Overview of Services Designated Agencies Currently Provide That Impact ED Wait Times

The following is a brief overview of the kinds of services and approaches DA's currently offer to decrease need for client waits in ED's pending in-patient psychiatric treatment. Most of these efforts are focused on supports that help individuals in crisis to stabilize in their communities and obviate the need for waits in ED's for either voluntary or involuntary hospitalizations. We feel it is useful to briefly summarize current practices and resources for these reasons:

- Not every Designated Agency utilizes each of these approaches to avert the need for hospital-level care for clients in crisis. Across the state, however, many promising, effective services have been developed. Sharing an overview of the services DA's have found to be effective may encourage replication of fruitful approaches and models in other agencies, as well as increased teaming with community partners, such as medical providers, advocacy groups, and law enforcement.
- It becomes clear that most of the approaches we have developed have been on the preventive end. We firmly believe these efforts lessen already severe pressure on a bogged-down system, thus preventing even longer waits in ED's not designed or prepared to offer treatment to clients experiencing a mental health crisis once there. However, we rarely have alternatives to ED's for those clients whose safety and/or treatment needs exceed what can be provided outpatient or in crisis beds, or for whom those beds are not available.
- It may help bring into focus where to concentrate advocacy for expanded funding.
- It may help clarify where there is greatest need for tracking outcomes.

Prevention-focused current approaches

- Assertive Community Treatment-type (ACT) models. ACT is an evidence-based treatment that can provide rapid response to crises, and provides an integrated range of services, delivered by an interdisciplinary mobile team that often includes peers, case managers, therapists, and psychiatrist. It is highly individualized, client-centered, and recognizes the importance of family, community, cultural influences and continuity of care for as long as the individual requires intensive support. The Howard Center's START Program is an example of this kind of approach.

- Open Dialogue-type teams to work with individuals in crisis and their support networks. This is a flexible, person-centered approach that originated in Finland and has stimulated much training and enthusiasm over recent years in Vermont. Howard Center and CSAC have been involved in training and developing teams, and are encouraged by results. Outcomes in Finland have been good, where it was originally used most often with individuals experiencing first psychosis, and has been effective in reducing hospitalizations. Here (and elsewhere) it has been adapted for use in a range of crisis situations. Quick initial response, ability to see people in their homes, ability to continue working with individuals at hospitals if in-patient admission becomes necessary may eliminate need for hospitalization, may shorten stays and provide post-discharge stability, and reducing re-admissions. Outcome data is being developed here. Initial data and anecdotal feedback are encouraging

- CRT and non-categorical case management helps address issues such as homelessness, benefits, medical needs, access to employment supports, and isolation, concerns which often precipitate, intensify, or prolong crises.

- Peer supports are utilized in many ways: Peers offer support in ED's; staff and provide support in crisis bed / hospital diversion programs; participate on ACT-type teams; lead groups and offer individual support in day programs (see below); provide home-based outreach and support.

- Drop-in centers provide a sense of community, and a range of wellness, treatment, and activity groups. These centers become very important to many individuals who report they regularly confront isolation, loneliness, unusual thought experiences, or intense mood states that, in the absence of supportive social and/or professional contacts, trigger crises. Wellness centers often become part of a safety plan with individuals initially requesting hospitalization that turns out to be unnecessary when other supports are identified. Expansion of hours of operation into evenings and weekends when other supports are less available has been helpful in decreasing risk of self-harm and diverting some ED visits (per client's self-reports.)

- Crisis beds are offered when supervision, 24-hr support, additional assessment and planning is appropriate, and an individual is able to maintain safety in that environment. Regional crisis beds allow individuals to stay connected to families and treatment teams and can ease transition back home. Currently, intensive residential programs are generally not available for direct referral without a preceding in-patient stay, but on rare occasion have presented alternative to hospitalization.

- Improved mental health/law enforcement collaboration provides the opportunity for joint mobile outreach that can intervene in a developing crisis and prevent escalation to where an individual needs to be brought by police to the ED for assessment and possible EE. Team Two training for mental health crisis staff and police has supported the improved collaboration. Staff capacity sometimes limits feasibility of joint response. Some DA's have crisis workers embedded in law enforcement agencies, enhancing teaming with good results reported.

<u>Interventions for people already at the ED</u>

- Assessment of mental status and risk for people presenting at the ED or brought in by ambulance or police is available 24-hrs/day. For the vast majority, there will be discharge with safety plans in place, follow-up appointments, involvement of collateral supports, and appropriate referrals.
- If a person requires a higher level of care, alternative to hospitalization, such as a crisis bed, is considered, if appropriate.
- For individuals on Emergency Exam status and waiting in the ED for a psychiatric bed: Crisis team staff re-assess twice each 24-hr period, and provide support both to the EE'd individual and to hospital staff. If clients during their stay no longer meet criteria, crisis staff will work with them, their families, any treatment team, sometimes consulting the DMH care Team, to facilitate a voluntary hospitalization or develop a safe, community-based plan.
- We coordinate additional supports while in the ED. Stays in ED's can be isolating, stigmatizing, and frightening as recently stressed by one agency's CRT Consumer Advisory Committee (sounds and sights of a busy ER, curtailed movement, lack of privacy…), and so there is generally effort to coordinate a rotation of familiar D.A. support workers, peers, and other agency supports. Please note: This staff-intensive presence is generally not fully sustainable throughout a prolonged ED wait.