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Think Tank – Day Two

LISTENING TOUR THEMES AND VISION STATEMENTS WITH SUPPORTING STRATEGIES

COMMUNITY BASED LEVEL OF CARE: *SUB-GROUP NAME*

LISTENING TOUR THEME	**VISION STATEMENT WITH SUPPORTING STRATEGIES IDENTIFIED**		
PERSON-CENTERED & COMPASSIONATE CARE	***EE's and ONH's are minimally used in Vermont***		
	Short-Term	Mid-Term	Long-Term
	Strategy: Coercive System Dialogue – Start with reminder of statutory mandate **Steps:** Assess Vermont level of what we consider coercive practice and is it prevalent- ONH's and EE's to start. Differentiate DMH ONH and Court ONH. Comparison with other states and our own longitudinal history.	**Strategy: Systemic way of identifying alternative supports for registry use?** **Steps:**	**Strategy: Consider benefit of allowing access to WRAP and Personal Safety Plans across providers with consent.** **Steps:** Acknowledge that long-term treatment options will improve. Benefits will outweigh costs. Use information from studies to leverage funding and statutory change.

	If EE'd to ED, formalize criteria to leave ED pending a bed being available. Assess whether building more hospital beds is increasing potential for more coercion in system of care. Is ONH for mental health treatment or for public safety? Examine paradigm shift of: what is the right place for someone to go and who determines what that place is? **Training ED staff to better intervene on clients when they are in a MH crisis** **Expand DA services and embed them in the ED so they can help the staff intervene at the ED level.**		

	Social Service Navigator at Southeastern Vermont Medical Center- clients come in from 10am- 12am		
COMMUNITY-BASED CARE, PERSON-CENTERED CARE	***A wide array of voluntary community-based treatment options is available minimizing the need for coercion. (All of this contributes to End State #1)***		
	Short-Term	Mid-Term	Long-Term
	Strategy: Expand capacity to assign case manager and or peer for someone experiencing crisis to help them navigate services needed or level of care if needed. **Steps:** Re-open discussion of where resources are placed to support community-based care versus	**Strategy:** **Steps:** Any legal barriers to standing up alternatives: Living Room model,	**Strategy:** **Steps:**

	inpatient beds. Where is resource best spent. • Telemedicine access to prevent more coercive efforts later. • Living Room Model • Urgent Care Alternatives that are resourced versus ED • ACT teams • Mobile Capacity – Children, Families, Adults • Peer Supports • **Embed MH clinicians with Law Enforcement** • **Collaborate with development of have/need work of the GMCB and the HRAP.** • **Look at CVMC capacity analysis as a starting place**	Urgent care, and Alternative medical clearance to ED. Workforce development for staff to provide services and with livable wages to provide additional services. Workforce Development for individual – importance of employment and Livable Wages Create training strategy for ED on use of involuntary strategies.	

	• **NOTE: things being built now that are contrary to this vision. EDs building more coercive ED spaces.** • **Regulatory requirements push people down a rabbit hole** • **Illegal- people being involuntarily held when there is no legal support.** • **Strategy- create transparency on coercion in ED to create- share data.** •		
THEMATIC AREA OF LISTENING TOUR NOTES HERE	***Robust training and collaborative partnerships exist to ensure an appropriate community response for mental health service needs.***		
	Short-Term	Mid-Term	Long-Term
	Strategy: Short term – evaluation of participants and current trainings and changes recommended. **Steps:** Clarify roles/guidance documents or protocols – Research what is	**Strategy: Changes to better Act 80 and Team Two trainings made.** **Steps:** Additional training models identified that may need to be added	

	happening currently. Include people with lived experience. Support MH First Aid	Establish statewide protocols and standards for responding to mental health needs.	
	Strategy: **Steps:**	**Strategy:** **Steps:**	**Strategy:** **Steps:**

FEEDBACK FROM STRATEGY PREVIEW:

Group D

Coercion lives in involuntary hospitalization- we recognize that that will not go away completely. Is our goal to reduce EEs/ONHs? They are minimally used in VT-is a last resort- because you are taking away civil liberties. Discussed civil vs. criminal court. What are some alternative supports to avoid needing EE/ONH? WRAP and personal safety plans. In every ED it is law that they have look up to see if you have an advance directive. Need a similar repository for crisis plans. Clarified terms. ONHs have no teeth- professionals don't want clients to have to go back into the system. Comment about WRAP plans- ten-week detailed curriculum- not just about filling it out once with a professional. Need to discuss WRAP plan curriculum. When you discuss EE/ONH did you discuss role of judiciary? Are we doing more because they are coming from judiciary- criminal system? Didn't see data that there is an increase in criminal EEs. Recently there was a person who spent a year in jail because they couldn't make bail. Group was focusing on how coercion affects people living with MH. Looking from a broader perspective. New ER designs- having a psych unit in ED that is locked. That is a cultural issue. That is a failure in our system. Add that police are often first line of access for many people- that is not ideal and is coercive. Want to train more ACT team, team two trainings. Act 79 has not funded social workers. Police social workers don't go out during arrests. Parachute project in NYC- different intervention that doesn't require police (really an ACT team). Similar work

is being started in Burlington. Police social workers stuck in ER. Talked about investing in services to minimize use of EEs. Talking about MHFA in schools. Fear too—shared story about the stress of not understanding those with mental health needs- fear response. Chittenden response could be a model for other counties. Chittenden is a start, it's not fully developed yet. Not best practice yet.

Coercion: from a kid view- this is an area that is heavy in the adult world. No ONH for kids but EE's do- discussions about the age of consent- it's a multi-perspective issue. Concerns about a 5 or 6-year-old that must consent to treat and has to go to BR for treatment. How do we approach this for children- its an issue of involuntary when its not necessarily a developmentally appropriate age of consent? This may be a legislative shift and we don't want to shift to allowing parents to involuntarily admit their children.

Stigma and fear prevent people from reaching out.

Great vision statements- MH First aid is a great curriculum but there are not resources like living room models and other ways to reduce coercion and to create a cultural shift about changing coercion and involuntary admissions and out culture in Vermont about that.

Is there a public messaging component- can we increase more messaging to communicate what is mental health and treatment of mental health? Rights of individuals, role of mental health, public safety.

If you include more WRAP planning for a ONH- support staff need to be involved.