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Recommendations regarding Mobile Crisis

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Summary of Community Feedback:

Discussions with local community groups, including at recent CAC meetings and a presentation by the mobile crisis director at CAC 3&4, indicate that Region 1 residents see Mobile Crisis as an important service provided by the state for individuals experiencing a behavioral health crisis. Mobile Crisis occupies a niche that is not filled by any other program and that meets an important need, whether an individual is having a psychotic break, is suicidal, or having an anxiety attack, or a family member is calling about an adult exhibiting strange behaviors who will not leave the house to seek help.

Mobile crisis staff offers a level of expertise that community members cannot access by calling a local therapist or police officer in times of crisis. As a result, the service can prevent unnecessary hospitalization by stabilizing a person in distress. The mobile crisis team members are recognized for their dedication and professionalism. According to the director, in 20 years they have had only one completed suicide. Many primary and secondary consumers have spoken of the negative experiences they have had when going to a hospital directly or calling the police, compared with their positive experiences using the crisis service. Social services providers have expressed appreciation for the ability to call on mobile crisis to assess challenging cases and help with hospitalization as necessary.

However, many people have expressed frustration that such a useful service is not more available—particularly in the evenings when other services are closed—or more mobile, since mobility is a challenge due to the very small staff size in Region 1 (currently 1 supervisor and 2 staff) and long travel times. Other concerns about the availability of the crisis service include long wait times in the suburbs when the team has had to come from Stamford or Bridgeport, and callers (including SWRMHB) calling at the end of the workday and not reaching anyone or else not being given information about options when the program is closed. A different concern is that vulnerable populations (including school faculty, staff and parents) lack awareness of mobile crisis.

Providers cite a need for more connection to care for individuals in crisis. They report that when mobile crisis determines that a client should be hospitalized, the client is frequently not admitted or is kept overnight and returns the next day. Social services professionals also repeatedly identify a need for mobile outreach workers to help connect clients who are very challenging to engage with, whether homeless or isolated at home. The Homeless Outreach Team (HOT) fills this need to some extent in Bridgeport, but is not available throughout the entire region.

As a result of the small staff size and limited hours of the adult mobile crisis program, the program is at risk of being seen as irrelevant. If the program is unable to be counted on to meet community needs, community agencies may stop calling for support and may stop telling residents about this service. At the same time, individuals and family members feel strongly that this is too important a service to lose, but invariably point out

that their own mental health crises have often been at night or on holidays and weekends, when the adult mobile crisis program is closed.

Meanwhile, the state's mobile crisis program for children under age 18, Emergency Mobile Psychiatric Services (EMPS), is available 24/7 but through a separate system. Community members are constantly surprised at the bifurcated access.

Recommendations at the State Level:

1. There should be <u>one access point</u> for mobile psychiatric crisis:

    a. 211, Option 1 should be the <u>only phone number</u> anyone in CT needs to know for Mobile Psychiatric Crisis for all ages. *Rationale*: It's memorable; there is already some awareness of this resource; and using 211 as the main number will facilitate connecting callers to other types of help as well.

    b. 211, Option 1 should be able to <u>connect callers directly</u> to their local adult mobile crisis. *Rationale*: Presently, when a caller reaches the 211 Mobile Crisis, EMPS can provide the number for the adult mobile crisis nearest to the caller, but cannot connect the caller directly. This means that someone in a crisis has to remember and correctly dial a 10-digit number—a big barrier to reaching out for help.

    c. It appears that the reason 211 does not connect callers directly to adult mobile crisis may be financial. It is, however, important to invest in this capacity. 211 is already a 24/7 resource, whereas adult mobile crisis is not available round-the-clock in some regions, so by calling 211, a caller would at least be able to reach a human being who could explain what to do if there were no adult crisis counselor available. If 211 had a contract with DMHAS, their call center could be asked to inform callers (at a minimum), or to assess and/or divert them (with a larger scope of work).

2. Serious consideration should be given to creating <u>one single mobile crisis system across the lifespan</u>, whereby staff can serve adult or child needs. *Rationale*: This would fill a gap in terms of client need, since adults in crisis would be able to reach a crisis counselor even past midnight. By merging these programs at the local level, there would be cost savings (space, systems) that could offset costs of changing staffing patterns. Merged programs would allow for more staffing during any given shift, which would facilitate teamwork, make allowances for staff absences, facilitate having a Spanish-speaking clinician on hand at all times, etc.

3. If adult mobile crisis cannot be available 24/7, the service should at least be <u>available after workday hours</u>, when crises often occur and outpatient clinics are not open. Specifically:

a. Ensure that the service is open and mobile until 9pm or 10pm. If staff cannot be available after 4pm or 5pm, consider contracting with EMPS to handle after-hours calls.

b. Mobile crisis should be available on weekends and holidays.

c. Having consistent hours across the state would help in promoting this resource.

4. If a single system is developed in which all mobile crisis services are accessed through the same number, open during the same days and hours, and provide the same service, create a statewide marketing campaign, in at least English and Spanish, to increase awareness. (Consider posters, PSAs on Pandora such as used by CT DPH, radio spots.)

Recommendations for SWCMHS:

5. Improve access to mobile crisis within Region 1:

   a. Extend program hours, since community members expect that a crisis service should be available in the evenings. CAC members recommend starting at 9am (which will save some money and recognizes that there are not many morning calls) and remain open until 9pm.

   b. To adequately serve the local population, ensure access to Spanish-speaking clinicians during all shifts.

   c. Require (and monitor) that callers after hours are given options by *whoever* answers the phone, including when the call goes to voice mail:

      i. Call 911 if you can't wait – ask for a CIT officer if available
      ii. Call the suicide prevention lifeline if you don't want to go to the hospital but need to talk (800-273-8255)
      iii. If you can wait, leave your name and number and you will be called back by [10am tomorrow/ Monday]

   d. Require (and monitor) that any on-call doctors or others who respond to calls document caller info: time, reason for call, info provided, contact info, etc. so there can be follow-up.

   e. Continue to follow-up with callers who were not hospitalized but were provided with community referrals.

f. These recommendations may best be achieved by merging the service with another service, such as EMPS (as noted in the state recommendations above) or as part of a larger outreach program (see recommendation 8 below).

6. Callers should always be given an assessment, a concrete list of steps, and a timeframe for when they will be called back.

    a. Establish a protocol for calls that come in when the crisis team is already with another client. Protocol should include maximum time that caller will be left on hold, identification of a back-up or on-call clinician who will be made available urgently when needed by crisis, identification of Spanish-speaking clinician who will be made available urgently when needed by crisis, etc.

7. Create a satellite location in Norwalk, the center of Region 1, or simply move the mobile crisis office there in order to better serve the region. Many agencies are located near the Town Green, which is a short distance from both 95 and the Merritt, making it easy to get to other parts of the region.

    a. EMPS already has an office at the HSC Building at 1 Park Street in Norwalk. This presents the possibility of piloting a shared adult and children's mobile crisis service. This location is also useful because the building is home to the Community Action Agency of Western CT (case management, DSS), Ability Beyond, SWRMHB, and CT Hospice.

8. Consider creating a crisis outreach and engagement service by developing a larger team combining staff from mobile crisis, HOT, Recovery Support Specialists, and others. This could allow for flexible deployment of different staff members depending on need, from one visit to deescalate a crisis, to multiple visits to engage someone isolating at home. The team could potentially be used to follow up on clients post-discharge, to support the Community Care Teams, etc., throughout the region.

9. Consider strengthening the relationship between the mobile crisis team (or expanded outreach and engagement service) and CIT officers in local police departments, through offering in-service trainings, Q&A discussions, etc., provided by the crisis staff. It should be helpful to draw on the mobile crisis director's expertise in forensic police psychology.

10. Promote the service while setting realistic expectations:

    a. Make sure information about mobile crisis (adult and child) gets to schools, including special education schools; guidance counselors and school social workers; outreach workers and case managers; parents.

        i. Consider developing a new mobile crisis marketing poster that highlights both the adult and children's services. It should be bilingual and attractive so people pay attention to it. Send it

to town halls, libraries, schools, provider agencies, and other community locations throughout the region.

ii. For good low-cost graphics design, consider using fiverr.com to hire people on a gig basis to do design/layout for $5 or $10 per document.

iii. SWRMHB and the RACs already distribute resource guides and SWRMHB's "Need Help?" posters throughout communities and SWRMHB highlights mobile crisis as a resource in all community talks. Our community networks can continue to get brochures and resource guides distributed through local towns.

b. Clarify the limitations of the region's mobile crisis service. Ensure that all information given out (brochure, website, information provided to callers) includes:

i. A definition of what type of "crisis" is best served by mobile crisis, including identifying other available services (Lifeline, Warm Line, 911) and when to use them;

ii. Identification of how to access children's mobile crisis and adult mobile crisis;

iii. Updated information on the days and hours that mobile crisis is reachable and/or mobile;

iv. Guidelines on what to expect in terms of response time (either from the mobile team or in terms of a callback);

v. Clarification of what the mobile crisis team can and cannot do in the community (for example, its role in homeless outreach).

c. SWRMHB has updated its resource guides to clarify the hours of the program.