC mobile crisis for situations that do not really meet the level of crisis.

Some other issues that came up include finding jobs that pay well and so people are able to retain housing. "They need to get better than $11.75 per hour at their job to afford a better quality of life." People need good jobs and housing; they lack stability otherwise.

Another issue that came up is access to care for young people who live with their families. Their parents call IOL, finding themselves in crisis on the weekend. When crises occur on weekends calls roll over to the IOL. From the perspective of IC staff, some of these calls are not at the level of crisis and could be de-escalated at the point of triage. Regardless, IOL has limited capacity to respond if people need intervention in the home or removal from the home environment. Now IC is funded for Young Adult Services (YAS) through DMHAS, so they will have the resources to intervene with more of the young adult crises. Another issue involves early detection for psychosis. IC is just getting involved in a learning collaborative via the National Council for Behavioral Health to address this issue.

Staff are very proud of the organizational culture of IC where the emphasis is on what can be done rather than the deficits within the system. If housing is not an option, they focus on what else can be done. One staff wants WRAP to be part of Common Ground intake. Another discussed interest in helping promote independence among people living in supportive housing. She believes her residents at Community Foundations function better with more structure or a routine.

Issues Raised by CAC 16 Members

In response to "What is a crisis situation?" one CAC member shared an experience with a crisis situation involving her son. He was assessed by a crew of firemen. She believes this situation happened because her son was at group home with inadequate professional help, which led to crisis and hospitalization at CVH. The primary issue she cited was lack of continuity of care.

Another woman shared that she has seen many instances of crisis response both personally and from neighbors and acquaintances. During her own crisis, she found she was not able to wait until crisis help arrived because of the severity of her episode, so she admitted herself to the ER.

A person shared that if the town has paid firefighters, they are usually trained EMTs or paramedics and may have had CIT or Mental Health First Aid training, but volunteer firefighters are often not adequately trained. **Since firefighters are often the first to arrive at a crisis, it is imperative that they are trained to respond to mental health crises.**

25

A man shared that when he was hospitalized, fire fighters came first. They seemed better trained than the police. He used to lie and say he was depressed instead of an alcoholic to get care. He called an ambulance and went to the ER and then was transferred to the Institute of Living (IOL). After 15 days, when he was ready to be transitioned from the IOL, he was destitute and released to a shelter in East Hartford. He experienced no follow up care from IOL, only by IC where he was a member. This example points out a gap in continuity of care. Another woman pointed out a lack of continuity in care in East Hartford, especially for children.

One woman's son was sent to the ER for 12 days, then sent back to a Board and Care, and then finally to the state psychiatric hospital, Connecticut Valley Hospital (CVH). She found that hospitals were not prepared to meet his needs, and it was difficult to be admitted to a psychiatric hospital. When he was finally admitted to CVH, he stayed there for a year, and got better. He is now living successfully in a group home in a community outside catchment area 16.

Another person called for an ambulance for her son during crisis. However, the police came with their sirens and he ran away. The police caught him and beat him with a baton. Now the woman is reluctant to call 9-1-1 again. Another woman perceived a lack of training by police who traumatized people in crisis rather than helped them. A clubhouse member asserted that **police need better training**. He believes they treat people too roughly and do not take people with delusions seriously. On a hopeful note, one member said that some police in East Hartford have CIT training, and another shared that their new police chief has a better understanding of mental health issues and is more responsive to crises.

STRENGTHS

Here are the major strengths identified by the R&E team**:**
1) Knowledgeable staff understand who have deep relationships with people.
2) Open Access is a great program that allows for same day access to care.
3) The willingness to make an emergency assignment for CSP services for hospital discharge planning.
4) First responders connect with staff and people served by IC via an annual picnic.
5) IC is a small agency that has strong teamwork to support crisis response (back-up administrators, Community Foundations, Open Access, FQHC look-alike medical clinic, technical assistance for early onset, Common Ground clubhouse for making days more structured.)

RECOMMENDATIONS

Here are recommendations from the R&E team:
1) Define "community" and align this definition with DMHAS and other LMHAs. Make sure that statistics accurately match what is being asked.
2) Work on police relationships in communities on the outskirts of the catchment area, even East Hartford – although relationship described was good according to mobile crisis and IC staff but not so by CAC 16 members.

PROVIDER COMMENT

In their feedback, IC wrote that there was a "good representation of the mobile crisis units" in NCRMHB's report. The only area of confusion for IC was regarding the notion that "IC staff defined 'community location' as inclusive of the IC outpatient clinic." IC reiterated, "the majority of mobile crisis that are conducted by IC are in the community and off-site." While IC admitted they have done mobile crisis assessments on-site, their understanding of policies is that agencies are allowed to have up to 20% on-site. IC asserted they have far less than 20% mobile crisis assessments on-site.

CAC 17
CHR – Mobile Crisis Response Team (MCRT)

*See CAC 15

DMHAS-FUNDED COMMUNITY HEALTH CENTER STAFF: CHR-ENFIELD

Staff at this meeting ranged from people on the ACT team, two on CSP, a medical prescriber, a person who runs respite care, a person who runs the group home, YAS staff, and staff on diversion.

At CHR-Enfield, crisis response is called when there are crises at the clubhouse. The Clubhouse director has called 9-1-1 with positive results. The male police officer was able to talk to the male member who was being aggressive – perhaps this situation worked because of gender.

CSP cited a case where they called crisis for a woman in a trailer. She had no heat, no toilet, and was refusing help. The police came to investigate and decided to let her stay there. The mobile crisis and CSP team did an assessment and she seemed okay.

In general, staff shared that mobile crisis is useful for checking in on the people they serve. It is important to have someone who can check in on people who miss appointments. This is also useful for doctors. Mobile crisis fills a big clinical gap since they can meet with people in the community. CHR staff also denoted the importance of the mobile crisis teams being integrated with clinical teams – that they are all CHR folks under one umbrella. The mobile crisis manager does a lot of training to cultivate understanding and communication among staff.

In terms of police role in crisis situations, CHR staff only call on the police when it is not appropriate to send mobile crisis. This means that the situation requires immediate intervention because action is imminent. When a person is volatile or poses a danger, CHR will not send in staff – they call 9-1-1. CHR shares information that they think is important with police to help keep people safe. This includes allergies, medications list, and history of suicidal attempts. Some CHR staff noted that EMS teams could use training in Enfield, Bloomfield, and Manchester. In regards to sharing information with police and other first responders, CHR's interpretation of HIPAA is that it is **okay to share information in an emergency**. CHR staff note that HIPAA is clear that **under continuity of care, responders can share information**. Finally, CHR noted that the Enfield police have been very understanding with the CHR group home.

CHR staff agree that there is very good coordination between CHR staff and crisis teams. Mobile crisis offers very detailed notes and CHR is always in contact with mobile crisis. They work together via problem solving. Mobile crisis is very proactive to push for a higher level of care if needed, and they are supportive of the group home.

The number of people who require a crisis response on a staff's caseload can vary. Staff are always thinking about whether individuals might need a crisis response. At the clubhouse, they call mobile

crisis only 4-5 times a year. For Young Adult Services (YAS), they rarely call mobile crisis because they have staff who can respond. Mobile crises or 9-1-1 are called from the YAS program about once per week, especially in East Windsor. Sometimes the situation may not be an emergency, but young adults might want a crisis response so they call themselves.

The mobile crisis teams do well at evaluating people quickly, responding immediately, supporting staff, offering good follow up reports, communication, acting as a liaison for police and other staff, and helping extend the reach of CHR into places staff cannot go. It is evident that the CHR staff appreciate the work of mobile crisis immensely, and that all CHR teams work closely with mobile crisis. One staff mentioned that they no longer get resistance from staff ever since the current mobile crisis director, Karen Hanley was hired. That was over ten years ago. Another staff mentioned that Ms. Hanley goes to statewide meetings to advocate on behalf of CHR staff and clients. In one case, she helped a person in a hospital go to a group home. CHR staff agreed that Ms. Hanley is a good contact outside of emergent issues.

When asked how the mobile crisis teams could improve, staff could only come up with one thought: that mobile crisis is stretched too thin. CHR advocated for mobile crisis to be a larger team for the geographic area covered.

In terms of successes or weaknesses in the system, CHR noted that YAS uses mobile crisis to access placement in the state psychiatric hospital. Ms. Hanley guides staff through the process. With the changes in healthcare, the pressure is on the hospitals. It is difficult to interface with hospitals – communication is poor and continuity of care with hospitals is difficult. The hospital is a different team and when they do not share as much information as needed, discharge becomes difficult. The inpatient unit is a different culture than CHR, so the transition from inpatient to outpatient needs to improve. To do this, CHR thinks they need more regular meetings with hospitals where leadership and key people communicate. They also need more resources, especially in regards to increasing the size of the mobile crisis unit. Finally, CHR needs to be involved at the moment someone is admitted to the hospital. At the hospital, the individual must give permission for CHR to be involved. It has become more difficult to get discharge summaries, or hospital summaries are not useful.

To prevent spiraling – CHR looks to increase the level of care for people. They try to get people into therapy. It would be helpful to have more prescriber time on the team. This is a funding issue and Medicaid does not reimburse prescribers sufficiently.

To reduce cycling into hospitals, we **need more supported living arrangements**. Housing is a significant issue for mental health and addiction wellness, and supported housing is an important step to stability. CHR has the Strickland House, which is a step-down from CT Valley Hospital (CVH). This means the Strickland House has fewer constraints, it's unlocked and people can come and go as they please, but there is still a lot of support in the housing units. Prescribers and nurses and staff are on hand to prevent crisis and spiraling. There is a shortage of beds at the level of the Strickland House. Everyone who goes to Strickland must also come from CVH. These constraints make it difficult for people who need supported housing to find stability after discharge. Living

alone is seen as the ultimate aspiration – but this is not necessarily good for all people. The isolation can make mental health issues worse. People's quality of life living alone can be horrendous with isolation, bed bugs, and lack of care.

The ACT Team does not use mobile crisis. There is a staff on the team who functions as a crisis clinician, and she helps mobile crisis. This person has the ability to do Emergency Certificates (ECs) which involuntarily puts a person into the hospital for a physician evaluation. YAS also has this ability. CHR staff said that it would help things if more people could write ECs. The Department of Public Health has a policy that psychologists and LCSWs on certain teams can write ECs, and one must complete a training via DMHAS to gain this ability. However, not enough people can write ECs, which creates tension with police. If the police officer writes a PEER it is based on an assessment of "danger to self or others" which has fewer levels of nuance than clinicians' criteria, which includes a "grave disability." When clinicians think someone needs to go to the hospital, if they cannot write ECs then they must call the police. If police disagree – then the determination is not based on clinicians' observations and people don't get the care they need. If police agree, it is still inconvenient for them to come out just to write a PEER. CHR says they need more staff who can write these admissions papers, or ECs, and also more prescribers.

ISSUES RAISED BY CAC 17 MEMBERS

One woman defined crisis as feeling hopeless, having their options exhausted, not knowing whether anyone can help, panic, desperation, vulnerability, and turmoil. Another woman said a person in crisis "doesn't care if live or die." Crisis is about "spiraling out of control" or "not being able to carry on activities like they used to." Lacking support and resources is another part of crisis.

Someone pointed out that the only option via the crisis line is the hospital, and if one doesn't want to go there, they are stuck. Another woman added that hospitals are limited as to what they can do. This person had to convince the hospital to keep someone in crisis – and even so they only allowed an overnight stay without a plan after discharge. The hospital changed all the medications of one person, and the psychiatrist berated her for going to the hospital – but she did not know how to call for crisis.

People talked about being unsure of who to call in crisis, and then being afraid of calling 9-1-1. CAC members also wondered what people should do after hours. They were assured that if they called 2-1-1 they would be connected to crisis lines. However, people expressed fear that if they called the police, they could can be arrested before going to the hospital. They were assured by the Mobile Crisis Director that this never happens in Enfield.

A person in recovery shared that the crisis team can access information about their situation and make judgments to involve the police, and the police can arrest someone instead of helping to provide care. A provider countered that there have not been any arrests of people in crisis in her area. On crisis calls, this provider only brings police to feel safe when approaching strangers in crisis. This provider also said she had access to police who are CIT trained, so they know how to approach people in crisis. According to this provider, police understand that assaultive behavior

worsens emotional crisis. Finally, this provider asserted that there is communication during and after crisis.

A woman was told that she had to find counseling without any information or referrals. She was still in crisis at the time of her release from the hospital, and she just numbed up. She was not ready to go home, and no one mentioned the possibility of going to respite care or Young Adult Services (YAS).

One CAC member talked about the lag between hospital discharge and the next step. She would never have reached out, and in fact attempted to overdose on the prescription she was given.

A provider member recommended that a person should be seen by a clinician within 2 days of discharge. A problem he identified was that if people are discharged from the hospital on a Friday, there is a lack of care from outpatient programs until Monday (at best).

One woman had a positive experience with CHR. She had a name and number to call after discharge. However, another woman was released from the hospital with nothing more than advice to get counseling – she called CHR for help.

Overall, CAC members agreed that there is a need for a warm handoff to providers in the case of crisis, and then be able to reconnect with everyone involved after crisis.

STRENGTHS

Here are the major strengths identified by the R&E team**:**
1) CHR's interpretation of HIPAA is helpful for sharing information with the police and other clinicians and community supports, as needed. CHR staff note that HIPAA is clear that **under continuity of care, responders can share information**.
2) There is very good coordination between CHR staff and crisis teams. Mobile crisis offers very detailed notes and CHR is always in contact with mobile crisis. They work together to problem solve.
3) The mobile crisis teams do well at evaluating people quickly, providing crisis debriefing, psychological first aid, post-traumatic stress management, providing resources, supporting staff, offering good follow up reports, communication, acting as a liaison for police and other staff, and helping extend the reach of CHR into places staff cannot go. They will do whatever is needed and are community involved.
4) It is evident that the CHR staff appreciate the work of mobile crisis immensely, and that the CHR teams work closely with mobile crisis. MCRT responders are described as sensitive and having empathy and compassion for the person or persons affected.

RECOMMENDATIONS

Here are recommendations from the R&E team:

1) Create clear messaging for people about who to call in crisis, especially after hours. People talked about being unsure of who to call in crisis, and then being afraid of calling 9-1-1.
2) CAC members also wondered what people should do after hours.
3) Promote education on the community level – train people and police about what to do in crisis. People expressed fear that if they called the police, they could can be arrested before going to the hospital.
4) Develop a warm handoff system to ensure that there is coordinated care to reassure people. CAC members agreed that there is a need for a warm handoff to providers in crisis, and then a need to reconnect with everyone involved after crisis.

CAC 18
Capitol Region Mental Health Center (CRMHC) – Mobile Unit

*See CAC 23

Issues Raised by CAC 18 Members

A member of CAC 18 who has lived through many crises talked about the issue of **transportation** during and after crisis. As someone with physical impairments, it was important to have access to vans that could accommodate his needs. Moreover, after discharge from the hospital, he felt there was **inadequate outpatient care** or **lack of follow-up** by appropriate providers to transition him back into day-to-day living. The paucity of services and inadequate help made it difficult for him to resume normal life, and made him vulnerable to circumstances that resulted in re-hospitalizations.

A woman who called for mobile crisis was directed to call 9-1-1 for police response instead. The police came with flashing lights, escalated the issue, and tasered her son who was in crisis. This situation highlighted the need for police training, especially in outlying towns where police are often first responders on the scene.

In regards to issues with referrals for shelter, people continue to express extreme difficulty with knowing where to go for help, finding providers, insurance complexities, and navigating the mental health service system and between systems of care. People expressed frustration with getting information or referral through 2-1-1 due to phone wait times and difficulty navigating the on-line system. Many people (providers, town social services, police, and people in crisis) noted difficulties experienced with the transition to the new Coordinated Access System for housing or shelter referrals (all referrals and appointments for priority designation must now go through 2-1-1). Phone wait times are a particular challenge to individuals who are homeless and without a cell phone or with a cell phone with limited minutes. NCRMHB attempted to collect feedback about people's experiences with 2-1-1, but was unable to collect enough survey responses to draw conclusions about the quality of service, barriers, or areas of recent improvement. The 2-1-1 service does offer opportunities for people to provide feedback directly and has added and adjusted staffing this spring in an attempt to address reported problems.

Central Access Networks (CANs) have been established to share data and work in a coordinated way to accelerate housing placements. The establishment of CANs was federally mandated, not a state created process, and the transition to that system continues to feel bumpy at the grassroots level regardless of progress being reported at the state level. The system requires going through 2-1-1 for all referrals and then to one of the CAN providers for an assessment to determine level of need (and priority for housing). All of these steps cause delay and distress for people (and those trying to help them) who are in immediate dire need. Although we are beginning to hear feedback reflecting better response times from 2-1-1, this is only the first step in a three-step process. In the end, there are not enough diversion or emergency shelter options to meet the need in Region IV and the problem is only getting worse as a number of shelters are closing their doors.

The League of Women Voters of Canton were prompted by concerns about resources for mental health care to conduct a study of mental health services for residents of the Farmington Valley.

The study committee gathered data from numerous sources including federal and state agencies and advocacy groups such as NAMI. The common concerns around behavioral health services are: 1) Stigma, 2) Mental health parity, 3) Early detection/intervention, 4) Lack of insurance coverage and inadequate coverage, 5) Too few professionals to diagnose and treat in the Farmington Valley, 6) Access to information and services is sometimes confusing and inadequate, 7) Housing and long-term solutions are lacking, 8) Transportation is a problem because many services are outside of towns.

The League of Women Voters of Canton determined that there are numerous obstacles that stand in the way of an individual's receiving appropriate crisis or long-term care. These may include the stigma associated with mental/behavioral health related illnesses, lack of emergency responders trained as part of a Crisis Intervention Team able to help in psychiatric emergencies, public ignorance about mental/behavioral health problems and how to handle them, lack of transportation to care, lack of local care providers, and lack of supportive housing and other supports such as readily available case managers. Towns vary in the services they offer. To address these concerns, they suggest providing more and better information about mental health and addiction services; expanding services and addressing gaps in the service system such as Assertive Community Treatment (ACT) and Crisis Intervention Team (CIT) training for all police in the Farmington Valley towns; and establishment of more mental health services in the Farmington Valley towns by Capitol Region Mental Health Center and other public and private providers.

STRENGTHS

Here are the major strengths identified by the R&E team**:**
1) CRMHC has a strong police training program for interested police departments. Those that take advantage of these training programs drastically improve their ability to respond to crisis.
2) Mental health crisis responders do a good job of showing up in a timely manner and being prepared to stabilize situation where they can rather than escalate. They coordinate with family, getting collateral information from family on the scene and/or making phone calls.
3) Mobile crisis staff tend to be well aware of resources and they usually respond in a team, which allows for mutual consultation. They have the credential and ability to hospitalize an individual, if necessary. They usually take time to be thorough in their evaluation.

RECOMMENDATIONS

Here are recommendations from the R&E team:
1) Focus attention on **developing relationships with police** and social services in Farmington Valley. Despite CRMHC staff Barry Skoletsky's relationship with Hartford Police, there is no mention of the CRMHC crisis team when we talked to the West Hartford Police.
2) Since towns in CAC 18 are at the periphery of LMHAs and mental health services, in an emergent situation, usually police are the first on the scene rather than mobile crisis. It is imperative that **police receive more mental health and de-escalation training**.

3) Address transportation barriers for people who live far away from services and clinical care. After discharge people need to access services, which is difficult to do throughout CAC 18. More community-based case management would be helpful.
4) Mental health crisis responders need to improve upon coordination with other agencies and families. Several Farmington Valley Social Services directors reported concerns about communication and follow-up with hospital and community mental health providers after a crisis or hospital discharge.

PROVIDER COMMENT

In response to the above recommendations, CRMHC wrote the following:
1) Despite a lower frequency referral rate, we have periodically reached out to West Hartford PD and Social Services in order to ensure a positive and collaborative relationship. We will also reach out to other Police Departments in the area.
2) We will send a written brochure/description of CIT training to all area police departments and will follow up with a phone call to determine interest in the training. If feasible, the description of CIT training will include a reference from the Hartford PD.
3) Transportation is a challenge in some parts of CAC 18. We access or make referrals for public transportation, dial- a ride, medical transportation, etc. Both UConn and Chrysalis have funded case management services in CAC 18.
4) In accordance with Joint Commission standards and best practice, CRMHC does provide follow up whenever possible, providing clients have signed a release. Many people from the Farmington Valley use the UConn John Dempsey services or other community mental health providers, so CRMHC may have no knowledge of their discharge plan.

CAC 19
<u>Wheeler Community Response Team - CMHA</u>

The Wheeler Community Response Team (CRT) operates with 2.5 staff. They provide well-being checks, coordination of care, and stabilization services. Wheeler also offers bridging services – wraparound and case management services while people are waiting for other services via CMHA. Scheduled meetings help transition high-risk people.

Wheeler provides mobile crisis services under contract with CMHA. Wheeler meets with CMHA quarterly to review contract performance. Data tracked includes time of call, time there, time left, and emergency versus scheduled meetings. Over the past year (July 2014-March 2015) Wheeler's report card reflects that they had 119 unique clients, 112 admits, and 110 discharges. They met their goal on initiating an evaluation within 1.5 hours of request (77%), but fell slightly short conducting evaluations in a community location (76%), and did not meet the goal for and follow-up service within 48 hours (23%). As discussed in the CAC 15 section, there are issues of concern about the sources of data for this measure, however staff indicate there usually is not a 48-hour follow up time for a DMHAS "touch point" and Bristol Hospital has longer than ideal wait times to access services. The trend in numbers of mobile crises this year was down; in fiscal year 2014 it was down 17% and in fiscal year 2013 it was up 23%. Wheeler and CMHA are exploring additional measures needed to make sure people land safely at CMHA. Weekly internal oversight meetings between the two organizations allow Wheeler's mobile crisis staff to discuss high-risk people with the CMHA clinical team.

CMHA requires a response to crisis calls within 1 hour with evaluation and follow-up completed within 3 hours. CMHA and Wheeler staff participate in weekly meetings together about high-risk users. The focus is on coordination of care and diversion from hospital whenever possible. Wheeler coordinates access to care for inpatient crisis, out-of-area beds, DMHAS beds (with CMHA approval), and uninsured inpatient people. CMHA picks up responsibility for services after discharge.

When Wheeler decides a person should go to the Emergency Department (ED), they call 9-1-1. They do not leave until the ambulance arrives. Wheeler staff contacts the ED and provides information about the person. They also contact the provider, typically because the referral for crisis response came from the provider. Police and mobile crisis will go after patients who walk out of the ED. If the person is not admitted, Wheeler coordinates care. Wheeler maintains relationships with the Hospital of Central CT, Bristol, St. Francis, Bristol and John Dempsey Hospitals.

HIGHLIGHTS:
Wheeler staff report they have a good relationship with EMT responders, CMHA and the community, and a care process for high-risk folks. Wheeler's Community Response Team (CRT) goes out regardless of people's insurance status. They also have access to emergency/mobile

psychiatric services, however these are very limited. CMHA staff also utilize the Wheeler mobile crisis team for after-hours wellness checks for people who have been in crisis.

CONCERNS:
Wheeler does not have a consistent relationship with the Bristol police, as their meetings are not yet regular and the Bristol Police Department may not know to call Wheeler for assistance with behavioral health crises. Wheeler reports that their best connection to local police is with New Britain and Plainville. In Plainville, Wheeler is a growing a relationship thanks to a new chief.

Sometimes there are people in crisis who do not have a permanent address. If the person in crisis is physically within CRT's area and in need of assistance, mobile crisis will respond regardless of the person's housing status. However, while mobile crisis can bring a homeless person to the hospital for help, once there, discharge can be a challenge if the client does not have a place to go after crisis, and follow up can be even more difficult.

Wheeler would like more focus on diversion, as the Director has been able to accomplish in Massachusetts. They have some frustrations, mostly dealing with lifelines (the 1-800 suicide line) and the access line for detox beds. Other frustrations from Wheeler include the fact that that they feel underutilized or perhaps called too late into a crisis situation. They also want a peer to go out on mobile crisis calls, but current education and certification requirements can be prohibitive to offering peer support. Wheeler needs more people with lived experience, however the agency has difficulty recruiting and retaining qualified peers on staff.

Wheeler reports that due to the Affordable Care Act (ACA) provisions, there was a 30% rise is population volume over the last year. This has increased the demand for their outpatient services and without **added psychological resources**, it will be a challenge to meet the need. However, the ACA has helped promote integrated health care and focuses on better outcomes. **Health and wellness centers, integrated health care, and a focus on better outcomes** are all important to meeting the needs.

Problems with hospitals persist. The Hospital of Central CT differentiates between behavioral and mental health problems, which results in discharge without treatment for those deemed to have a behavioral problem. CMHA often has no notice when a person they are concerned about is discharged from the ER.

RECOMMENDATIONS:
There is concern expressed about lack of step down options.

DMHAS-FUNDED COMMUNITY HEALTH CENTER STAFF: CMHA-NEW BRITAIN

CMHA subcontracts with Wheeler Clinic's mobile crisis in lieu of providing the service in-house. This is the only LMHA with this distinction and, in fact, CMHA leadership is currently reviewing the efficacy and efficiency of this service design in light of the needs of the people they serve.

CMHA leadership feels that as an agency they need more and more of their services to be mobile and responsive (as are with their ACT and MACCT teams). CMHA staff report that not all calls to CRT are answered promptly and sometimes staff have to make a second call. Most staff has experienced this at least once. This pushes staff to call 9-1-1 more – which means police become first responders for crisis situations. However, communications with CRT have improved in the last year. CRT now automatically calls and gets information from CMHA staff to coordinate care. In the last 3 years, there has been a much better collaboration between CRT in CMHA meetings. Although the mobile crisis team is not fully integrated with other CMHA services there are mechanisms in place to ensure good communication and collaboration. CMHA holds a weekly **oversight committee** where people considered to be at risk are discussed with the Wheeler team.

Situations that require crisis response range from check-ins to suicidal ideation. If a staff needs assistance to check in with a person, they will call mobile crisis to go into the community and assess him/her. For a person who may be suicidal, staff call Community Response Team (CRT) or 9-1-1. Sometimes individuals will call themselves for help. On weekends, mobile crisis calls are diverted to police for help if staff are not available. Staff report needing to nudge mobile crisis to check in with people. The contract between Wheeler and CMHA requires follow up for reports. The contract requires point of contact within 2 hours of a crisis call. There are 5.8 full time staff available from 8am – 10 pm, and then calls are diverted to 2-1-1. According to CMHA leadership, Wheeler is contracted to serve 356 people – but due to flat funding, the number they can serve will be limited.

CMHA has no same day access, but according to staff people can be seen within an hour if in an emergent situation, within 2 days if in an urgent situation, and within 2 weeks if in a non-urgent situation.

CMHA has a Modified Assertive Community Treatment (MACT) Team that works with individuals to secure stable housing. The team has worked closely with the town of New Britain and reportedly has reduced the number of police calls to the New Britain green for homeless individuals by 50% in a very short period of time.

The police role varies depending on the officer. Some help de-escalate; others take 2 hours to arrive; few are comfortable with writing a PEER to involuntarily send an individual to the hospital to be assessed by a physician. According to CMHA staff, some police decide when they see a name or an address to come slowly to the scene because they think those are "frequent flyers" – the police are frustrated with the system. CMHA works with the New Britain police, the Bristol police, and Plainville police most frequently. In Bristol they have the Abilities Beyond housing unit for young adults. CMHA wants to work with police more – as they feel the response is not as good as it could be. They feel that they need better training and a better relationship.

Concerns expressed by CMHA include funding and difficulties associated with helping a growing number of people living in the community with much more serious mental illness than in the past – resulting in a frequent need to manage high-risk situations. They are now providing services as a DMHAS-funded Behavioral Health Home to over 800 people at CMHA. This program is much

needed because it promotes coordination and integration of care and covers services that are not typically covered by insurance.

CMHA has a written contract that meets HIPAA standards and allows them to collaborate and communicate about high-risk individuals they have in common. Law enforcement is not included in these meetings because their involvement is seen to violate HIPAA privacy requirements. The NCRMHB review team wonders whether this is an interpretation issue or whether HIPAA guidelines do indeed restrict greater collaboration with law enforcement– especially since other towns and other mobile crisis teams meet monthly in a coordinated care team to discuss people in their communities in emergent situations. This is an issue that requires greater clarification and perhaps guidance from DMHAS as it is area of inconsistency among providers of mobile crisis services.

Primary recommendations are:
- More respite beds – mobile crisis needs them to transition people out of EDs
- Increase funding to expand ACT capacity – CMHA has over 100 people needing the ACT level of care
- Evaluate the current service design for mobile crisis services to determine whether this is something that should remain a subcontracted service, and if so, ensure greater integration with other CMHA services.

Issues Raised by CAC 19 Members

At CAC 19, members felt that someone is in a crisis situation when they're suicidal, unsure of how they feel, overwhelmed, or feeling a loss of a family member. This could be a person who stays in the apartment all day with suicidal or homicidal thoughts.

When in crisis, people would call a crisis hotline, family and friends, and for help finding services, call 2-1-1, Community Response Team (CRT), or call 9-1-1. People would deal with the crisis in steps, perhaps call the warm line, and rely on mobile crisis that goes out to homes. A few talked about coming up with a plan to avert crisis instead of ending up in the hospital. One person said she needs someone to call on her behalf.

One person shared a story about being in crisis and being put into W1, a mental health ward at Hospital of Central CT. There was no fight or argument because she felt supported. She also felt treated well by fire fighters who came to the scene. They talked to her and helped her de-escalate.

Another person shared here experience going to the hospital after a suicide attempt and released the next day without medication or anything. The person sharing the story was confused about lack of care.

Another person expressed that police treat people with mental illness differently than other people – more likely to be arrested. In 2010 something happened where she felt they got tired of her and treated her badly.

Clinicians hearing about potential homicide will call the police – they call this "duty to warn." The police can come a lot faster than mobile crisis, so sometimes they arrive first. In Berlin, the police or ambulance might arrive first and they will reach out to mobile crisis.

In New Britain, one person had suicidal ideation. Their family called 9-1-1, and the police and ambulance came. The person went to the ER and then was admitted to the mental health unit at the Hospital of Central CT. The interaction with police went well.

A black woman stated she feels police and hospitals treat different races differently. She feels that blacks and Spanish people wait in the ER or in the hospital and must wait to be released. She said "if you are seen as a regular in the hospital, doctors get tired of you and treat you like crap."

People who are "regulars" are discussed at a monthly providers' meeting – providers try to prevent recidivism. This is a new policy. Dr. Atkins at CMHA leads this meeting.

For people who are homeless it is unclear who can advocate for them in the ER. One person went 75 times in the last 3 months.

Berlin started identifying and tracking people who become dependent on 9-1-1. They also have a program to figure out if dispatcher is best or if a counselor or other resources could help.
In terms of follow up after crisis – for people who are disabled with mental health issues, there are home visits or mobile crisis comes out to meet them. Many people do not fit the criteria for inpatient care. They must get help in the home.

STRENGTHS

Here are the major strengths identified by the R&E team:
1) The CMHA MACT Team has established a good working relationship with the New Britain police department. CMHA's MACT Team works with individuals to secure stable housing. The team has worked closely with the town of New Britain and reportedly has reduced the number of police calls to the New Britain green for homeless individuals by 50% in a very short period of time.
2) There are good mechanisms in place for communication and collaboration between CMHA and Wheeler and, reportedly communication has improved over the last 3 years.

RECOMMENDATIONS

Here are recommendations from the R&E team:
1) Develop and or enhance relationships with local police throughout the catchment area.
2) Promote use of Community Care Teams to address issues with discharge and frequent visits to the ER or readmissions.

PROVIDER COMMENT

Wheeler staff stated, "Thank you for sharing this comprehensive and thorough report. We are sure it will be useful in further developing and improving services in our region."

In regards to HIPAA, a Wheeler staff shared, "Wheeler interprets HIPAA in a manner that allows for the free flow of information in a crisis situation between the crisis team, police and other first responders. In an emergency situation, our staff share information with police and first responders without releases. This has been our standard of operations for many years. The releases referred in the report are shared among providers to participate in the teams that coordinate around hospital ED utilizers. All providers in our catchment area are in agreement releases are required for discussion in this circumstance."

CAC 23
Capitol Region Mental Health Center (CRMHC) – Mobile Unit

Over the past year (July 2014-March 2015) CRMHCs report card reflects that they had 226 unique clients, 256 admits, and 263 discharges. They exceeded their goal on initiating an evaluation within 1.5 hours of request (76%), conducting evaluations in a community location (93%), but fell short on their goal for follow-up service within 48 hours (51%).

The report card shows a slight decrease in the number of people seen. CRMHC attributes this to a lack of treatment options available in the community, lack of insurance, and lack of access to a prescriber within a reasonable timeframe. As a result they carry a certain number of brief treatment cases. CRMHC reports an increase in the number of people being assessed who are experiencing their first break. There is also an increase in the number of people coming out of hospitals who do not have access to follow-up care in a reasonable amount of time. Other outpatient clinics (non-profits in the community) are slowing down the number of people they can accept because of **lack of prescribers**. While the current report card dashboard is not yet a full year, the trend is that numbers are down from last year. They were up in fiscal year 2014 (14%) and down in fiscal year 2013 (-23%).

When people call in extreme crisis, police response may be faster and safer. Police are involved when there is a threat of physical safety, and the hope it that police called to the scene are CIT trained. Involvement of law enforcement, however, raises the concern that there will be an arrest and charges pressed if police are assaulted. Whether the police are deployed has to do with timing, safety, and circumstance, as well as **whether mobile crisis teams are adequately staffed** to handle the crisis. There is no data tracking re: decision to deploy law enforcement instead of mobile crisis staff, only manual notes. The police are considered part of the toolbox the mobile crisis team relies on.

In regards to the community measure, the mobile crisis director feels strongly that crisis assessment should occur in the community – in the environment where the person is experiencing crisis. The reasons include concerns for their safety, and desire to avoid putting the person in crisis in a strange place to assess. There is a need to distinguish between crisis and intake assessment.

In order to address wait lists and access to care issues, mobile crisis directors meet as a **"gridlock group"** twice a month. There is a good collaboration with community hospitals and providers. They track the use of acute care beds. They provide a lot of training in the community with people who make referrals for mobile crisis services.

In terms of data tracked, the trend shows an increase in individuals with co-morbid, complicated needs. There are also more older adults, and more young people experiencing their first break. There are more referrals for people with dementia.

After crisis, the follow up involves calling the hospital to give a report. This also involves checking to see if the person receives CRMHC services, and if so, to fax additional information to the

hospital. Mobile crisis directors also call the ED to follow the disposition, and make necessary referrals for services and shelter if needed. They may go to the hospital for engagement, especially if a person has been hospitalized a few times or if they don't think he/she will follow up with care. The crisis staff also arranges for same day intake at CRMHC from the hospital.

HIGHLIGHTS:
CRMHC is the only one of five state-operated LMHAs receiving state funding in CT that has a **police liaison**, Barry Skoletsky. Mr. Skoletsky carries a police radio and can respond to any calls for which police are dispatched for a possible Emotionally Disturbed Person (EDP) situation. Mr. Skoletsky is highly regarded by the police he works with, meets with them regularly and provides CIT training throughout CAC 18 and CAC 23.

CONCERNS:
A significant number of people who are undocumented are not helped by the ACA. Spend Down is still a problem for people who might qualify for Medicaid. People who cannot afford the premium continue to go without insurance. Some people cannot afford the co-pay so they go without medication.

DMHAS-FUNDED COMMUNITY HEALTH CENTER STAFF: CRMHC – Hartford
At the CRMHC focus group, staff ranging from the Hilltop, a supportive housing unit for young adults, to the Director of the Med Management Team came participated.

At CRMHC, situations that require a crisis response mostly occur during the evening hours. The Medication Management Director only asks mobile crisis to come with her on assessments in the evenings. For the most part staff try to address problem situations with de-escalation techniques, and after all attempted staff interventions fail, then they call mobile crisis. Sometimes young adults call mobile crisis themselves – they find staff to be reliable. YAS staff rely on mobile crisis staff to help on weekends.

Every morning, each CRMHC team reviews the mobile crisis reports from the evening before for status updates and identifying situations that require follow-up by the team. Staff work proactively with the mobile crises team providing critical information and establishing crisis plans. Information that would need to be shared in the event of hospitalization is shared in advance whenever possible. In the event of hospitalization ER staff would call mobile crisis for information or guidance. Hospitals involved in this information sharing include St. Francis, Hartford Hospital, and UConn.

CRMHC also has a Gridlock Meeting which happens twice a month to address frequent users of the ER and extended hospital stays. This meeting involves hospitals, mobile crisis, CRMHC administration, and certain clinicians. The Gridlock meeting is similar to a Community Care Team except it has been around for over 10 years and started to address concerns about people who were stuck in the ER or inpatient psychiatric beds because there is no appropriate setting available for discharge.

CRMHC reports that police play a key mediation role in crisis management. They are patient and understanding, and excellent with 3-way communication between mobile crisis, the ER, and CRMHC staff. Police tend to respond more behaviorally than legally – meaning they work to de-escalate the situation rather than come in to assert the law. Police are also called to write a Police Emergency Evaluation Response (PEER) hold and are now more likely to write a PEER hold than arrest a person in crisis. CRMHC staff call police for safety, when weapons and alcohol are involved. CRMHC's excellent rapport with the police stems from the police liaison, Barry Skoletsky. This liaison spends a lot of his time training the police department, including those from other towns. It was stated that younger or newer police recruits are easier to work with, because they are more open minded to the training.

Staff assert that there is "phenomenal" communication between them and the mobile crisis responder during and after crisis. The phone is always picked up and never busy. There are always debriefings afterwards. Mobile crisis will call the ER to find out what happened. And every day mobile crisis writes great notes to fill in the information gaps for every shift. Sometimes people they have served in the past will call just to check in because they have such a great relationship with mobile crisis staff.

Follow up care shows gaps in the system – according to staff, there are no residential services. Also, when people who are undocumented have no funds, ERs release them more quickly. This does not match up well with follow up care that is needed. Part of the problem is there is no sub-acute unit, and more step-down transition options are needed. Sub-acute units are unlocked housing units with nurses and a medication closet available 24/7. They are voluntary home settings where people are learning skills. Another issue is that sometimes ERs let people go too quickly when they need more care. CRMHC tries to get the ER to keep people longer. But there are too many people on wait lists for care – both public and private hospital beds are full. Another level of care that is missing is day programming – but CRMHC has none. CRMHC used to offer food – they would serve lunch daily and all the appointments would revolve around ensuring that people got a warm meal – sometimes their only warm meal for the day. Now they no longer serve food and people coming in for appointments can no longer rely on staff for food. Also some of the CRMHC prescribers are reluctant to send people on their caseload to IOL for day programming because they would have to give up their prescriber role (IOL would become the prescriber and might adjust the medication regime). So in order to ensure continuity of care and to keep people stable on a prescribed medication regiment, doctors are hesitant to refer, even when an intensive outpatient day program might benefit the person. The last big gap is a meaningful substance use program for young adults. This seems to be lacking.

In terms of frequency of crisis response, this varies from staff to staff. In the medication management program, there are daily crisis calls – but this is the largest program. In the community support program, crisis calls are less than daily. With supportive housing, crisis calls do not happen often. And within YAS, crisis calls occur 2-3 times daily.

Overall, the mobile unit does a good job. They offer a quick response for assistance, they know people well, and they are integrated into the agency. This means crisis care staff go to all agency meetings, the CRMHC staff know them, they're well trained, and they have good police contacts. There is a low turnover in the mobile crisis staff. One person has been there for over 16 years! The police liaison has been around for over a decade, and he helps handle telephone triage.

An area on concern is staffing – they need more people handling crises. They also need to address the fact that when the police liaison retires, no one can fill his spot. He has worked for a long time to create the knowledge of the community and of the police in the area. CRMHC staff thinks they need someone in the mobile crisis unit to act as back up and to start grooming new people into the police liaison position.

Mobile crisis used to be 24 hours a day. Now CRMHC has whittled back these hours for budget constraints and for staff safety. The curfew is getting shorter. There have been 19 shootings in Hartford this year – the environment is getting more dangerous in the community, so if a crisis occurs late into the night, CRMHC staff must leave the crisis to the police or wait until the next day. Moreover, CRMHC is dealing with an aging population. The services are not catered to the unique needs of older adult. To prevent spiraling, people need visiting nurses, people teaching living and cooking skills, residential support programs, wellness checks, and peer support. People could also use services through the WISE program, have a lot of support groups, and learn distress tolerance skills. Soon, CRMHC will start extended hours for warm lines to help callers who may not be in crisis but still need someone to talk to. Staff also talked about Dialectical Behavioral Therapy (DBT) coaching – to try steps taught in therapy before calling mobile crisis – and to give mobile crisis staff a coaching sheet to calm people before the team decides to come out to meet the person in distress.

Issues Raised by CAC 23 Members

In CAC 23, the definition of crisis was described as having to do with abuse, post-traumatic stress disorder, somebody causing pain, and psychosis. If someone feels unstable, suicidal, cannot control themselves, have unworthy feelings, or are a victim of domestic violence, child abuse, or neglect, then they are in crisis.

When in crisis, people call first responders, a counselor, case manager, 2-1-1 or 9-1-1. Someone brought up the Re-entry Roundtable which helps people coming out of incarceration. Members perceive a lack of training for law enforcement in mental health issues and feel strongly that mental health awareness training must be mandated.

The people who first come to the scene tend to be fire fighters, family members, and Emergency Medical Professionals (EMP). Some people noted that family members could be triggering but they are often most helpful for anticipating the triggers of the person in crisis. Responders sometimes don't know how to react appropriately.

Interactions with official responders were described as generally negative. People shared feeling "crappy" and feeling like responders are not compassionate. Some people wonder why responders don't take Mental Health First Aid (MHFA) training. Many people agreed that **mobile crisis is a broken system**. If the person in crisis gets a good responder, then things tend to go well. But sometimes responders can escalate crisis. One outpatient clinic director said that she told police not to come to the scene with sirens, but they still did – there is often a **disconnection in communication between the responder on the phone, and the police on the scene.** It is rare that there is someone responding with compassion. There was a positive story in which first responders had training for mobile crisis so they had a better understanding of mental health issues and treated the situation compassionately.

Someone noted that if you call 9-1-1, fire trucks will come before the police. Another person noted that a Hartford fireman listened to her – and that crisis was averted thanks to his compassion and patience. This person felt that the police were less sensitive than firemen, and that ER staff were the most insensitive.

In regards to the hospital experience – people had mostly positive comments. Someone said that the Emergency Department (ED) can isolate you in a room and restrain you; she said the ED nurses were not helpful and just threw her into a room. But people had positive comments about the IOL – people said they understood what was going on and were helpful. At St. Francis hospital, one man felt he was treated with dignity. He broke his ankle and had heart problems in addition to his mental health issues, so the doctors assisted him with the physical ailments too. People complained about the nurses, saying that they treated physical symptoms but needed mental health training. In general people felt the field of medicine needed to change. Some people complained about the waiting times in the ER. People shared they needed to spend 18-24 hours waiting to be triaged. There was no crisis response team of licensed clinicians to bring people to the appropriate unit.

People felt there were enough communication tools for medical practitioners, and every mental health unit has trained clinicians, so they should have better communication and more family sessions. They wondered whether HIPAA requirements got in the way. The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information.

STRENGTHS

Here are the major strengths identified by the R&E team**:**
1) Services are integrated well with other agency clinical and support services staff.
2) Mobile crisis responds quickly, know clients well, and are aptly trained in crisis management.
3) Mobile crisis serves as a good liaison for 3-way communication with police, clinical staff, and the hospital
4) Barry Skoletsky is a great police liaison. He is always on the walkie-talkie, trains police (especially new recruits) on crisis care, and is trusted by police.
5) The morning report for all CRMHC teams help people plan their days and aid with triage.
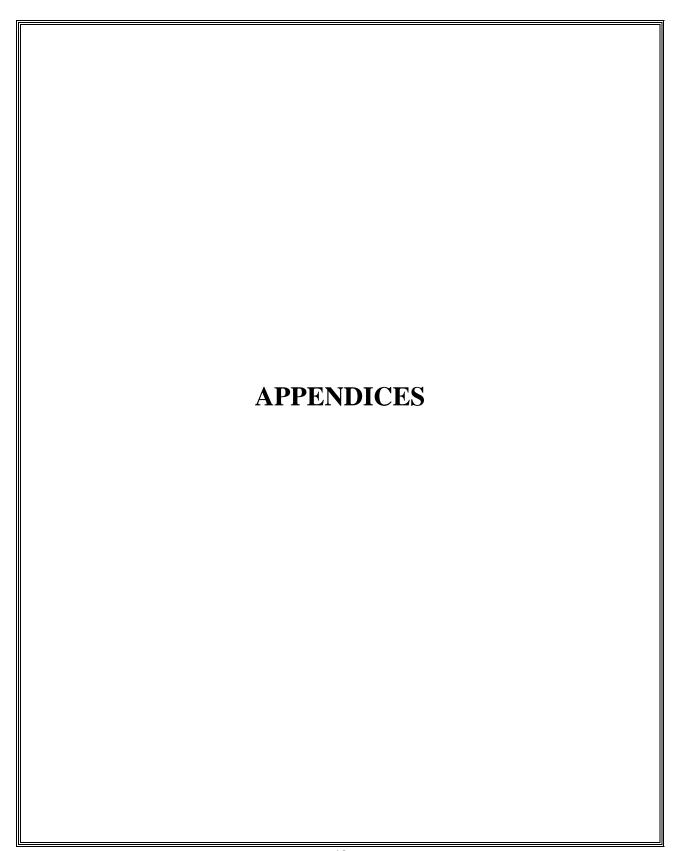
RECOMMENDATIONS

Here are recommendations from the R&E team:

1) Address conflicts for people who need intensive day services (i.e. at IOL – prescribers are reluctant to discharge people because they do not want to release the prescriber role and see medication changes).
2) Develop resources for offering food to people who come for service during the day. People enjoyed getting their meals at CRMHC and for many it was their only meal of the day – this was a way of motivating people to come in for groups and appointments. Now they have no meal to look forward to when they come to CRMHC for their appointments.
3) Plan for grooming someone to replace Mr. Skoletsky when he retires. He is currently near retirement age and there is no plan in place to train another police liaison.

PROVIDER COMMENT

In response to the above recommendations, CRMHC wrote the following:

1) CRMHC does not typically discharge clients who are attending IOP as they return to CRMHC upon discharge from the IOP. The IOP is generally time limited. The CRMHC Medical Director will consider whether there is any inherent conflict with the prescriber roles.
2) Meal service to outpatient clients was stopped many years ago. In addition to budgetary concerns, it was determined that providing food was a deterrent to people moving on to more independent levels of care. CRMHC teams work closely with people to ensure they have entitlements and know how to access community resources like soup kitchens and food pantries.
3) Mr. Skoletsky has no imminent plan to retire. Given state hiring procedures, a replacement position cannot be sought until his retirement is formalized, nor can anyone be "groomed," since all positions must be posted and filled based on seniority. All core Mobile staff is CIT trained.

APPENDICES

CAC 15
Town Social Services Comment

Town Social Services comments are organized by Catchment Area Councils (CACs). These comments were obtained through face-to-face or phone interviews and responses to written surveys. Two towns responded for CAC 15.

CAC 15 Town Social Services staff report that they call 2-1-1 in case of crisis. Emergency workers come to the scene if the person needs safe transportation to the hospital. Staff are also aware that the mobile crisis can come to the office or homes. Primary responders include the town services person, police, LMHA mobile crisis services and an ambulance. Some towns have a licensed therapist on staff. From the perspective of town social services staff, the follow up after crisis primarily involves the town services person contacting the hospital and family.

Mental health crisis providers do a good job of assessing the situation. They do a good job of listening to validate concerns, and they take their time. CHR does a good job and also provides preventative care. The police play the important role of securing the location and assessment and are considered to be partners in the communities.

To create proper transitions from hospital to community, there is a newly developed "care team" which offers community social services. The **Community Care Transition Team** is comprised of health care professionals, family, social services, mobile crisis, and is based upon an individual needs assessment.

Regarding any differences in access to care for people with private versus public insurance, staff report that for crisis care there is no difference, but for follow-up and treatment there is a big difference. The insurance carrier, what is covered and cost of the co-pays are some major issues determined by insurance.

Identified weaknesses/gaps in the system include access to transportation for follow up care, especially for children and adolescents, and access to treatment programs and psychiatric care for youth. More resources are needed for existing services to provide longer periods of service. This insures that people are stabilized before release into the community, and that once there, they have the supports needed to maintain stability. To create proper transitions from hospital to community, more structured community support services are needed. Also, **communication is very important between mental health providers and local social services.** The consequence of not accessing appropriate levels of care is more and repeated institutional placement.

There needs to be a provision for psychiatric services to be delivered in the home for people who do **not have transportation to get to the provider building**. When someone who is in crisis really needs services, they cannot be seen in time so they end up calling the police. When the crisis is over, they are left with a big bill and no services. Crisis response time needs to improve.

The successes in the system involve **people getting access to services** in the home. In terms of access to care for people in all stages of their life, parents and young people seem to get information through the schools. Town social services might be requested to assist the family with basic needs, food, housing, and transportation. For the elderly, access to care is always a challenge. Transportation is an issue; some elderly need a companion, etc. Ideally there would be groups or individual counseling in the community or home.

Access to care for people who need more structure and support is limited. More group homes are needed. The barriers at each point in the continuum of care could be ameliorated with a coach to help individuals find and apply for resources. The consequences of not accessing appropriate levels of care are 1) readmission to the hospital, 2) not being able to integrate back into the community, and 3) frustration, challenges for people, and feeling like they are alone and on their own.

We need low-income housing with mental health supports. Moreover, mental health is not being addressed if people who are suffering do not seek help. Sometimes people can be in denial. Nonetheless, available services are hard to find, and there are long waits for these services. "Those needing and wanting help need to commit to it and work on it. They can't if services are long in coming or hard to access. Large group counseling may be necessary to meet the demands. We need a "friendly" facility where everyone feels welcome."

The following story was shared by one town social services director. His office has been working with a 74-year old female who lives in subsidized housing. She has been deteriorating significantly during the past months. For example:
- She is very agitated and constantly on high alert,
- She is convinced that people are breaking into her apartment and stealing items. She makes frequent calls to police about this.
- She is convinced that her daughter is spying on her from across the street
- She believes her daughter disguises herself as a man and visits her (the resident's) neighbors,
- She reports being dive-bombed by bugs with huge beaks,
- She does not eat or sleep for days at a time because she has to stay awake and be on the lookout for people trying to break in. She has lost approximately 20lbs. in past months.

These are some efforts that he and his staff have taken:
- Called Protective Services for the Elderly. They visited and determined that the apartment was well-maintained and the resident appeared oriented. No case was opened.
- Mobile Crisis Team was contacted at least three times (twice his social worker and once by CT Homecare Program). MCT came out once, determined that the resident was not at risk and left. A second time MCT spoke with the resident by phone and again determined that there was nothing they could do.
- The social worker called CHR directly and was told that the resident would have to make an intake appointment and go to the CHR office. After much convincing, the social worker brought the resident to CHR for an intake. The intake worker quickly became frustrated because she "couldn't get a straight answer" from the resident. The resident felt insulted

when the intake worker offered her an alcohol group (not appropriate for this resident). The resident declined individual therapy and CHR said there is nothing more they can do. There was no offer of community support services or an appointment at the clinic for a medical evaluation.

- The police department reached out to the resident's doctor and the doctor scheduled a psychiatric evaluation. After her bad experience at CHR, the resident now refuses to go to the psychiatric evaluation.

The resident comes to her social worker's office on a daily basis in a highly agitated state and the social worker has to send her away fearing for her safety and well-being, especially since she is not eating or sleeping. The police are afraid that she may hurt someone if she is constantly on high alert and believes that people are breaking into her apartment.

CAC 16

Town Social Services Comment

One town responded to written survey and two other towns participated in CAC 16 discussions:

Social Services staff reports that when working with someone in crisis, it is standard protocol to call in reinforcements as necessary to ensure that the person is safe. The approach taken depends on the person's specific crisis and whether or not they are requesting help or aware of their situation. If the person is asking for help and self-reports a need to be hospitalized, a family member or the treating physician can be contacted for a direct admittance to a hospital. Otherwise, police (if person is resistant or aggressive), medical care/ambulance (if self-injurious or high risk), or mobile crisis would be called for transport to an emergency room for a psychiatric evaluation.

Follow up care is also dependent on how the situation was handled. Often times if a person is admitted to an inpatient setting, a social worker is responsible to set up a discharge plan, often including services such as Intensive Outpatient Programs (IOP), Partial Hospitalization Program (PHP), or outpatient treatment. If the person is not admitted for psychiatric reasons, then it is often the responsibility of the clinician who last saw them to provide treatment options available in the community and potential referrals to address the person's needs.

Social services staff reports that mental health crisis responders are very good at assessing a situation quickly and taking charge of an often chaotic environment. Crisis responders in general are well informed on the community resources, wait lists and referral procedures that often expedite treatment and keep insurance costs down by avoiding a hospital visit if unnecessary.

The role that police play in mobile crisis depends greatly on the training they have received and their specific understanding of the system. Some are very helpful and communicate well on scene, looking to follow the lead of mental health professionals and assist as best they can. Others appear ignorant of the "system" and annoyed that they are contacted for a situation that is non-law enforcement related.

The major difference in access to care for people with private versus public insurance is the lack of providers and wait lists. Often private outpatient treatment providers do not take public insurance and therefore options are limited to larger non-profit agencies with long wait lists. Also, specialized referrals such as neuro-psychological evaluations are difficult to locate and transportation becomes difficult due to limited options.

Weaknesses in the system center around limitations for treatment (mostly due to insurance constraints) that leave people without adequate treatment and often times decompensating further than their initial struggle. Discharge standards are predetermined and not individualized to address co-morbidity, the unique set of struggles or life experiences of specific age groups, and other issues that should determine the best setting, type, and course of treatment. Mental health care has become a very "brief therapy/solution focused" model and often times that leaves the providers with a difficult task. Many diagnoses are long-term problems and have treatment modalities that require a higher level of care and structure; however, many of these options have been downsized or

eliminated altogether. We need more residential settings, both short and long term, to address mental health, substance abuse, etc. that an outpatient setting is ill-equipped to handle (at least initially). Not accessing appropriate levels of care contributes to the breakdown of programs, utilization, funding, and leaves gaps in services. Oftentimes, valuable time is wasted and services are not put in place specifically geared at the targeted outcome due to the lack of assessment.

Improvement is needed in the areas of communication and collaboration with community providers and stakeholders. Often when mental health providers make referrals such as to DCF, DSS, or APS, no follow up takes place. This leaves the referral source with questions as to responsibility to follow up or not. Improved communication and collaboration are needed for continuity of care. The transition from hospital to community needs to be a group effort. Communication regarding the discharge plan needs to be communicated to the providers who will be resuming or beginning treatment as well as a social worker/case manager to be contacted to ensure that discharge planning, referrals, and paperwork were followed through with.

An East Hartford provider who offers suicide prevention training in public schools shared the following information: East Hartford used 2-1-1 about 200 times in 2013. The ball is dropped somewhere in crisis care, resulting in a revolving door of people who come in and out of crisis. In some cases the family may drop the ball, but psychiatric services also play a role. There has to be some sort of a plan. **Training is also important for the police** – Newington has been doing training with Youth and Adult Mental Health First Aid (MHFA).

CAC 17

Town Social Services Comment

Two towns responded, Enfield and Bloomfield:

Who is contacted in a crisis depends on whether the person is imminently at risk or acutely suicidal. For emergencies – 911; if regarding teen safety – 211; for adults - CHR mobile crisis; if a low-to-moderate risk situation - outpatient therapy. The person who comes to the scene also depends upon the level of risk. The police respond to a 911 call, otherwise mobile crisis personnel responds via 211 or CHR.

The people involved in crisis response also depend upon the level of risk. In Enfield, out of response to a series of tragic youth suicides, an Enfield Training and Crisis Response Team has been created comprised of Youth Services, Mental Health, Police, School, Faith, Funeral Home. They can respond to suicide attempts and would enact post-vention and connect with families in the event of a death by suicide. They are seeing much success with use of their team and with monitoring at-risk youth. A lot of follow-up happens after crisis. The town obtains appropriate releases of information so they case manage to make sure services are in place for whoever needs them. If the person is a youth and in school, the school requires a safe return form. They also notify physicians of the event so they can check in with the school nurses and social workers over time. If the site of the crisis is school, responders include trained school personnel, Police, Youth Services, and again depending upon level of risk, 911, and 211. They will also connect people to outpatient care.

Mental health crisis responders do a good job of providing crisis debriefing, psychological first aid, post-traumatic stress management and providing resources. They will do whatever is needed and are community involved. They do need more and improved training especially for universal screenings and QPR. Police play a physical safety role in mobile crisis management. In Bloomfield the police department will need additional training as the department is losing long time employees and new employees are not trained in crisis management. CHR is seen as helpful. MCT responders are described as sensitive and having empathy and compassion for the person or persons affected. The Bloomfield team has never known them to refuse a request for assistance when people have a crisis issue.

Other supports in Bloomfield are places of worship and the library. The library seems to be a gathering place for people who find themselves homeless. In these situations, the library personnel contact town social services for assistance. Town personnel go to meet with these individuals and refer them for help.

Follow-up is provided by the town social services when notified, however communication is an issue that needs to be addressed. In Bloomfield there has not been a need to call mobile crisis in a while. This may be due to the fact that people in crisis often call 911 instead of contacting them. That is a concern if those calls are not referred to them for follow-up.

Town social services do not report any noticeable difference in access to care for people with private versus public insurance.

Weaknesses include the fact that mental health agencies are reluctant to involve and embrace the community safety net. To create proper transitions from hospital to community, releases have to be signed and the community (town social services school, doctors, etc.) has to know about the transition. We have to get better about communication – and ensure that clinicians check-up on and monitors their clientele. For youth, if we can get in early, treatment is more effective. There are also concerns regarding getting through to info line and that their on-line resources are not updated on a regular basis.

Access to care for people who need more structure and support is lacking for youth and adults. Adults who require more structure and support are referred to CHR. One big issue facing the elderly and young adults is transportation. If a person needs help filling out forms, applications or paying bills, and has no family or other support, they will lack consistent care and may end up homeless or worse. The consequence of not accessing appropriate levels of care is crisis. It is frustrating to see people get into chronic life situations when it could have been prevented.

For youth transitioning to the adult system a significant barrier at each point in the continuum of care is the fact that youth services is not familiar with adult services. Also, some of these youth come from homes in which the parents are involved with drugs and alcohol. Moreover, children and youth experience trauma when police are involved in a crisis and guns are drawn.

CAC 18
Town Social Services Comment

Three towns responded:

When town Social Services staff are working with someone in crisis, who they call depends on the crisis. This can include mobile crisis, police, the fire department, protective services for the elderly, etc. Sometimes crisis responders come to the scene, sometimes not. It depends on the severity of incident. People usually come when the police are also involved. When people are in crisis, primary responders include Police, EMT if police call them, and the Mobile Crisis Unit.

West Hartford social workers sometimes go to the scene, though those mentioned above usually are there first. If there are family members in need or there has been a fire, or there is a hoarding situation and health department needs to be notified – these are all times that Human Services might go out to the scene. They are occasionally asked by first responders on nights or weekends to go to the scene also.

Mental health crisis responders do a good job of showing up. They also stabilize situations where they can rather than escalate, and they coordinate with family. Mental health crisis responders need to improve upon coordination with other agencies and families.

They tend to be well aware of resources, they usually respond in a team, which allows for mutual consultation. They have the credentials and ability to hospitalize an individual, if necessary. They usually have time to be thorough in their evaluation. And importantly, they go to the scene. They are good at getting collateral information from family on the scene and/or make phone calls. From Avon's perspective there is a need to improve upon coordination with other agencies and families.

Police offer protection and awareness of statutory and other resources. If well trained, they can be a consultant for what action to take. They are often first on scene. In **Avon** there is a need for more police trained in de-escalation. In fact, they recently had meeting with the police department regarding this issue, and now the police department is committed to training more officers in mental health crisis response. Currently they have staffing issues that prevent this happening sooner, but the department is committed from the top. It is important that all mental health crisis responders improve upon talking people "down" or de-escalating triggers in a potentially violent situation without having to resort to stun guns or other potentially lethal means. In Simsbury police play a primary role in crisis management. They are perceived to be good at assessing the situation and determining what services are necessary. They communicate effectively and trust the assessment and recommendations of others in addition to their own.

After the crisis, mobile crisis will call with their outcome, and there may be follow-up by town social services. West Hartford sees a diverse array of crises, not just for mental health situations. If they are called out by fire, police and/or health departments they work collaboratively with them. Fire, police and/or health departments send reports and request follow up, or assistance with follow-up. After crisis, UConn Hospital/John Dempsey staff are often involved, and the town gets a case report; they follow up only when needed.

Social services staff in Avon and West Hartford see a big difference in access to care between private and public insurance, but the differences go both ways. Private insurance allows more choice of providers and access than public insurance for some services, but there are services not covered by private insurance. For instance, people with private insurance can go to mental health and substance abuse providers who do not accept Medicaid/Medicare (or new patients with Medicaid/Medicare). People with private insurance, on the other hand, who need services that are only for those on Medicaid and public assistance, cannot access them.

Education is needed to raise awareness and remove the stigma of mental illness. Furthermore, those finally willing to accept help often find it difficult to find a therapist; get an appointment within six months; and find a therapist willing to accept their insurance. The availability of clinicians and the wait time for mental health care needs to be improved.

There is also a need for mental health professionals who specialize in treating seniors and accept Medicare for their services. More resources are needed as well as access to information about services provided and eligibility requirements. For those who rely on Medicare and supplementary Medicare, access is pretty good. Connecticut has protective services for the elderly, age 60 and over. West Hartford sees a gap for people ages 18-60, where there are no protective services and would love to see the state address this.

Young adults are very different as the problem can often be a "whole family" or family dynamics issue. It can also be an issue of misdiagnosis or misidentification. Another complication is that therapists want to see commitment before taking a case on. This is complicated to solve, the whole family needs to be on board. Sometimes young adults just don't leave the home because they are unable to cope with the pressures of outside world.

Another gap is there is no supported housing locally, just via the state.

As for access to care for people who need more structure and support, this is a very difficult area. Services are very fragmented and difficult to access. Healthcare providers are sometimes not good at this. Sometimes there is no referral process. Often these issues are left to the family to solve.

The issue with preventative care is early identification and referral by family, church, or school. Preventive care should include outreach to seniors who have an adult child with mental health issues residing with them. Also, we need to promote the "Start The Conversation" suicide prevention training in all towns.

To create proper transitions from hospital to community, discharge planning psychiatric social work staff at John Dempsey play a role, but people can get overwhelmed very easily. There is no safety net. **More community-based case management would be helpful.** Hospital discharge managers should have the ability to spend more time and demonstration if needed for medication, etc., with patient and family than currently exists. The barriers at each point in the continuum of care include income, transportation, housing, a support system, and community.

Major barriers to crisis care are the stigma of mental illness, and awareness of and access to services without having to travel to Hartford.

The consequences of not accessing appropriate levels of care include health and mental health decline, re-hospitalization, premature hospitalization, not being employed, not being engaged in society, not being happy; it can be the whole spectrum. The negative consequences are visible at all levels – individual, family, and community. This results in higher costs in the longer term if not addressed early. Other consequences of not accessing care mentioned include violence, suicide, homicide, homelessness, substance abuse, crime and family deterioration.

Family Member Experience

One family member believes that someone is in crisis when there are four conditions at hand:
1) When that person is experiencing psychosis from their illness and they need help. Psychosis can happen to anyone, however, psychosis is often associated with schizophrenia, which involves hearing voices; hallucinations; delusions; etc. Psychotic features can also be associated with severe untreated Bipolar disorders, Depression, PTSD, etc.
2) When someone who is ill has become gravely disabled and unable to care for themselves (not eating, not bathing, cognitive abilities, psychosis, etc.) and they need urgent medical intervention.
3) When medications are not working properly and or side effects are extreme.
4) When they talk about possibly hurting themselves OR wanting to end their pain.

When her son is in crisis, she calls mobile emergency crisis and when mobile crisis is not available, then the only alternative is to call 911 for the local police to respond. She believes that when mobile crisis is not available, 911 should provide urgent medical treatment and a visit to the hospital for any illness that requires immediate intervention, similar to any other crisis emergency.

Recently, in July 2014, this woman's son was in the car with her and they arrived at a Subway in Avon where she called mobile crisis. At the time, he was hearing voices and delusional, and required psychiatric emergency intervention. Mobile crisis told her to call 911 and she did. Her son got out of the car and was sitting quietly at a table in Subway, when multiple police officers arrived on the scene. He got up, became fearful, and the police officers escalated the situation. They surrounded him. He tried to get away from the police officers and in the process pushed away from them during a heightened psychotic state. After this, they surrounded against him closer and told him to put his hands behind his head. Because her son did not have the mental capacity at this point to understand the police command, he was tasered. He fell over flat on his face on the street concrete and they did not check to see if he was hurt, they just handcuffed him.

Her son was doing absolutely nothing wrong except experiencing psychosis; he was not armed, he was not threatening the police, and he was not disturbing the peace in any manner.

Following this, they made him stand up. Her son could not regain control of his bodily limbs and could not stand up nor could he walk because of the tasering, and four policemen had to hold onto him to help him up. Her son was handcuffed, had blood running down his face, he did not have bodily limb function control, and had difficulty breathing. After a while, they made him stand up again, and walked him over and put him behind a police SUV van. When one police man saw where the woman's son was placed, he immediately told her that her son was being arrested, even after she had explained to him many different times that her son is ill with schizophrenia, experiencing psychosis and delusional and needed urgent medical attention and had to be taken to a hospital.

The woman believes that stigmatizing language in laws regarding gun control exacerbates discrimination and empowers law enforcement and police to believe that all individuals with mental illness are criminals and dangerous and this is how they ultimately respond to and deal with individuals living with mental illness when confronting them during a psychiatric crisis emergency.

Five days later, following the incident, after her son had received the emergency psychiatric intervention that he needed and was released from the hospital, he was brought home to his apartment by his social worker at Capital Region Mental Health Center. Her son called the Police Department that afternoon because the hospital had not returned his wallet and he wondered if his wallet had fallen out of his pocket during the incident and been found and turned in to the police.

The woman arrived to her son's apartment as the fourth Police Officer vehicle came on the scene. When she entered her son's apartment, one police officer was on his left, and another police officer standing next to him on his right. Her son was quiet, standing in the middle of the two police officers. The policemen were in his apartment without a search warrant. All officers left rather quickly once the woman showed up. She felt that this was the most ridiculous thing she has experienced.

Ten days later, the police department called the woman to inform her that her son was being arrested. Additionally, the police officer who called her stated that from now on, anytime she calls the police department, they will summon multiple police officers concerning her son.

In other words, she feels "my son has no civil rights and they (police) will do whatever the heck they wish to do, because my son has a mental illness. Law Enforcement officials, are paid with our tax dollars and supposed to protect the citizens of this state, not hurt them or criminalize them!" The woman's concerns for her loved one include not having mobile crisis available when she has to call for her son's crisis next time. She is fearful just thinking of calling 911. "I am terrified about calling 911 and terrified of police officers!"

She deplores the lack of awareness, sympathy, and empathy by law enforcement toward mental illness and mental health issues in the state.

The woman shared that mobile crisis has been called on several occasions, and when they have

assisted they did help. A therapist and psychiatrist arrived with police and an ambulance, and everything went very smoothly.

Another time when mobile crisis was called for her son's psychiatric emergency crisis, mobile crisis arrived with an ambulance and the police. Although her son did not pose a threat to himself or others, but was in a crisis and required psychiatric intervention, the police officer who arrived on the scene refused to cooperate with the Mobile Crisis Psychiatrist from Capital Region. The psychiatrist and the Avon police officer had an argument in her living room, and the police said: "I am not taking anyone out of their home against their will if they are not a threat to themselves or others, I do not want to be sued". The Mobile Crisis unit took control and said they were making themselves responsible and the psychiatrist did an involuntary commitment and had her son taken to the hospital because he REQUIRED psychiatric emergency medical treatment. This police officer did not realize that individuals with mental illness do not need to hurt themselves or others in-order for them to receive psychiatric intervention, treatment, and emergency medical help.

The woman feels like someone dropped the ball in her situation. She suggests, "Instead of mobile crisis asking folks to call 911, perhaps they should be the ones to call on behalf of their clients. The reason is this: if family members call and there is an psychiatric emergency crisis, most times they may not say the right things to the dispatcher who answers the phone and even when they do say the right things, untrained police departments might act out of fear and ignorance rather than from a place of compassion, and use excessive force. She believes that if we continue to have police officers who do not understand mental illness, we will end up with incarceration or death of individuals living with a mental illness. She says, "There are one too many deaths caused by police showing up to the scene to handle emergency psychiatric crisis in our state all because individuals living with mental illness are criminalized, discriminated, and have their civil rights violated by law enforcement officials. Most importantly, we end up criminalizing the mentally ill instead of providing them with the urgent medical treatment they need. One death of a mentally ill individual by law enforcement is one too many and should not be acceptable to anyone under any circumstance."

The woman usually does not stay in touch with any one person after her son's crises. She shares, "The mobile crisis has not usually followed up with me after any of the intervention calls I have made. The mobile crisis team is part of the Capitol Region Mental Health Center and it is normally the psychiatrist and social worker there who will be informed by the mobile crisis and follow up after this.

Follow-up after crisis involves her son visiting his psychiatrist and social worker at Capital Region in their Young Adults program.

The woman asserts that mobile crisis teams do a lot of good, "when they show up." She acknowledges that "Teams include social workers, psychiatrists, therapists, and they have knowledge and experience with mental illness. They know how to de-escalate psychiatric emergencies, and assess the situation. They are equipped with awareness and bring an ambulance and the police with them when necessary and most importantly, they evaluate and assess the

individual who is in crisis and seek medical treatment for the individual."

To improve, this woman believes that mobile crisis teams must be a liaison to the police rather than telling callers to call 911. There is also an urgent need for more mobile crisis teams in our state. The amount of time they take to arrive at the crisis is lengthy at times. She confirms that sometimes, "It can take two hours or longer depending on wait time." This is because mobile crisis teams are busy and there aren't sufficient resources in our state. Although they do a fantastic job when they are involved on the scene of a psychiatric emergency, there just are not enough resources.

The woman experiences her son in crisis off and on. She states, "It varies from time to time; sometimes when the medications are not administered to him in a timely manner; and or are not working well or don't work at all; others, when my loved one stops taking them; other times when there are side effects caused by medications. Finding a cure for mental illness; better medications; and preventative treatment measures would improve his life."

She adds, "My son lives alone. He has nothing to do all day and no one to help him. A home visiting nurse shows up to administer additional medication each morning and spends about one minute - she does not evaluate him and does not talk to him. My son opens the door and at the door he hands her the black medicine box, she opens the locked medicine box and gives him the pill or pills and then she rushes off to her car." This woman believes that having more ACT Teams in the state to help individuals living with mental illness towards recovery will help prevent crisis. "Assertive Community Teams are in dire need and should be available to all individuals who live alone regardless of age, and who do not live in group homes!"

Her son has both public and private insurance. Capital Region Mental l Health Center staff told her to cancel the private insurance because the private insurance and the state insurance do not communicate well, and the amount of the work that has to be done just to get medications approved for her son is a hassle and can delay getting his medication on time.

She believes that "state insurance offers people services, whereas private insurance only offers immediate mental health care and emergency crisis care, which is only offered when patients are a threat to themselves or to someone else and/or the hospital receives approval from private insurance." She thinks that other than this, the patient is "kicked out of the hospital within two week or less, and sometimes without any post care instructions or treatment plans."

She says she has so many issues with private and state insurance in getting medications approved for her son that she cannot fathom of having to deal with nor does she have the time to understand what this Affordable Care Act is all about. Her son is disabled.

Police Comment from the West Hartford Police (WHPD) Captain and an officer

When police officers respond to a mental health crisis they involve mobile crisis and Town Social Services as needed. Every case is different, but every case has a report and a supervisor reviews

every report. The supervisor looks to see if (1) officer deescalated situation. 95% of time, no "force" is needed. (2) Was the proper documentation used before going to the hospital? (3) If force was used, did the meet the criteria set forth in their use of force policy?

The way that police are called into a crisis situation starts with a civilian dispatchers who take the call. Sometimes mobile crisis calls asking for a police assist. Police refer to a PEER form, which has criteria to commit someone to a hospital. At the scene of crisis, police usually come with an ambulance. They are trained to talk to the person in crisis, get a feel for what's going on, and they fill out the PEER form if needed.

Communication with family, mobile crisis, etc., is also handled on a case-by-case basis. The first line is protection of citizens. Some information from a concerned caller is reliable, while some is not, so next step is to provide assistance to the person. When in doubt about mental stability or alcohol abuse, the officer brings the resident to the hospital. About 85% of cases result in going to hospital. If it's a juvenile then WHPD makes sure parents arrange a counselor for their child. Then after the ambulance brings person to hospital, the WHPD is not involved.

A minimum of two officers would come in response to a crisis call with an ambulance and a paramedic (after confirming the scene is safe). If unsafe, then the supervisor will come. Force is only used when a person is combative, throwing things, attacking officer, or attacking someone else. Even if someone needs to be arrested, they will first go to the hospital. If incapacitated, then the person will go to the hospital.

Police only use tasers when they feel it is a "use of force" issue. There are strict protocols and guidelines for taser usage. There is a Professional Reference Directory (PRD) for emotionally disturbed persons, which sets the guidelines to send people in an ambulance to the hospital if they are in clear danger to themselves or others; if they are not in imminent danger then police call the doctor. If there is no doctor, then police call mobile crisis. "Use of force" is in its own PRD – every situation can require the use of force. Nonetheless, WHPD has a strong education plan and aims to use force wisely.

All officers complete a week long training, of which part is dedicated to mental health education. 10-15% of Department has completed CIT training; all first line supervisors complete CIT. Officers bi-annually review material by hearing from someone in the MH Crisis Team, or other similar program.

An officer we spoke with was very enthusiastic about West Hartford's training offerings, and shared that the WHPD trains 12-13 area towns. He also asserted that most towns have 4 days of training annually, but WH has 5 days. Within this training is included dementia training, and they also offer CIT training. Police are offered free therapy if needed.

Events like the Newtown shootings and the Ferguson riots have caused us to review how we perform and has reignited discussion on our use of force policies. WHPD has a great relationship with community, so it seems unlikely that a Ferguson situation would happen in West Hartford, whereas "we've been talking about [Newtown] for 15 years." For example, in Newtown, they assigned a police officer to every family who lost a child to provide assistance, keep media away,

and as a means for providing services without having to go outside their network. If something like Newtown happened in West Hartford, the follow-up would be similar. In other words, the greater the crisis, the greater the follow-up would be.

In terms of preventing crisis, the role of police is the iceberg above the water. The resources do not exist for WHPD to deal with an ongoing set of issues for those who are not in crisis. WHPD responds to 50,000 calls for service/year. **They do have meetings with DMHAS**, the juvenile review board and the Bridge through the school system. WHPD does not hold regular meetings with other providers.

CAC 19

Town Social Services Comment

Southington Town Social Services Commented for this CAC and the Town of Berlin participated in the CAC discussion.

The Director of Southington Community Services answered the questions.

They have only had a crisis experience twice, and they called Wheeler Clinic. Mobile Crisis came to the premises, but it's been over 5 years since this incident. The last time police came to town for a mental health crisis was 10 years ago. There's no follow up after crisis – only unofficially. She thinks mental health crisis responders do well at their job.

She considers the police useful to call an agency that will put up homeless people in a hotel for a night. Public and private insurance do not affect the services the Town offers.

Her biggest concerns involve **211 and homelessness**. She considers housing as a big issue. In terms of access to care for people in different stages of life, she thinks that we should not mix younger groups with elderly with housing. In regards to access to care for people who need more structure and support, she says the town will often go out to the homeless and do outreach.

Some preventative care measures include education with utility companies – not having to pay full balance to get lights turned back on. This will help people be stably housed. Access to online setup accounts for food stamps would also be helpful. The Director believes there is no continuum of care.

Person in Recovery Comment

One person in crisis called 911. The police came first, then an ambulance, and then a fire truck. Her father wanted to follow them in his car. While the ambulance was fine with him following them, he felt upset and nervous because he did not know what was going on and he didn't understand where they were taking her. More than one person and the hospital stayed in touch with her after the crisis. His daughter feels that public insurance does impact the quality of care; she believes there is greater care but she's only allowed to see certain doctors, which is an issue. She thinks that mobile crisis should have slowed down and explained the situation to her father. She also thinks it was problematic that mobile crisis did not come and that they should have come to evaluate her psychiatric crisis.

64

No Town Social Services Comment for this CAC.

Hospital Inpatient Comment: CRMHC

If we could wake up tomorrow morning into a perfect system, there would be affordable housing and safe places where people could live not surrounded by others who sell drugs. There would be assisted living options for people with comorbid conditions. We have an aging population who are encountering medical conditions that they can't manage on their own; regular assisted living places won't take people with persistent mental health diagnoses. Behavioral health would be integrated with primary medicine. We need to recognize that most of our population lives in poverty; we can't fix things unless we address poverty as a cause.

When people come to CRMHC in crisis with mental health or addiction concerns, they typically start out in our intake department for outpatient services; someone can walk in or call or be referred by hospital. Walk in if possible, if not then appointment to come back. If they call on the phone we can ascertain what is needed. We complete a clinical psycho-social intake and make sure people walk out with medication if needed; if they don't have insurance we can get them medication from our pharmacy on site. In an emergency, we have some capacity to have same day access.

Once done with intake, they would be assigned to a clinical patient team; a prescriber for medication management; and case manager to help with housing concerns. There are 200 residential slots – so if the person needs help with their living situation, we can help with that. We serve about 1500 people each day. We have 2 MRO (Medicaid rehab options) group homes. We are starting up a behavioral health home services; our staffing includes LPNs, mental health workers; and recovery support specialists. We can help coordinate medical appointments and help people sort out medical issues.

Once the crisis is addressed we try to step the person down to a lower level of care. Sometimes people drop off. If can't find them or not responding, then after 120-150 days then will let them go. Won't discharge people until they are situated in new clinic or other provider.

How is the profile of people coming through ER or inpatient services now compared to the past? If someone requires an impatient stay in a psychiatric hospital, we work closely with the hospital to get them back into the community. A lot of people, in addition to mental illness, have long-term cognitive disorders. We are seeing more of this. So, how we teach or help people retain learning is very labor intensive. Can you give someone a two-sentence direction or one? How many steps can someone follow at a time? Cognitive limitations make it harder for someone to recognize when something is not safe. Trying to understand how someone's brain is working and whether they can learn from their environment – this takes complex teaching tools and the organization doesn't have this capacity. We also see a lot of people with co-occurring issues –

stemming from trauma – and very few programs address the whole person for the length of time needed. We are better at recognizing the trauma now – but we need to develop capacity to help them. We are also getting more people out of long-term incarceration – coming out with felonies and sexual offenses and having to register as sexual offenders. These people are limited in terms of where they can live, getting a job, and how to interact with community. The process of getting a pardon is difficult – complicated and expensive.

We have a strong network system in Hartford – and close working relationships with other organizations. But this can't create a level of care when it doesn't exist. Just because we have good relationships with other organizations doesn't mean we can create housing for sex offenders.

What are some challenges in working with people in crisis?
We think it is important to meet the cultural and language needs of people who come to us for care. We employ a deaf and hard of hearing translator; have clinicians who are deaf on site; ability to speak 16 languages among clinicians; use language lines; use iPads and use interpreter app; use app on mobile crisis.

In terms of our policy on restraints and seclusion and under what circumstances we would use these tools, we do not use restraints or seclusion in our outpatient site at all. Usage in the inpatient setting is tracked and a doctor has to sign off on this – usually when a patient is trying to attack a staff person, or when a person is trying to injure themselves or another client.

A couple of challenges we face: we have no access to emergency funds so for example, if someone has bedbugs, we must go through other organizations to help them out. Our ability to respond to environmental crises is slow. Environmental stressors destabilize people, but we don't have control over that.

Also, when people have mental health and substance use issues it is hard to get them into treatment. It is very difficult to get a substance use probate order for someone's safety.

At the time of crisis we work as a multidisciplinary team: nurse, psychiatrist, APRN, counselors, occupational therapist. We assess the person and do a safety plan; we work with the person to identify what helps soothe them. Individualized safety plans are on record so mobile crisis can use them – plans detail whether person is conserved, advanced directives if they have them, how they would like to be spoken to, etc.

After a crisis outpatient teams continue to be in contact. There are daily meetings; teams do an alert to mobile crisis. There are clinical rounds and Utilization Management meetings in which staff can assist with planning; review discharge plans, decide what resources are needed, everyone needs to be in agreement about discharge. Families are welcome, in fact, people who have family involvement fare better. The Young Adult Services (YAS) team works with families in meetings.

Some people who are sent to the hospital for crisis are not getting adequate treatment. This is based in reality: there's a certain percentage of the time where treatment is not as active as it

should be on inpatient unit. We need to get better at this. We need to have more groups and work with people so their goals are based in getting to the community and staying there.

DISCHARGE:
There's a percentage of people who, once they've been inpatient that we really struggles with for follow-up services community. Many have developed medical complications to the psychiatric medications they are taking, so they can't take that medication anymore, or they are intermittently non-compliant with their medication regime. We don't have a level of care to address this. We also have people who are developing dementia. People are dying 25 years younger, and developing those aging diseases 25 years younger.

But when someone has dementia – how do you know if they're feeding themselves? Might not remember what they ate or how to eat; diabetics can't give themselves insulin? The issue is whether you can keep someone safe in the community.

Whenever there is a budget deficit, the staff levels are cut. There is a ratio of fewer staff to the individuals we serve, which makes it harder to pay attention to all the needs and create valuable outcomes. At some point you're only having enough staff to put out the fire instead of having that creative preventive work. We worry about it today and for the future. We also really worry about backlash and discrimination for people who are mentally ill. The issues of "Not in my back yard" and fear – people fear what they don't know; people are worried about violence (Newtown, Sandy Hook, etc.). When you get the crowd mentality – even people in charge who are very rational worry about being stoned. Where is our voice? Who has the voice to come out and talk about mental health stats? Who's the voice of reason?

Family Member/Clinician Comment (M)

Crisis is when a person perceives that their life is in danger, where a person is going to be impacted physically, mentally, and socially.

Who people call for help in crisis largely depends on whether they have connections in the behavioral health realm – if they know and understand the system they will call specific contacts at outpatient clinics such as Charter Oak, Community Renewal Team, etc. If it is a housing issue, people might call social services. **Many people say they would not call 2-1-1 due to the negative publicity** about the service. Some people call 9-1-1 for a psychotic break. Police, crisis workers, and EMTs come to the scene of a crisis situation.

People must be prepared to create continuity of care or it will not happen. One clinician M spoke with shares her contact with crisis workers before they are dispatched. M said that it helps to have a contact person to follow up with – if someone calls the team without a specific contact, then they are triaged and transferred from one person to the next. This clinician also recommended that if someone is calling the crisis line, to ask for a crisis worker to come assess the situation so that they can de-escalate the crisis. M asserted **that we must coach responders on the phone before they get to the scene** (not to be aggressive in their approach, tell police not to use the sirens, etc.). The

system is not currently set up to be thoughtful and culturally competent in responding to crisis situations.

Help varies according to people's responses to coaching or advice. Some police officers are more knowledgeable about Mental Health issues than others. The person being interviewed recommended that when someone calls, they should ask for a CIT-trained officer, or one with mental health experience.

In one of the communities, where the police department is small and did not have a crisis worker the clinician was able to stay on the phone with the dispatcher to maintain contact with the police the whole time and to give advice. But this type of communication is not possible all the time in crisis situations. Due to Newtown, police are more aware and more prepared to deal with mental health issues. However there is still a lot to be done in terms of training.

Some people feel that crisis responders drop the ball. Dropping the ball is not being able to provide the individual the supportive services they need during crisis. One clinician felt the ball was dropped 40% of the time. Families do not always cooperate; people react rather than respond. It is important to engage family in crisis.

Follow up depends on how much you advocate for the individual in crisis. Family members don't know they have the right to call and to ask for services. It is common for ERs to just discharge without follow-up. The system that is in place is not working. Skills and resources applied to situation can help – knowledge of system is important. If someone is in crisis – it is important to call the clinician first so that they can help connect with other providers, and provide pertinent information to the crisis workers. ERs are Band-Aids that treat symptoms and then let them go. We can't expect people in crisis to think rationally.

Service providers need to take more ownership of crises spiraling. They should not blame or put too much onus on the family, but also engage the family in the healing process. In the discharge plan, clinicians should include the family, individual, clinician, and ER doctor – and encourage face-to-face conversation. Perhaps one tactic is to use something that's valuable to the individual in crisis to incentivize that person to be healthy – and encourage them to take steps to be healthy (i.e.: if they want to be good to their children, then they must take care of themselves). Clinicians who discharge people because they refuse to comply are actually hurting them – those are people need more support; clinicians must incentivize them or engage with them differently. **Clinicians need more time and training devoted to multicultural issues.** Clinicians-in-training need a field placement requirement for at least one semester so they can see exactly what's going on.

Mobile crisis teams have gotten better with being sensitive and in-the-moment for person in crisis. There has also been increased training for clinicians about what responding to crisis means, what it looks like, etc. There are now 2 people instead of 1 person on a mobile crisis call, trying to tackle an issue – which is helpful to manage everything. Response time has improved. But positives depend on the mobile crisis person an individual is able to connect with during a crisis situation.

Diversity of staff could be improved in mobile crisis care. Increased clinical trainings and better relationships with community also help. There is a **need to have an outreach component** (such as attending community events, etc.) for mobile crisis, so the community knows who to call and so crisis teams build relationships with community.

Mental health services are geared towards Caucasians. In the Asian culture, it is not acceptable to talk about mental health issues. The shame and stigma around mental health and addiction can exacerbate issues. It is not always about the identified patient – the family is also part of the identified patient. Environment is a crucial part of creating safety or triggers. At Asian Family Services – Asians are able to accept help for mental health issues because the organization takes the time to talk about physical ailments and build up trust and relationships. However, mainstream health providers do not make the time nor allocate resources for this. Sometimes sessions for minorities may take longer because they need time to gain trust. Our system must do a better job at understanding culture. It is also important to help gear people towards a positive, change-maker role. Clinicians need to do a better job of listening actively and reading non-verbal cues.

To prevent or lessen crisis situations, a more collaborative approach is needed. Bringing everyone to the table and having them be part of the process is important, so they can start conversations for the whole process. Don't dictate to people what needs to be done. Also outreach to families, communities, and service providers. Try to make the playing field more level, and not so anxiety-driven or fearful: crisis is a service that should be used. Our providers and systems are equipped with tools and resources – we just need people to know and understand resources better. Mental health treatment teams are an integral part of helping prevent crisis situations

There is a huge difference between public and private insurance in terms of level of care. M's brother is on public, and M is on private insurance. Public insurance really limits care and quality and quantity of service that you can get. The providers that are available for state insurance are limited. M's mom waited 3.5 hours to get M's brother seen for his appointment with the doctor – M knows how to advocate to make sure they get service faster – but the provider is often overbooked and there are limited state-funded providers, so the volume of clients is too much. The capacity to follow through with the caseload is not good. Medicare is not so easy to deal with. There is currently a huge imbalance in public and private insurance. People are taken advantage of – limited English speakers might be taken advantage of.

A lot of work needs to be done to leverage the Affordable Care Act (ACA). Lots of people don't know what the ACA is. There are all different levels of ACA's impact that people are not knowledgeable of. M wonders what Access Health CT is doing to dispel the myths.

The ideal situation for crisis care is that individuals with perceived crisis can get resources and support for issue or situation they're in. People should not be minimized by the crisis situation they're in – if providers don't think their issue is a crisis, and if there is no sensitivity from providers, it can make it worse. If someone has a bad experience with a crisis situation – then they can associate that with everyone. All it takes is one person to say, "Don't go here for crisis help, I

had a bad experience" to make a community distrust the service. Providers need to be as supportive and as sensitive as possible because it impacts future way that community connects with program.

Clinician Comment

A clinician we interviewed in Hartford shared her perspective on crisis care in the area. In regards to hospitals, she said there were not enough beds in hospitals and not enough mental health professionals to do the assessment, so there are long wait times in the Emergency Department (ED). She also noted that the curtain walls in the hospital provided no privacy when it came to conversations. While this therapist has never had to call police for crisis, she has had to walk a person in crisis to the Emergency Department. The person was no longer responsive to therapy, admitted to being on medication withdrawal for 3 weeks, wasn't going to work anymore, not willing to engage in life, and functioning was limited.

The overall picture of the person, including the husband's report, was about how she was disengaging from life. This caused the therapist to accompany her to the ED. Once she did this, she no longer had contact with the ED or with the person's healthcare providers after discharge from the ED. The IOL unit didn't want visits outside of visiting hours, making it difficult to access the person. The husband was the main contact with the therapist for continuity of care. There were discharge planning meetings with providers at St. Francis hospital, but the therapist was never invited to any of these meetings. The therapist said she can only be involved in follow up treatment if the person signs a release of information for the treatment team to contact her, or if they call her directly.

She said to prevent or lessen crisis situations, create treatment where medications are not at the center of the treatment plan. The main focus of treatment should not be medication management – at the heart there should be a relationship with a therapist. Another way to help prevent crisis situations is to have an open conversation about what the person in crisis is looking for. There should also be a conversation about how to reduce medication or a wellness approach. The therapist said, "People on psychiatric medications have the same compliance rate as people taking diabetes medications. There is about 30% complete compliance." She cited Robert Whitaker for this information. She continued, "Using medication short-term in a systems approach can be helpful." She said it is important to have an open dialogue – where we bring everyone involved in a person's life to the table and talk about different perspectives and plan for crises together.

In regards to the impact of the Affordable Care Act, she said that there are a lot of high deductible plans available on the Exchange which prevents people from accessing services. People who don't qualify for Husky can suffer if they choose high deductible plans and can't afford to pay out-of-pocket for medical visits.

As for her hopes for crisis care, the therapist said there ought to be more variety and more homey relationship-based crisis centers with respite programs. There should be opportunities for learning and lifestyle changes, instruction on nutrition, yoga, and a clinical team comprised of peers, a

shelter without expectations. There should be a variety of places of care to choose from: EDs, inpatient care with medication management and crowd control, and peer respite programs.

Interviews of Individuals & Families in Crisis

<u>Individual Who Experienced Crisis: Steve</u>

Crisis doesn't have to be life or death; it's an ongoing state of malaise. Steve feels a crisis is when one is not sure what to do or where to turn, how to get help – when someone is in the realm of hopelessness.

In December last year, overwhelmed with circumstances of the day, Steve wasn't able to get stuff done for Xmas eve, so he panicked. He didn't know what to do. He thought about driving himself to a hospital. If he doesn't know what to do or where to turn, he tends to panic. If he can't take care of self and has to rely on other people to take care of him, then he feels out of control. **In order to feel hope, he must have control**. Steve feels he must have some health care access and have tools to help himself to feel in control, like to know where to go to get information.

Steve feels that people are still lost. Many don't know where to go. There is an insurance barrier – providers struggle to get approval. When in crisis, Steve calls his therapist, psychiatrist, and a couple's psychiatrist. He hasn't called ER or urgent care. The closest he has come to a crisis is having an emergency session with couple's therapist. He felt heard from therapist and got a quick response. However, the insurance company doesn't give quick response or coverage – he is covered through his employer (with a high deductible).

Steve discusses problems with his therapist and then he can use this information to apply to the next time. He feels that crises are perceived – he learned how not to be triggered or to escalate. He does not involve medication – just behavioral therapy. Nonetheless, it is good for him to know that medication is there in case he needs it.

Therapists might refer him to books, or just talk to him in more sessions. After crisis, he feels like he needs support, and a listening ear. To prevent or lessen crisis situations, Steve avoids triggers. He works to identify what is going on and works on controlling issues, and access information.

Even though Steve has private insurance through work, he still worries about insurance and access to mental health services. His concerns involve lack of access to information and not knowing where to go. Steve believes it would be good if primary care doctors knew more about the mental health system of care.

Steve feels that the crisis care system is able to deal with the real issues that people have and to embrace each person as an individual, with dignity, accept people where they are at, based on where they are.

<u>Individual Who Experienced Crisis</u>

A woman from a different part of the state shared that she was arrested during crisis. She said that mobile crisis responders came but she did not feel heard. Her situation was not treated as a crisis, there was no follow-up, and she tried to articulate that she needed help as things were spiraling, but nothing was done. The friend who called mobile crisis for the woman was concerned for her well-being. They called 2-1-1 and could not connect; they had to call another number, even though

it was at the middle of the day on a Friday. The police involvement was a result of a breakdown in communication. Her friend noted that people outside of the mental health system do not have the language to discuss their situation.

NAMI Member

A crisis is any event that is, or is expected to lead to, an unstable and dangerous situation affecting an individual, group, community, or whole society. When this person's loved one is in crisis, they call the primary care doctor or 211 or 911. When they call for help, 911 police and an ambulance comes to the scene. On one occasion when "help" came, police took his son in handcuffs (which were clearly not needed) to the hospital. After crisis, the officer shared his business card. They contacted the family and charges were dropped. The police explained that he is familiar with mental illness as his son has some problems too.

Mobile crisis teams need to improve upon being upfront about what they can provide. First they said they would send someone to evaluate the situation; instead they called the police. Mobile crisis teams did a good job of contacting the police and ambulance. However, during crisis, a lot of people came with sirens. It would have been better if they came without sirens and without so many people to invade the family's house.

The family member has not seen his loved one in crisis since he had intensive therapy at IOL.

To prevent or lessen crisis situations, there should be medications that are injectable so the responsibility of taking medications does not completely fall on the patient. The patient and caregivers should also be educated. We need more availability of cognitive behavioral therapy.

The family member has heard of ACT teams. After discharging a patient an ACT team should be assigned to help prevent crisis. When the person's son had public insurance, care was good. However, not all care providers accept public insurance.

The person believes if CIT trained officers come they can de-escalate the situation. The person believes mobile crisis care has helped his son during crisis. The person states, "Just like 911, **more marketing of 211 should take place**."

A total of 11 staff from Emergency Departments, Inpatient Units, and Phone Triage programs attended this focus group. Hospitals represented were Hartford Hospital (HH), St. Francis, John Dempsey, and Hospital of Central CT. Also represented were CHR Health, and InterCommunity (IC).

If you can wake up tomorrow morning into a perfect system, what would it look like? What would be different?

- We don't have to turn people away.
- Increased number of respite beds. Identified the difference between crisis and respite beds. Avoid letting people become inpatient clients. More detox and rehabilitation beds; level four beds are impossible to get into. Appropriate residential care for higher level of care. Plenty of shelter beds.
- A detox for adolescents. Better services for young adults aging out of DCF. Transition to DMHAS is difficult. More services for children.
- Immediate access to resources for basic needs (food, clothing, etc.).
- 2-1-1 problems for getting services in timely manner. Shelter access is a problem. 2-1-1 is challenging and still hasn't improved.
- Faster access to providers/prescribers.

Observations:

- InterCommunity is a good referral source; CHR has walk-ins for prescribers.
- Working with DCF is hard. DCF has higher tolerance to work with and has a lot of issues in YA. There is not an adequate handover from DCF to DDS or DMHAS. Conflict between DDS & DMHAS affiliation for kids/young adults.
- The Assessment Center is a good resource for LMHAS. They get calls to relay to Central Access; the Assessment Center triages, calls mobile crisis, IC, etc. and takes calls from all over. People call the Assessment Center from outpatient services. The Center also hears a lot of complaints about ERs and insurance.

When people come to the hospital in crisis mental health or addiction concerns, what do you offer? What determines whose situation is most urgent? What kind of interaction occurs when someone is waiting in the ER?

- EMPS (emergency mobile psychiatric services) for children - up to 19 outpatient services, up to six weeks.
- Psychiatric evaluation; Medical evaluation; Intensive out-patient services; Chemical dependency evaluation
- Children in crisis a priority at St. Francis. Mobile crisis for children is offered.
- Level of care determination in ER
  - In St. Francis & Hartford Hospital (HH) purple pod: people wait there to determine level of care
  - There is a nursing intake, then social worker meets with them

- o Level of crisis evaluated, then placed in appropriate area
- o Medical & Psychiatric evaluation
- o Eighteen hours to complete evaluations-agreed that this is bad but ERs get backed up-recidivism makes things worse for everyone
- o Both HH & St. Francis have a psychiatrist in ERs

How is the profile of people coming through ER or inpatient services compared to the past? What is the average ER stay for psychiatric crises? Why?
- Profile of clients changed – more homeless folks.
- See more people medically compromised (physically sick).
    - o Early onset dementia from years of psych. meds; comorbid substance abuse.
- People with cognitive issues at younger ages.
    - o More children coming to ER with psychological issues/crisis.
    - o Young adults with behavioral and substance issues. More use of drugs such as PCP, dust; excitable delirium
- Families with loved ones struggling with addictions beg for help because more people with alcohol problems are being brought in by EMS. They used to put patients in lock up.
    - o If client walks away, hospital is liable if harmed while intoxicated.

What are some challenges in working with people in crisis?
- Violence & guns with mobile crisis in community.
- Refusal of services (ex. Medication, therapy).
- People discharged from prison with no medication and homeless which pushes clinicians to send them to the hospital.
- Addiction is a challenge - can't force them to go to rehab, and sometimes they are dangerous. Many more people with alcohol problems are brought in by EMS now than five years ago.
- Discerning what behaviors qualify treatment or admission.
- Hard for mobile crisis to walk away (they're liable).

How do cultural and language issues affect your ability to help people in psychiatric crisis?
- "Language lines" don't work well.
- We have a difficult time working with deaf patients. Sign language interpreters are expensive (must reserve for a minimum of two hours). And you have to call ahead so it doesn't work for crisis!
- There is a Satellite TV tool called Marty where there are live people (in any language) to help translate.

What is your policy on restraints and seclusion? Under what circumstances would you use these tools?
- The restraints used include mesh-covered beds for patients at risk of falling, or who are violent or threatening violence. Sometimes a patient is zipped into bed if patient is elderly or intoxicated and could fall.
- "Hands-off" policy for restraints.

- Restraint/seclusion – only as last resort if being threatened.

What is the level of communication between you and counselors, family, and/or mobile crisis responders during and after crisis?
- If sending someone to hospital, mobile crisis calls in and sends collateral information.
- Hospital staff will call providers if person doesn't meet threshold for hospital.
- Hospital only consults family if given the "okay." ER closes contact with providers and family.
- Hospital staff will call providers in the community for discharge planning, help schedule appointments.
- Staff consult family if person asks. Staff confer with LMHAs.
- InterCommunity gives updates and communicate with local police
- For CHR, there is a level of communication coordinated by Ms. Hanley's team between counselors, family, etc. during a crisis and a verbal report after crisis.

What is the level of communication between you and counselors, family, and/or mobile crisis responders after crisis?
- There are meetings where clinicians discuss the person
- Staff only consult family if people are disabled.
- Call hospital to check status bi-monthly.
- People use the ER as a crash pad, or a place to sleep; clogs system.
- Community Care Team (Value Options Pilot Program) has 41 agencies - most of them very connected to care. High percentage of substance use. Seven visits in 6 months. People reviewed are not the psychiatric emergencies but the ones causing the 18-hour back up.

Some people who are sent to the hospital for crisis care perceive they are not getting adequate treatment: why do you think perception exists?
- Housing issues – no place to go or ability to deal with the problem.
- Insurance doesn't cover certain services.
- Family member(s) expect more intervention than can be provided.
- Lack of perception of what ER can do for families like quick treatment for strep throat.
- People are disappointed to find insurance doesn't fund detox.
- People compare their experience with a friend's experience.
- Families want ER to have "magic wands"
- ER is used as primary care for people.
- People come to expect quick service.

How do you ensure that people's advance directives are sought out and followed?
- Asked about advance directives at admission – most people seen in the ER don't have them.

- Some young adults express their wants, but don't have it in writing. They want clinicians to respond to them in specific way (medical plan).
- Some don't ask.
- Very few hospital staff have encountered advance directives.
- A mobile crisis staff commented that she had two people she worked with who came in with advanced directive in hand - and only one insurance company asked for it.

How do you decide when to discharge someone? From Emergency? From Inpatient? From Intensive Outpatient program?
- When the person is stabilized on medication.
- When the person is clinically sober (don't do blood test because some are functional at three hundred level).
- When the risk assessment is done.
- This is individualized per patient.
- When crisis is no longer acute and there's a plan in place.
- When there is a contract for safety.
- When patient says they are ready to go.
- InterCommunity says discharge is individualized but they complete a risk assessment to discern.
- Hartford Hospital has no "policy" – everyone is different.

What follow-up happens after discharge? How do hospitals review whether discharge staff is doing a good job in mental health or addiction crisis situations? Please help us understand to what standards are discharge staff held accountable.
- DMHAS has quality dashboard. DMHAS monitors follow-up care through DDAP (data and BHP tracking); data kept on remissions
- There is a call-back nurse to follow up
- There is lack of money for intensive follow up
- Billing based on per ED service, not length of stay.
- Hospital staff recommend support groups: NAMI, Value Options Family Matters monthly meetings
- Community Care Team follow ups.
- At CHR if people don't show up for appointment, they send out mobile crisis to investigate.
- At St. Francis, they have client satisfaction surveys. (they track the number of clients in ED, review length of stay – shorter is better); penalty for readmission.

What data is tracked?
- Data is tracked via a patient survey; tracking for readmission.
- Length of stay is tracked for billing. Some hospitals have a different billing: One ED visit is charged at the same rate regardless of how much time someone spent in the hospital - three hours or three weeks.

o Sometimes people are held overnight in order for the hospital to get paid. If people are released early and readmitted after 23 hours, the penalty is not getting compensated for the person's previous stay.

What kinds of supports can be given to the family and the patients so they can get better?
- There are supports for family such as IC family support group, Wheeler Clinic, NAMI, and other family support groups.
- Monthly dinners at CHR, Al anon groups,
- Hospital staff give out literature of supports

Please talk about your ability to discharge people to appropriate settings from the hospital. How does the discharge team work with community mental health providers or housing agencies in the area to coordinate discharge plans?
- Need more resources
- CVH wait list very long. Sometimes patient improves while waiting.
  o CVH waitlist is longer than three months – now if someone's feeling better, then what?
  o Try to use intermediate beds.
- Enhanced Care Clinics (ECC) are the best thing that has happened. Enhanced care facilities are the biggest asset for people to go for treatment.
  o Enhanced care clinics in LMHAS make it easier for ERs to discharge people into community.
- Housing is a huge issue; some people have such trauma they don't want to go to a shelter. (Need affordable housing).
- Homeless people are harder to place in long-term care beds.
  o Can't put someone into Intermediate Care beds if homeless, must have a disposition with an address to return to.
  o Patients have to have a place to go, same with geriatric psychiatric beds.
- Kids and inpatient for dementia are hard to get in appropriate care on weekends.
- People who call assessment center complain about the ER.
- One barrier to good patient care during crisis is the **reach of coordination** on the part of discharge planners on inpatient units. High-risk people stabilize to the point of discharge to the community, but community providers aren't included in discharge plans and sometimes aren't notified of the discharge before it happens, even though providers make attempts to communicate with inpatient staff. Police departments also lack training on how to deal with people who are in acute psychiatric crisis.

- Site visits completed at CRMHC; CHR; IC; CMHA (Wheeler Clinic)

- Met with Program Directors for overview of crisis services

- Obtained policies and procedures

- Reviewed 10 charts at each site

- Reviewed dashboard reports at each site (Evaluation within 1.5 hours of request; Community Location Evaluation; Follow-up Service within 48 hours)

Site Visit Findings

- Approximately 40-50% of clients seen in Region 4 are unknown to the evaluating crisis team

- IC – Same Day Access – walk-in hours (individual can access treatment at any time of day) demand for after-hours crisis services have decreased – knowing that services can be accessed quickly sometimes lessens the need for the person to be seen by crisis teams – continuum of more intensive services available to known clients has also diminished the number of calls i.e. ACT; CSP; peers; # of calls have gone down due to better access.

- Longevity of Crisis Team staff in all locations.

- At CHR and IC, mobile crisis staff will conduct visit with clients, CSP, or ACT staff person when possible. They go out in pairs.

- Charts – mix of referrals and representation of self-referral; clinic offices (medical clinics); family; other behavioral health providers; documented response within 1.5; follow-up within 48 hours or sooner; all teams working to have Electronic Health Records (EHRs) capture the timeliness of response.

- Relationships with Law Enforcement have been positive – the newly appointed East Hartford Police Chief very supportive of mental health / integrated care needs. Officers carry a paper pad with IC contact information for distribution at scene to individuals in crisis. They also reach out to those who may have an issue that has not yet reached the level of a crisis, but who could benefit from a behavioral health intervention or medical services. Individuals do not have to be a client in IC's behavioral health clinic to receive primary care. Nice development of relationship between police and mobile crisis.

- Why are dashboard results showing very low follow-up after 48 hours? There has been an increase in the number of individuals who have no connections to the LMHA or to behavioral health services. After the crisis intervention the individual is uninterested in further services – don't allow 48-hour follow-up to happen. The mobile crisis staff should document mobile crisis follow-up attempts (phone calls, re-visits).

- Calls from individuals unknown to the system have increased and there are particular challenges when unable to refer to previous history (are behaviors/symptoms attributable to substance use vs. mental health; does individual have a history of violence? Homicidal ideation? Suicidal ideation?) All of these factors exacerbate teams concerns about safety.

- Emphasis on community-based treatment – hospitalization is not first course of action – team members ensure that all other least restrictive settings have been considered.

- Education of families and community referrals; role of mobile crisis; assessment versus hospitalization; use of Emergency Certificate (EC) – M.D. must assess within 24 hours and outcome may be different than that of mobile crisis.

- Consultation – FYI referrals (CHR) – mechanism of communication of information for emerging referrals/needs. Mobile crisis team member is able to talk to an individual who may be distressed but the situation has not reached a crisis.

- Implementation of protocols to address various levels of crisis.

- Levels of coordination with hospital - staff carry along face sheet with important identifying and medication information for ED.

- Emphasis on Family Engagement – provide materials (NAMI; agency dinners – CHR, IC, Wheeler, CRMHC)

- DMHAS - Division of Education and Training – ongoing provision of trainings related to proper use of writing of Emergency Certificate (EC) to ensure that ED is not over or under-utilized – importance of speaking to ED staff directly even after EC written to communicate concerns that may not translate into the EC

- Data – Dashboard Reports – re-visit Benchmarks on Dashboard to ensure that they accurately represent desired mobile crisis response outcomes.

Alternative Programs

Afiya

In our research about models of care, we learned about Afiya, a peer respite program in Massachusetts. There is no cost to staying here. The program is completely funded by the Massachusetts Department of Mental Health (DMH). People can have stays up to 7 days, and can continue to go about with job and school activities while staying at the house. In comparison, the respite house in Santa Cruz is funded completely by federal government. Afiya has a $300K budget, which is the normal size for a peer respite program. Team members are paid $12/hr. There are no limits to how many times a person can return to stay at Afiya. Afiya has a warm line, but does not connect to hotlines. There is no predictable day.

Afiya opened in August 2012. The staff affirmed the importance of offering trainings before opening up the center. A central question is how to structure the staffing for the home.. Staff do not live onsite. Afiya has 1 to 3 staff present 24/7; they also have overnight shifts. There were 5 original team members; Afiya lost 5 and there was turnover. Staff often tell people about other mental health programs during their stay. Staff do paperwork and an annual report on usage; they keep numbers on how many people are calling. Staff are starting to collect optional surveys at the end of peoples' stay there. In terms of teamwork, staff meet regularly to talk about big and small decisions. There is one main supervisor (an interim director), but this person does not work overnight. However, the supervisor is in the on-call rotation.

Afiya has 3 rooms, with a 3-person in wait list. For people who are desperate, staff recommend that they call every day until they can get in. People must be from central MA and can be from as far away as Boston. Everyone who stays at Afiya must be over 18. The intended use of space is to find peace and process feelings or difficult issues away from distractions. Afiya does not take people who just need a place to crash; they must have similar values to the center. Every person must have a conversation with staff before they move in to ascertain values and interest. Once living at Afiya, people tend to cook separately. There are no formal meals together; except for free pizza night on Fridays. The budget for food is $100/week for everyone. There is no structured programming. Afiya has a lot of art supplies and music instruments, as well as weight and workout equipment in its fully functional basement recreation area.

Afiya does not function as a homeless shelter. DMH does not like it when staff allow people without a home to stay at Afiya, but staff are willing to carefully negotiate this as needed.

Community Care Teams

Background: Homelessness and housing instability are associated with poor health outcomes, including high mortality and high rates of chronic illnesses. Often those experiencing homelessness or housing instability cycle in and out of hospital emergency departments (ED), costing the medical system millions of dollars each year. Adults who are homeless represent 5% of the Medicaid population but are overrepresented in some types of care:

• 17% inpatient care
• 19% ED visits for adults with a primary behavioral health diagnosis
• 39% with 3+ inpatient medical detox episodes

Given these findings, hospitals have the potential to be a critical partner in interventions and care coordination for those experiencing homelessness. The Opening Doors CT Hospital Initiative was launched in 2014 as a collaboration between the Partnership for Strong Communities and the Connecticut Hospital Association. This project focuses on bridging the gap between hospitals and community providers, and better serving those who are homeless. The target population is frequent visitors of hospital emergency departments (ED) and inpatient beds, also known as super-utilizers. Frequent visitors are those who have: Visited an ED 7+ times in the past 6 months

Goals:
1. Better identify individuals experiencing homelessness or housing instability
2. Reduce emergency department visits and inpatient readmissions
3. Improve care coordination upon discharge from inpatient and outpatient settings
4. Reduce costs for the medical and health care system

Strategies:
• Implement homelessness screener in emergency department electronic health records
• Establish Community Care Teams (CCTs) to improve care coordination between hospital staff and community providers
• Develop peer sharing across participating hospitals

Outcomes Tracked:
• Demographics (age, race, gender)
• Health insurance
• % ED visits accounted for by frequent visitors
• Readmission rates to ED and inpatient care (7- and 30-day follow up)
• Connection to care (7- and 30-day follow up)
• Housing/homelessness status
• Medicaid claims data
• SF-12 physical and mental health scales
• Substance use

Lessons Learned:
• Importance of peer sharing across Community Care Teams (CCTs)
• Extensive time needed to develop release of information
• Need for flexible care plans
• Movement of frequent visitors between hospitals
• Prevalence of substance use by frequent visitors
• Value of having the Administrative Service Organization (ASO) at the table

Next Steps:
• Evaluate the initiative - both process and outcome
• Expand the model to other institutions
• Develop a predictive model to better identify and serve frequent visitors
• Expand respite care options across the state
• Develop a more comprehensive continuum of care for substance users
• Explore Medicaid payments for supportive housing services
• Develop a model for sustainability

Preliminary Findings:
- 35-40% Percent of frequent visitors experiencing homelessness or housing instability
- 7-69 Number of ED visits per frequent visitor in the past six months
- 34% Percent of frequent visitors who visited 3 or more EDs during the previous six months
- 62% Percent of frequent visitors who are male

Camden Coalition

The Camden Coalition (CC) in New Jersey is an example of how we can continue to address complex medical cases and help the high utilizers of EDs and hospitals. Camden Coalition members share information through the **Camden Health Information Exchange** (Camden HIE). With relevant, real-time data, CC's cross-disciplinary **care teams** connect quickly with people who have high rates of hospitalization and emergency room use, and help them address their complex needs. Since 2002, CC has been demonstrating that human-centered, coordinated care, combined with the smart use of data, can improve patients' quality of care and reduce expensive, ineffective inpatient stays and emergency room visits.

In 2007, the Coalition began implementation of a citywide Care Management Project to intervene and direct appropriate outreach attention to Camden's most frequent utilizers of the city's EDs and hospitals. These patients lack consistent primary care, often suffer from chronic illness, mental illness, and substance abuse. Frequent utilizers visit multiple EDs seeking medical attention with little or no coordination of care across institutions. Thus, services and tests are often duplicated, resulting in inefficient, uncoordinated, fragmented, and expensive care.

CC's staff has segmented this patient population into two groups: those who have no source of primary care and typically have significant social and mental health issues; and those with more stable primary care and less severe social issues. Both groups of patients are in need of a primary care medical home with the capacity to manage care transitions and provide care coordination. The Coalition has developed a Citywide Collaborative of primary care, behavioral health, social service and other supportive service providers to improve care for this patient population.

Care management patients are enrolled into the program after they are admitted to the hospital, in the community, or at their home or shelter. Using an outreach team consisting of a social worker, a health outreach worker/medical assistant, and a nurse practitioner, the team helps enrolled

clients stabilize their social environment and health conditions, with a goal of finding a primary care medical home.

The team assists with coordinating primary and specialty care, applying for government assistance benefits; securing temporary shelter; and enrolling in medical day programs.

The Coalition holds a monthly Care Management Committee meeting that rotates between the hospitals and is attended by social workers and other supportive services providers from across the city. This committee helped to oversee the development of the high utilizer team and continues to advise the Care Management Program.

Through the Coalition's work with high utilizers the staff has built close relationships with emergency room physicians, hospitalists, specialists, social workers, and nurse discharge planners across the city. These relationships are crucial to the team's success and ensure good discharge planning and care coordination upon discharge.

Questionnaires

Questions for Mobile Crisis Directors

1) Please help us understand the Report Card. To what standards are responders held accountable?
2) What is DMHAS scrutinizing in their review of the mobile crisis program? How do they review whether responders are doing a good job?
3) What data is tracked?
4) What follow-up happens after crisis?
5) Why is there a failure in meeting the goal of follow-up service in 48 hours?
6) Discuss the impact of the Affordable Care Act – how will providers meet the level of need?
7) Is there a natural forum that we could attend where you meet with the police? Can we get on the agenda to connect with the police about the involvement with mobile crisis response?

Questions for Town Social Services

1) When you are working with someone in crisis, who do you call?
2) Does anyone come to the scene? If so, who?
3) Who is involved when people are in crisis? Who are some primary responders?
4) What follow-up happens after crisis?
5) Who is involved when people are in crisis? Who are some primary responders? (Explain LMHA mobile crisis services)
6) What do mental health crisis responders do well?
7) What do mental health crisis responders need to improve upon?
8) What role do the police play in mobile crisis management?
9) What's the difference in access to care for people with private versus public insurance?
10) What's succeeding? What are the weaknesses in the system? What are the real problems out there (ask the people)?
11) What about access to care for people in all stages of their life? What about the young adults, or the elderly?
12) What about access to care for people who need more structure and support?
13) What are some preventative care measures accessible to people? What are some services that could be improved to prevent spiraling?
14) How do we create proper transitions from hospital to community?
15) What are the barriers to each point in the continuum of care? (Explain what is meant by that – supportive housing vs. board & care vs. group home)
16) What do you see as the consequences of not accessing appropriate levels of care?

Questions for Individuals

1) Define a crisis – when do you feel like you are in a crisis situation?
2) Who do you call for help when you are in crisis?
3) When you call for help, does anyone come to the scene? If so, who?
4) What is the level of communication between you and the crisis responder during and after crisis? (continuity of care)
    a. Did the responders come? Did they help you, and how?
    b. Did you feel heard?
    c. Did anyone drop the ball?
    d. Was there one person that you stayed in touch with?
5) What follow-up happens after crisis?
6) What do you need after crisis? Does this match up with the follow up care that you get?
7) What do mobile crisis teams do well?
8) What do mobile crisis teams need to improve upon?
9) How often do you experience crisis?
10) What can be done to prevent or lessen crisis situations?
11) How can mental health treatment teams be a part of helping prevent crisis situations?
12) Do you have public or private insurance? How does this impact your access to and level of care?
13) Discuss the impact of the Affordable Care Act – how does that affect your level of care?
14) What role do the police play in this?
15) What are your concerns?
16) What are your hopes for mobile crisis care?

Questions for Family Members

1) Define a crisis – when is someone in a crisis situation?
2) Who do you call for help when your loved one is in crisis?
3) When you call for help, does anyone come to the scene? If so, who?
4) What is the level of communication between you and the crisis responder during and after crisis? (continuity of care)
    a. Did the responders come? Did they help you, and how?
    b. Did you feel heard?
    c. Did anyone drop the ball?
    d. Was there one person that you stayed in touch with?
5) What follow-up happens after crisis?
6) What do mobile crisis teams do well?
7) What do mobile crisis teams need to improve upon?
8) How often do you experience your loved one in crisis?
9) What can be done to prevent or lessen crisis situations?

10) How can mental health treatment teams be a part of helping prevent crisis situations?
11) Does your loved one have public or private insurance? How does this impact their access to and level of care?
12) Discuss the impact of the Affordable Care Act – how does that affect your loved one's level of care?
13) What role do the police play in this?
14) What are your concerns for your loved one?
15) What are your hopes for mobile crisis care?

Questions for Police
1) How do police departments review whether responders are doing a good job in mental health or addiction crisis situations?
    a. Please help us understand to what standards are responders held accountable?
2) What is the level of communication between you and counselors, family, and/or mobile crisis responders before crisis?
    a. How about during crisis?
    b. After crisis?
3) How do you decide when to use force?
    a. What prerequisites does the department have for using force?
4) What percentage of your department has CIT or Mental Health First Aid training?
5) How many officers usually come to a crisis situation?
6) How do officers decide whether to put someone in jail or in a hospital?
7) How do events like Newtown shootings and the Ferguson riots affect this police department?
8) What data is tracked?
9) What follow-up happens after crisis?
10) How does the police department work with other mental health providers or housing agencies in the area to avert or address crisis?
    a. Do police meet with other providers to have preventative meetings? When? Where?
11) Is there a natural forum that we could attend where we can meet with the police?
    a. Can we get on the agenda to connect with the police about the involvement with mobile crisis response?

Hospital Inpatient and Discharge Staff Community Focus Group
If you can wake up tomorrow morning into a perfect system, what would it look like?
What would be different?

INTAKE:
1) When people come to the hospital in crisis mental health or addiction concerns, what do you offer?

        a. PROMPT: What determines whose situation is most urgent?

        b. PROMPT: What kind of interaction occurs when someone is waiting in the ER?

2) How is the profile of people coming through ER or inpatient services compared to the past?

        a. PROMPT: What is the average ER stay for psychiatric crises? Why?

CRISIS CARE:

3) What are some challenges in working with people in crisis?

        a. PROMPT: How do cultural and language issues affect your ability to help people in psychiatric crisis?

        b. PROMPT: What is your policy on restraints and seclusion? Under what circumstances would you use these tools?

4) What is the level of communication between you and counselors, family, and/or mobile crisis responders during crisis?

        a. After crisis?

5) Some people who are sent to the hospital for crisis care perceive they are not getting adequate treatment; why do you think this perception exists?

6) How do you ensure that people's advance directives are sought out and followed?

DISCHARGE:

7) How do you decide when to discharge someone?

        a. From Emergency?

        b. From Inpatient?

        c. From Intensive Outpatient program?

8) What follow-up happens after discharge?

        a. PROMPT: What data is tracked?

        b. PROMPT: How do hospitals review whether discharge staff are doing a good job in mental health or addiction crisis situations?

            i. Please help us understand to what standards are discharge staff held accountable.

            ii. What kinds of supports can be given to the family and the patients so they can get better?

        c. PROMPT: Please talk about your ability to discharge people to appropriate settings from the hospital.

9) How does the discharge team work with community mental health providers or housing agencies in the area to coordinate discharge plans?

Focus group with LMHA staff who interact with Mobile Crisis Teams

1. Can you describe some situations that have required a crisis response for someone your caseload?

2. What happened in those situations?
   - Who called for help?
   - To whom?
   - Who came?
   - How did that go?
   - Was an assessment done?
   - Where?
   - What was the result?

3. What role do the police play in these situations? How well have you seen that played out?

4. Describe the level and quality of communication between you and the crisis responder during and after the crisis.

5. Describe the follow-up that you have seen happen after crisis.

6. How well does that match up with the follow-up care that was needed? What else is needed?

7. How often do you see situations with people on your caseload that require a crisis response?

8. What do mobile crisis teams do well?

9. What do mobile crisis teams need to improve upon?

10. What's succeeding? What are the weaknesses in the system? What are the real problems out there?

   - What about access to care for people in all stages of their life? What about the young adults,
   - What about access to care for people who need more structure and support?
   - What are some preventative care measures accessible to people? What are some services
   - How do we create proper transitions from hospital to community?
   - What are the barriers to each point in the continuum of care? (Explain what is meant by that – supportive housing vs. board & care vs. group home)
   - What do you see as the consequences of not accessing appropriate levels of care?

11. Do you have any other concerns or kudos you would like to share?