EMERGENCY MOBILE PSYCHIATRIC SERVICES (EMPS): Recommendations for Model Enhancement

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CONTENTS

EXECUTIVE SUMMARY

Introduction

Connecticut's Emergency Mobile Psychiatric Services (EMPS) is a community-based program intended to provide youth and families with immediate access to in-person mental health assessment and brief intervention, linkage to appropriate community mental health resources, and prevention of unnecessary hospital emergency department (ED) visits or placement in restrictive clinical settings. EMPS was originally contracted to be a highly mobile community-based service that would serve as an integral aspect of the service array in Connecticut and a convenient point of access into the behavioral health system. However, at least three issues have arisen that call for an enhanced model of care for EMPS:

1. A growing divergence between the original goals and intent of EMPS as it was originally procured, and current implementation practices and program performance
2. Increased utilization of hospital emergency departments (EDs) for behavioral health treatment
3. A recently settled class action lawsuit that called for enhancement of the EMPS system.

Staff at the Connecticut Center for Effective Practice (CCEP) of the Child Health and Development Institute (CHDI) systematically examined these issues. The results of that process are presented, along with specific recommendations for model enhancement.

Methods

Staff at CCEP engaged in a number of systematic activities in developing the current recommendations for model enhancement. Methods included:

- Review of existing documents and data related to the current EMPS model of care
- Independent review of the relevant empirical and best practices literature
- Site visits to selected Connecticut EMPS providers
- Consultation with selected national providers of emergency mobile services.

Findings

Empirical and Best Practices Literature Review

The literature reveals that emergency mobile psychiatric services are an important element of the service array in many states. They are intended to provide face-to-face crisis assessment, intervention, and stabilization in the community, and most programs have a primary purpose of diverting youth from ED admissions and residential placements. Although the published literature evaluating emergency mobile psychiatric programs is limited, 35 published empirical and non-empirical studies were identified. The empirical literature suggests that community-based, as opposed to hospital-based, emergency mobile teams were most successful in diverting youth from inpatient and residential placements. Most programs provide a

linkage function whereby they ensure that youth in crisis are referred to appropriate longer-term treatment options in the community. Staff members in these programs are highly trained mental health professionals who are skilled in providing crisis intervention services, are knowledgeable about available treatment options in the community, and are able to collaborate effectively with other community providers. Finally, although we found that guidelines and structures of individual programs were available, we also discovered that very little has been reported in developing a statewide system of emergency mobile services for children.

Consultation with National Providers of Emergency Mobile Services for Children
The Child, Adolescent, and Family Branch of SAMHSA's Center for Mental Health Services (CMHS), was contacted for assistance in identifying national emergency psychiatric programs for children. Respondents to this inquiry included the Directors of the Community Crisis Outreach Services (CCORS) program in King County Washington and the Mobile Urgent Treatment Team (MUTT) at Wraparound Milwaukee in Wisconsin. These directors were contacted by phone and interviewed about relevant aspects of their programs.

Our results indicated that these national providers utilized one centralized call center to answer all calls and refer to the appropriate regions within their catchment areas. Most programs were open from early in the morning (typically 8:00am) until about 8:00pm, but offered mobility during the overnight hours by paying staff to carry pagers and respond to crises during these hours. Most programs were highly mobile, but offered non-mobile response as part of their service delivery structure. Training of staff members was comprehensive and in some cases subcontracted with an independent provider. Diversion from emergency departments and inpatient admissions was a high priority, and in addition to linking youth and families to needed community-based services, both programs had immediate access to crisis stabilization and respite beds. Methods of quality assurance varied from collecting parent satisfaction measures only, to more comprehensive data collection and reporting procedures.

Site Visits with Selected Providers of EMPS in Connecticut
Site visits were conducted with a DCF-identified sample of EMPS programs that represented different regions across Connecticut. Site visits focused on assessing the structures of the program including hours of operation, call centers, and staffing requirements. In addition, processes and procedures were assessed, including call disposition options, assessment procedures for referred children and their families, and staff training. Furthermore, EMPS directors were asked about their relationships and MOUs with EDs and other community providers (e.g., schools, law enforcement, foster care and group homes), their efforts at linking families to other community-based services, and their perceived strengths and weaknesses.

The results of our site visits indicated that EMPS providers had access to 24 hour a day, 7 day a week call centers, and that this service was operated by their own agency or subcontracted to another local provider. Most call centers provided triage

and dispatched calls to the mobile team. Hours of operation were in compliance with the requirements of the original RFP, furthermore, some providers dispatched mobile teams only during hours of operation and one provider offered 24/7 mobility. Providers also noted that some callers did not require or request a mobile response.

EMPS staff members often were shared with other programs, and teams often included at least one care coordination staff member who facilitated establishing linkages to other community-based treatments. Higher pay and team building activities were effective strategies in preventing staff turnover. Relationships with EDs were inconsistent, as was the development of MOUs with EDs. All providers reported that DCF assistance in facilitating effective relationships and MOUs with EDs was necessary. Relationships with other community-based agencies reportedly were good, but logistical barriers (e.g., time consuming assessments by EMPS programs) discouraged some community agencies from referring to EMPS. Barriers to establishing timely linkage to community-based services included long waitlists and inadequate numbers of crisis respite beds.

Models of care generally were not present and assessment protocols were found to be similar in comprehensiveness and length to what might be found in outpatient departments. Training of staff was inconsistent, ranging from pre-service training and job shadowing, to comprehensive pre-service and in-service training. Quality assurance also was inconsistent. Although most providers consistently collected basic referral and demographic information and parent satisfaction measures, there was inconsistent use of data to inform clinical and programmatic decision-making. All providers expressed a desire for a more comprehensive data collection and quality assurance process with site-specific feedback in order to inform continuous quality improvement.

Recommendations

We recommend that Connecticut take the following steps toward model enhancement in re-procuring EMPS in Connecticut.

1. Implement a consistent, clearly defined EMPS model
2. Recognize and support the diversionary and short-term intervention roles of EMPS
3. Establish guidelines for follow-up services
4. Distinguish two functions of EMPS providers in each contracted agency
5. Establish realistic expectations for mobility among EMPS providers
6. Increase the availability and utilization of crisis stabilization units
7. Establish regional catchment areas
8. Establish a centralized statewide call center
9. Engage in relationship-building with community providers
10. Use paraprofessional staff/family advocates to assist in program implementation
11. Ensure training and certification of EMPS staff
12. Develop effective triage and assessment protocols
13. Develop and implement an effective quality assurance plan
14. Utilize a phased implementation approach

INTRODUCTION AND OVERVIEW

Definition of Emergency Mobile Psychiatric Services

Connecticut's Emergency Mobile Psychiatric Services (EMPS) are a group of community-based crisis services intended to provide youth and families with immediate access to in-person mental health assessment and brief intervention, linkage to appropriate community mental health resources, and prevention of unnecessary hospital emergency department (ED) visits and placement in restrictive clinical settings. EMPS is a core behavioral health service in Connecticut's community-based system of care. According to the most recent version of the Department of Children and Families (DCF) Practice Standards, EMPS is a:

> *"Community-based program intended to provide early intervention in response to crises; clinical assessments in locations of parental preference; and stabilization services to prevent unnecessary placements into hospitals, emergency departments or residential facilities; and rapid triage into supervised, structured settings for those youth whose clinical conditions require a higher level of care"*
>
> *(Practice Standards for Emergency Mobile Services, 2003, p. 4).*

Background and Context of EMPS Model Enhancement

In response to the growing concern of the long waitlists for mental health services that children and youth face and the lack of quality assurance implemented for these services, the legislature requested in June 1999 that the Department of Social Services (DSS) conduct an evaluation of the mental health service array in Connecticut. In February 2000, a report titled, "Delivering and Financing Children's Behavioral Health Services in Connecticut" was submitted to the Connecticut General Assembly by DSS. This report, prepared for DSS by the Child Health and Development Institute (CHDI), details the service system gaps and barriers facing the behavioral health care system for children and families in Connecticut. Among the most important findings in the report was that 70% of behavioral health spending was dedicated to psychiatric hospitals and residential treatment, though only 19% of youth enrolled in Connecticut's Husky-A program utilized these services.

The report recommended that Connecticut restructure its behavioral health care system to be consistent with a system of care framework, and develop a stronger emphasis on utilization of community-based services. Specific recommendations included:

- Better care coordination
- Enhanced community-based resources and treatment alternatives
- Better integrated funding mechanisms
- Family involvement in policy and service planning
- Redistribution of resources and refinancing of the service system

Following this initial report, the Connecticut General Assembly requested that DCF and DSS submit a plan to enact these recommendations, and in 2001, a report was delivered detailing an implementation plan for *Connecticut Community KidCare*. Legislation was subsequently passed in 2005, which officially authorized the development and implementation of the Connecticut Behavioral Health Partnership (BHP), a behavioral health service system that would oversee the integrated financing and delivery system for community-based behavioral health care.

EMPS, an important element of the vision of KidCare legislation and the mission of the BHP, is a community-based service that provides therapeutic mobile crisis response capacity in the community, and is one point of entry into the behavioral health care system. Among the primary goals of EMPS is increasing access to and coordination of behavioral health services in the community.

Rationale for Model Enhancement

Two contextual issues provide a rationale for enhancement of EMPS in Connecticut. The first is the increased utilization of hospital emergency departments for the treatment of mental health problems among children and adolescents. A recent report titled “A Rising Tide” (released by CHDI in January 2007), summarizes the results of a study that examined ED utilization for mental health care among Connecticut’s children. The rate of ED utilization for youth with primary psychiatric diagnoses increased 38 percent between 2002 and 2005 among HUSKY-A clients. In addition, between 58 and 64 percent of youth had some contact with the mental health system in Connecticut in the six months prior to the index ED visit, which suggests that despite recent treatment, many youth present to EDs for emergency mental health treatment. The study also found that among youth who had recently been hospitalized for a mental health problem, many did not receive adequate follow-up care, which resulted in subsequent ED visits.

The results of this study suggest that there is a need for enhanced crisis services for Connecticut’s youth and their families, so that youth at high-risk for ED utilization receive the necessary follow-up services to prevent subsequent crises and unnecessary utilization of EDs for mental health treatment. Changes in the service system array, particularly services that appropriately manage mental health crises and facilitate appropriate community-based linkages, are likely to decrease the burden placed on EDs.

The second contextual issue is a recently settled class action lawsuit involving Connecticut DCF, *W.R. v. Department of Children and Families*, resulting in specific recommendations for enhancement of EMPS for children and adolescents. In March 2002, a class action lawsuit was filed in U.S. District Court against DCF, on behalf of all children, youth, and young adults in DCF’s care who have mental illness or serious behavioral issues, who should live in the community, and who have not had the opportunity to do so. At the core of the lawsuit were claims that DCF had discriminated against class members by:

- Failing to provide appropriate community-based placements
- Failing to provide a continuum of appropriate placements
- Relying excessively on restrictive and inappropriate institutional and foster care placements

DCF denied these allegations and settled the lawsuit. The results of the settlement will impact the services that are provided to all class members in Connecticut. One of the primary terms of the settlement involves increasing access to EMPS and enhancing the effectiveness of this service. The State of Connecticut has increased funding to the EMPS program and asked CHDI's Connecticut Center for Effective Practice, under the auspices of its multiyear KidCare evaluation PSA, to develop recommendations for enhancement of these services.

Overview of Current EMPS Model

The original Request for Proposals (RFP) in 2001 for EMPS services listed several goals and outcomes for EMPS that included preventing hospitalization or placement of children and youth, supporting families and caregivers, offering specific behavioral assistance, and assuring the transition to a community-based support system that would remain in place after crisis stabilization. The goal of the original procurement and contracting of EMPS services was to provide a consistent local point of access along with immediate mobile care from qualified mental health professionals. The goals of EMPS as specified in the original RFP are to:

- Establish local points of access and assistance in each DCF region in response to child and youth who experience a behavioral health crisis;
- Provide immediate, mobile, on-site crisis assessment and stabilization;
- Provide short-term on-site therapeutic intervention;
- Provide intensive care coordination for children and youth with complex service needs;
- Participate in all collaboratives within each applicant's catchment area to ensure the balanced planning for and provision of both treatment needs and holistic child and family care.

(Emergency Mobile Psychiatric Services Request for Proposals, Connecticut Department of Children and Families, August 2001)

The intended outcomes included preventing hospitalization and placement in residential facilities, supporting families and caregivers, offering specific behavioral assistance, and assuring the transition to a community-based support system that would remain in place after crisis stabilization. EMPS providers thus were required to deliver emergency mobile services with a focus on access to services, operations and direct service provision, clinical decision-making protocols and documentation, and team composition. These service elements are described in more detail below:

Access to services. Each contracted EMPS provider originally was expected to operate a toll-free number that would be available to the public 24/7/365. A trained screener would staff this phone number at each contracted EMPS provider site and

facilitate immediate access to EMPS staff. Each provider was expected to develop protocols to describe specific intake, screening, and referral procedures. EMPS providers were asked to provide a detailed plan as to how they would market and advertise their call center and their services to the community, particularly to parents. Finally, EMPS providers were required to describe how they would arrange EMPS services when children already had a behavioral health provider, including delineating clinical roles and responsibilities in such situations.

Operations and direct service provision. Each center was expected to provide phone assessment, triage, and de-escalation of crises as well as general referral and/or linkage to appropriate behavioral health care. Centers were asked to provide rapid phone follow-up from EMPS staff within 15 minutes of the initial phone call and to provide access to immediate psychiatric assessment and medication consultation. In the event of mobile response, EMPS providers were required to be on-site within 30 minutes, while maintaining concurrent capacity to dispatch multiple mobile crisis teams into the community.

Providers were asked to provide a plan to demonstrate how they would provide adequate coverage during high and low utilization periods and also were asked to detail how they would engage in community outreach and education about EMPS services. The original RFP recognized the need for providers to establish linkages with local EDs, and to provide containment and crisis stabilization linkages. EMPS providers were required to describe their plan to offer medication assessment and short-term medication management, home- or site-based short-term crisis intervention, and linkage to traditional and non-traditional service and support systems.

Clinical decision-making protocols and documentation. The original RFP indicated that EMPS providers must establish standardized assessment protocols and decision-making tools, and develop an Individualized Crisis Plan for each youth and family served.

Team composition. EMPS staff were expected to be highly trained licensed clinical and medical professionals. The model specified that two mobile crisis teams per catchment area should be available to be dispatched concurrently. The recommended staffing complement included positions of Senior Executive (0.25 FTE), Clinical Director (1.0 FTE), and Administrative Assistant/Data Manager (0.5 FTE). The recommendations for direct clinical care staff included a team of mental health professionals with degrees of MSW, RN, or APRN (totaling 5.50 FTE). In addition, a Comprehensive Care Manager (1.0 FTE) and a Service Effectiveness Coordinator (1.0 FTE) were part of the required staffing complement. Staffing guidelines called for the use of full-time rather than part-time rotation staff for EMPS. In addition, the RFP described the importance of recruiting and hiring a diverse and culturally competent staff.

Descriptive Data on EMPS

The data collected on EMPS utilization statewide places the performance of the program into context relative to its original goals and intent. During 2006, statewide EMPS providers received 5,877 calls, representing 4,932 unduplicated cases. The volume of calls received results in an average of 44.5 calls per month, per contracted provider, with a range of 0 to 134 calls per month across all providers. However, issues in developing consistent definitions and tracking of a "call" resulted in one provider reporting no monthly calls, when this provider actually did receive calls and provided services. The data presented below is an estimate of referral and disposition rates from 2006, but the accuracy of these rates likely would be improved with more consistent definitions of the data elements. Table 1 summarizes the most common EMPS referral sources:

Table 1. EMPS Referral Sources

Family	**School**	**Hospital**	**DCF**	**Juvenile Justice**	**Doctor**	**Self**	**Other**
32.8%	25.4%	12.4%	9.5%	3.2%	2.0%	1.3%	13.4%

Source: 2006 Emergency Mobile Services Data Report, Quarter Two Summary (January 19, 2006)

Patterns of call disposition help to ascertain the overall rates of mobility and the most common sites to which EMPS staff are dispatched for crisis evaluations. Over half (51.4%) of the calls that are received by EMPS result in a non-mobile disposition. Table 2 summarizes the dispositions of calls received by EMPS, including non-mobile and mobile responses.

Table 2. Mobile and Non-Mobile Call Disposition

Disposition Type	**Percentage**
Non-mobile response: Office visit	27.9%
Non-mobile response: Telephone only	23.5%
Mobile Response: Residence	23.3%
Mobile Response: School	14.3%
Mobile Response: Emergency Department	8.3%
Mobile Response: Shelter	1.0%
Other Face to Face	1.8%

Source: Data Presented to EMPS Planning Team, October 1, 2007 (DCF, October 2007)

Concerns with EMPS Implementation Practices

Currently, there is wide variability among contracted EMPS providers in meeting the goals and practice standards specified in the original RFP. Providers offer services that support families and caregivers and offer behavioral assistance through assessment, stabilization, and intervention; however, the goals for other areas of implementation have been met less consistently. For example, follow-up services have been provided, but for many providers these services have extended beyond the original intervention time frame of 45-days or six-to-eight visits. Providers have varied in the degree to which they have developed effective relationships and Memorandums of Understanding (MOUs) with EDs that are crucial to meeting the

goal for preventing inpatient admissions. EMPS staff members often are not full-time but instead are shared with other programs within contracted agencies, and in some cases have not received the training necessary to adhere to the goals of the EMPS program. A summary of the major points of concern expressed by DCF include:

- Redundancy/Inefficiency involved in operating 11 primary providers and 5 subcontracted providers
- Lower than anticipated overall rates of mobility, and wide variability in mobility rates across providers
- Extensive follow-up of cases by a large number of providers beyond the approximately 6-week timeframe specified in the Practice Standards
- Wide range of assessment procedures
- Wide range of credentialing and training of staff members
- Opportunity for improved relationships between some EMPS providers and other community agencies (e.g., hospitals, schools, law enforcement)
- High costs per call due in part to program resources diverted to long-term follow-up associated with EMPS services
- Insufficient outreach and marketing of service
- Negative perceptions of EMPS program by some vocal consumers, advocates, and families

Goals of Model Enhancement

Based on the discrepancies between the original intent and standards of EMPS and its current implementation and practices, as well as the broader system and contextual influences in Connecticut, DCF has identified several goals for improving the effectiveness of EMPS. These goals include:

- Increase the number and percentage of calls that are diverted from EDs
- Increase capacity for mobile response to community crises
- Increase the total number of calls to the EMPS system
- Improve the relationship between EMPS providers and EDs
- Improve the relationship between EMPS providers and family advocacy organizations as well as with families who utilize the service
- Increase linkages between the EMPS providers and community providers
- Ensure a competent crisis assessment by all EMPS staff
- Improve the public perception of EMPS

METHODS FOR THE CURRENT EVALUATION

CCEP staff collaborated with DCF, the Connecticut Behavioral Health Partnership (BHP), contracted EMPS providers, and other stakeholders to determine recommendations and the primary areas of focus for model enhancement. CCEP staff utilized four approaches to conducting this analysis including: a descriptive analysis of the current EMPS model; an independent review of the relevant empirical and best practices literature; site visits to selected Connecticut EMPS providers; and consultation with selected national providers of emergency mobile services. Below is a more detailed description of each of the methods used to prepare this report.

1) Review of EMPS Program Documents and Descriptive Data

CCEP staff reviewed the available descriptive information for Connecticut's EMPS, including the original RFP, the *Practice Standards for Emergency Mobile Services*, and descriptive data that had been presented in various stakeholder forums. This review provided a basis for understanding the current functioning of EMPS as it fits into the broader service array in Connecticut, and a perspective regarding the program's current functioning relative to its original intent and goals. This information is reviewed above, in the section titled, "Introduction and Overview."

2) Literature and Best Practices Review

A review was conducted of the empirical and non-empirical literature related to crisis and emergency services for children and adolescents. Guidelines and data originally focused on adult services also were reviewed if they were relevant to emergency services for children. Articles, book chapters, and internet sources were reviewed for descriptions of national models for children's emergency mobile psychiatric services.

3) Individual Consultation with Selected National Providers of Emergency Services

Selected national programs with known experience in implementing emergency crisis services for children were contacted via phone calls and e-mails. In addition, requests for proposals issued by these programs and individual contracts with providers were obtained when available. Programs that were consulted included Children's Crisis Outreach Response System (CCORS) in King County, Washington and the Mobile Urgent Treatment Team (MUTT) of Wraparound Milwaukee in Milwaukee, Wisconsin.

4) Connecticut EMPS Provider Site Visits

CCEP staff conducted site visits with individual EMPS providers, based on DCF's identification of a representative sample of providers in regional catchment areas. Information was gathered regarding the operation of their EMPS program, the strengths of the services provided, the challenges faced by individual providers, and ideas, recommendations, and concerns about Connecticut's EMPS enhancement project. To guide these sites visits, discussions were centered on a number of questions and topics developed in advance by CCEP staff in collaboration with DCF,

BHP, and other stakeholders (see Appendix A). The EMPS sites that were visited included:

- Bridgeport Child Guidance Clinic
- Wheeler Clinic
- United Community & Family Services
- Waterbury Child Guidance Clinic

In addition, CCEP staff met with staff members from the Yale Psychiatric Hospital Emergency Department to gather additional information about EMPS from the perspective of an ED provider. This interview focused on the strengths and challenges of managing mental health crises in EDs, as well as the strengths and challenges of working with EMPS to manage the psychiatric emergencies of Connecticut's youth.

EVALUATION FINDINGS

Literature and Best Practices Review

Emergency mobile services as a diversionary service. Although emergency psychiatric service programs historically have been hospital-based, research comparing these services to community-based mobile psychiatric programs has found that hospital-based programs have higher rates of inpatient admissions for youth and adults (Guo, Biegel, Johnsen, & Dyches, 2001; Hugo, Smout, & Bannister, 2002). Conversely, research on community-based mobile psychiatric services suggest that these types of services are able to respond to crises on-site as they occur in the community, which is likely to result in increased capacity to divert youth from ED visits as well as restrictive residential services. Shulman and Athey (1993) compared mobile services in New York City with short-term residential and in-home services, and found that mobile services were more effective in preventing ED visits. The authors estimated that their mobile services prevented 250 hospitalizations during the study period.

Several other studies have reported that mobile psychiatric services successfully diverted from inpatient hospitalizations and residential placements (Bishop & McNally, 1993; Moore, 1990; Pastore, Thomas, & Newman, 1990). For example, Bishop and McNally (1993) reported that participants in a home-based crisis service were less likely to experience psychiatric hospitalization at 3 and 12-month follow-ups. Consumers of home-based mobile crisis response have a high likelihood of being referred to or enrolled in other community-based services (Boothroyd et al, 1998; Singer, 2005), which is likely to contribute to successful ED diversions.

Common characteristics among emergency services. Although the program elements and practices employed by individual programs differ greatly based on community needs and underlying treatment philosophies, there are certain characteristics that are common to EMPS programs. Goldman (1988) summarized the common elements among programs that provided emergency services for children, which included:

- Available 24 hours a day, 7 days a week
- Provide stabilization and crisis intervention and prevent hospitalization
- Emphasize short-term intervention
- Serve relatively small numbers of youth and families
- Include evaluation/assessment, intervention/stabilization, and follow-up services
- Employ staff that are flexible and adaptable, competent and highly skilled, and able to establish rapport and terminate therapeutic relationships quickly

Recommended guidelines for emergency mobile services. In addition to identifying common elements, researchers (Gaynor & Hargroves, 1980; Goldman, 1988; Kutash & Rivera, 1995) and national mental health organizations (e.g., American Psychiatric Association) have developed recommended guidelines and

implementation standards for emergency services. In their description of emergency service guidelines, Gaynor and Hargroves emphasized call centers, training, and mobile response time frames. Their recommendations included:

- Staff should be available to respond by phone 24/7
- Crisis call responders should have adequate training in handling psychiatric crises;
- There should be face-to-face contact within one hour;
- If needed, psychiatrists should be available by phone within 30 minutes.

In 2002, the American Psychiatric Association (APA) published its recommended guidelines for mobile psychiatric interventions that mirror those of Gaynor and Hargroves (1980) and include additional recommendations for implementing these services on an individual program basis. These guidelines include:

- 24-hour access to crisis professionals
- Triage capabilities
- Comprehensive “screening telephone assessments”
- Written protocols for determining safety risk
- Two-person teams for face-to-face contact that may include police
- In-person response within one hour
- Comprehensive data collection and quality assurance
- Written models to aid in aftercare referrals
- Outpatient appointments within one week

Model considerations for emergency mobile services. Other research has focused on the structuring of emergency mobile services, including training, staffing, and community linkages (Goldman, 1988; Kutash & Rivera, 1995). Guidelines in these areas have included:

- Intensive staff orientation and ongoing training
    - Include current best practices on crisis response and child/youth assessment and treatment, collaboration with multiple service systems, cultural competence, parent training, and utilization of decision-making tools
- Utilization of paraprofessional staff
    - Include community and family members to assist in youth/family support and help aid in transition to aftercare services
- Access to short-term stabilization beds
- Medication assessment and management
- Disaster response and counseling
- Follow-up services including outpatient or other community-based services
- Immediate referral/admission to acute psychiatry and addictions services when appropriate

Many of these program descriptions, guidelines, standards, and models still apply to the design and implementation of today's emergency psychiatric service programs. However, they tend to be tailored to individual programs that serve smaller regions, such as cities or counties. As a result, most guidelines and recommendations available in the literature are limited in their applicability to the design and implementation of statewide emergency psychiatric services.

Some research has been conducted to establish crisis intervention models that guide the delivery of emergency services. Many programs adhere to a simplified model that identifies three stages of crisis services, including assessment and evaluation, crisis intervention and stabilization, and follow-up (SAMHSA, 2007).

Roberts (1996) has proposed a seven-stage crisis intervention model that has some relevance to EMPS. The model does not specify a specific time frame for which these stages should occur, but provides a step-by-step guide to intervention. The seven stages involve the following actions by the crisis provider:

- Stage 1: Assess lethality at the point of the initial phone contact
- Stage 2: Establish rapport
- Stage 3: Identify major problems
- Stage 4: Help the youth cope with his or her feelings
- Stage 5: Work to explore alternatives
- Stage 6: Develop action plan
- Stage 7: Determine to what degree the action plans were successful

Re-procuring the Massachusetts emergency services program network.
Massachusetts is one of the few states to engage in a re-design and re-procurement of their Emergency Service Program (ESP) Network for *statewide* implementation (Emergency Service Program Network: Massachusetts, 2004). The service originally was designed to be the "front door" service to determine the need for inpatient psychiatric hospitalization for the child and adult population. The original ESP network consisted of 26 providers that handled 101,000 crisis encounters each year. The Massachusetts Behavioral Health Partnership managed the network, and this entity conducted managerial tasks that included sites visits, administrative management, continuity of care reports, performance indicator analyses, and action planning for continuous program improvement.

The re-procurement report described strengths, weaknesses, and recommendations for enhancement of emergency services in the state, addressing systems-level and practice-oriented factors. Some of the weaknesses of emergency services in Massachusetts prior to the re-design included a wide range of financing and reimbursement levels across providers, inconsistent skills and training of staff, variability in the types of crisis interventions, a lack of culturally and linguistically appropriate services, and insufficient use of technology in service delivery.

Based on statewide program conditions, and the lessons learned from re-procuring one region of the state, the report recommended that several steps be taken to strengthen the existing emergency network in Massachusetts. The report recommended establishing a network of six regional emergency centers, each with a regional call center, two or more urgent care centers, immediate access to crisis stabilization units, mobile crisis teams, and a child/adolescent consultation team. The recommendation for reducing the number of contracted providers from 26 to 6 ensured access to high quality care and consolidated clinical and administrative structures and functions.

In addition to this change in the structure of emergency services, the use of urgent care centers and mobile crisis teams for assessment was emphasized, contrary to the existing culture that supported conducting assessments in hospital EDs. Also, stronger relationships with emergency departments and community-based diversionary services were recommended. Core clinical competencies were developed for staff in an effort to standardize skills and training. It was recommended that consultation be available to mobile staff 24 hours a day, 7 days a week, particularly for child and adolescent cases. Finally, a consistent statewide financial reimbursement structure was recommended.

As noted above, specific recommendations were made for emergency mobile psychiatric teams to be available in each of the six regions. Mobile teams were to be housed either in the main emergency services center or one of the urgent care centers. A 24/7 regional call center was recommended to provide triage, information and referral, and linkage to community providers. This call center would service the entire regional emergency network, including the mobile psychiatric teams. Mobile teams were expected to provide assessment and intervention services in a variety of community locations. It was recommended that staffing of emergency teams be accomplished by sharing resources and staff between the emergency center and urgent care centers.

Furthermore, mobile crisis teams were expected to provide a range of services in the community, including timely assessment and clinical evaluation, referrals to community and inpatient treatment resources, crisis intervention and prevention planning, acute treatment and stabilization, access to psychopharmacological intervention, follow-up appointments, and access to crisis stabilization units. The mobile teams were to be sufficiently staffed by urgent care and emergency center personnel with flexibility for community-based service delivery, for example, by being given sufficient travel time to respond to crises in the community.

Summary of the empirical and best-practices literature. The literature reveals that emergency mobile psychiatric services are an important element of the service array. They are intended to provide face-to-face crisis assessment, intervention, and stabilization in the community, and most have a primary purpose of diverting youth from ED admissions and residential placements. As such, most programs also provide a linkage function whereby they ensure that youth in crisis are referred to

appropriate longer-term treatment options in the community. Staff members in these programs are highly trained mental health professionals who are skilled in providing crisis intervention services, are knowledgeable about available treatment options in the community, and are able to collaborate effectively with other community providers. Although guidelines are available for the structures and processes of individual programs, little work has been conducted on developing a statewide system for emergency mobile services for children.

Consultation with National Emergency Services Programs

Gary Blau, Branch Chief of the Child, Adolescent, and Family Branch of SAMHSA's Center for Mental Health Services (CMHS), was contacted for assistance in identifying national emergency psychiatric programs for children. Dr. Blau posted an e-mail that described the Connecticut EMPS enhancement to a CMHS listserv composed of the directors of individual state child mental health departments. Interested individuals were asked to email contact information directly to CCEP staff.

Respondents that were willing to be interviewed by phone were included as key informants for the current project. Respondents included the Directors of the Community Crisis Outreach Services (CCORS) program in King County, Washington and the Mobile Urgent Treatment Team (MUTT) at Wraparound Milwaukee in Wisconsin. These individuals were contacted by phone and interviewed about relevant aspects of their respective programs. The results from these two in-depth interviews are described below, and categorized into domains that are relevant to the current model enhancement project in Connecticut (see Appendix B).

Call centers. Both programs utilized a 24/7 centralized phone number that was advertised throughout their catchment area. Although these programs were not statewide, each program had coverage areas that encompassed the population of major U.S. cities, and each program covered total populations of over 1 million residents. Both call centers screened phone calls for appropriateness, and routed to an appropriate mobile team located in the same region as the child/family that was in crisis. One of the call centers collected data from the caller during the initial contact.

Hours of operation and degree of mobility. Both programs offered regular hours of operation along with an on-call system and the capacity for 24-hour mobility. For example, MUTT maintains full teams of mobile staff from 9 am to 10 pm Monday through Friday, and from 1:30pm to 10pm on weekends, but pays staff to carry pagers and respond to calls daily from 10 pm to 7 am. The CCORS program equips their on-call staff with cell phones and laptop computers in order to conduct assessments during the "overnight" hours. For both of these programs, staff that are paged during the overnight hours have the ability to conduct mobile assessments at the site of the crisis (e.g., client's residence, emergency department). In addition to an immediate mobile response option, the CCORS team included a "non-emergent" level of care so that families who placed a call during the day or overnight hours, but

did not require an immediate response, were given next-day appointments, at which time a mobile response team would visit the family in the community.

Staffing. Both programs utilized a team approach to crisis intervention, both in terms of providing back-up mobile teams and sending two staff members out on every call. The CCORS team consists of one active mobile response team and one on-call team that can go mobile if multiple simultaneous responses are required. Both programs respond to calls with two staff members consisting of one mental health professional (typically a Master's level clinician) and one paraprofessional, usually a former consumer or community member. For both programs, the paraprofessional supports the family and assists with accessing natural and community supports. In the case of the MUTT program, over 150 paraprofessionals are paid on a per diem basis to assist clinicians on mobile responses.

Diversion from inpatient treatment and ED visits. Both programs engage in community outreach and training to schools, law enforcement, and EDs in order to educate about their services and offer alternatives to costly and restrictive inpatient stays and ED visits. The CCORS team meets regularly with law enforcement professionals to prevent arrests due to mental health/behavioral crises and divert youth from juvenile justice entry. The MUTT team has a close relationship and a history of promoting their services with the county ED, which is located in the same building as the MUTT program. In addition, the MUTT team has contracts with the local school district and with the foster care system to provide crisis assessment and community linkage services.

Importantly, both programs either operate their own crisis/respite homes (MUTT) or have immediate and dedicated access to crisis/respite beds (CCORS). Both programs pointed to the availability of crisis beds as a critically important element of their success in diverting clients from inpatient stays and ED visits. The MUTT program reported that since their services have been fully operational, the number of inpatient beds in their region has been drastically reduced, from 150 to 12 beds. The CCORS program reported that with the enhancement dollars that will be added to their program in the coming year, they plan to offer more crisis/respite beds. Currently, CCORS offers crisis beds for stays of 3 to 14 days.

Community linkages. As discussed earlier, both programs have immediate access to crisis stabilization beds that also are used to assist youth as they transition out of EDs and inpatient treatment. The CCORS program handles all discharge planning for their local EDs in order to increase the likelihood of being linked to community treatment services. The policy of the MUTT program is to link a client to a community-based treatment provider within 30 days of the initial contact with their mobile crisis team.

Model and phases of treatment. Both programs offer assessment, crisis intervention, community linkages, and follow-up services. The CCORS team assessment procedures include completion during the initial visit of a safety plan that identifies

natural and community supports that will help to stabilize the youth. CCORS currently offers two "phases" of treatment, including initial crisis stabilization (up to four days) and crisis stabilization (up to 8 weeks). In addition, the CCORS team can petition for an extension of the 8-week crisis stabilization phase in cases where appropriate community linkages cannot be made (usually due to wait lists). With the enhancement dollars the program is scheduled to receive, CCORS will add an additional level of extended crisis stabilization (up to 90 days). Although it is unclear whether phases or levels of treatment exist, the policy of the MUTT team is to link to a community provider within 30 days.

Training. The CCORS program provides core trainings on their systems of care approach and crisis stabilization. The MUTT program offers 40 hours of pre-service training to staff with little or no crisis intervention experience, and 20 hours of pre-service training to incoming staff with more extensive crisis intervention experience.

Quality assurance. Whereas the CCORS collects satisfaction survey data from consumers of their service, MUTT collects more comprehensive data that allows them to track youth and determine the effectiveness of their services in diverting youth from costly and restrictive placements.

Site Visits

Site visits were conducted with a DCF-identified sample of EMPS programs that represented different regions across Connecticut. The same set of questions were used to guide the discussion with providers along relevant dimensions of the EMPS enhancement (e.g., call centers, hours of operation, community linkages), and open-ended questions were presented regarding their individual strengths, challenges, and recommendations for the enhancement and re-design of EMPS (see Appendices A&C).

Call centers. All providers were in compliance with the requirement that their call centers were operational 24 hours a day, 7 days a week. Some providers had their call centers routed through the agency's general phone number, while others had dedicated numbers for the mobile crisis teams. Generally, the call centers collected basic information on demographics and presenting problems, triaged the calls, then routed the call to the appropriate mobile team. However, one provider reported that having their call center conduct triage resulted in inappropriate decisions on whether to recommend mobility, and the mobile teams eventually had to take over the triage responsibilities. In addition, one site reported that their call center had immediate on-site consultation with EMPS staff, because staff members were located in the same building as the call center. They reported that this level of proximity and consultation was useful to the call center and to EMPS staff as they made decisions about assessment and triage.

Hours of operation and mobility. All programs had hours of operation that met the minimum requirements in the Practice Standards, and one program offered 24-hour mobility. Some programs paid their staff more for overnight crisis assessments,

which they believed contributed to lower turnover and less difficulty staffing the overnight calls. Other programs reported that they received few overnight calls, but the calls they did receive outside their hours of operation were immediately given an appointment for a mobile visit on the following day. One program reported that they conducted a mobile assessment in response to approximately 2/3 of their calls. Another contracted provider reported nearly 100% mobility at one of their sites, but that this high level of mobility was in part due to not having clinic office space for in-office visits at that particular site.

All providers interviewed noted that not all phone calls received by their EMPS program required mobility. In fact, one program reported that approximately 10 percent of callers refused a mobile visit. In explanation of this, providers reported that some calls were for information and referral only, and even when mobility was offered, there was a substantial portion of parents who did not want home visits from the mobile crisis team. In these cases, there seemed to be a fear of having mental health professionals in their home. This may be particularly true among families with a history of child protective services involvement and/or child removal from the home. Providers also reported that parents often have misconceptions about the scope and range of services available through EMPS. The most common misconception was that parents often called expecting EMPS to provide a respite bed. Some sites reported their perception that foster parents are more likely to call EMPS requesting respite care. For these reasons, providers reported that 100% mobility may be an unrealistic goal for EMPS programs and that the data collected by DCF on mobility rates did not adequately capture these realities.

Staffing. Providers reported various arrangements in staffing their EMPS programs. All programs reported having EMPS staff that were shared with other departments in their clinics, such as care coordination or community policing. Individual programs reported that their staff experience low referrals during the summer, during which time their staff members conduct outreach with other community agencies. One site reported that low pay and irregular hours contributed to high staff turnover. However, other sites reported that team building and supplemental compensation for after-hours crisis assessment assisted in staff retention. It also was noted that DCF central office sometimes inadvertently competes with EMPS programs for staff and are able to offer higher salaries. From a statewide systems perspective, this practice may be counterproductive to helping EMPS maintain a consistent workforce.

Relationships with EDs*.* Sites reported varying degrees of relationships with their local EDs. In general, MOUs were useful for maintaining relationships, but only if they were paired with effective and ongoing collaboration and communication with the ED. Other providers reported excellent relationships with local EDs in the absence of an MOU, while some providers pointed out that MOUs with hospitals were only helpful if they worked. One provider reported having a planning meeting with an ED in which they asked them how EMPS could best serve their needs. The ED reported a desire for assistance with evaluating their youngest patients who were “stuck” in their ED, and assistance with discharge planning for children and families

who presented to their ED for assessment. In this way, the provider was able to establish a consultant role with their local ED and further promote a sustainable working relationship.

However, these types of ongoing collaborations have not occurred with every local ED, despite provider efforts to establish relationships with all EDs. For example, one EMPS provider reported a good relationship with one area ED, but not with another. The reasons given for these difficulties in establishing some relationships more than others included:

- "Personality differences" (i.e., difficulty collaborating with specific individuals in leadership positions in the ED)
- ED liability concerns that EMPS staff are not employed by the hospital and therefore not able to view patient information
- The need for some EDs to keep inpatient beds filled and using EDs as a referral source for inpatient care
- In some cases EDs do not always defer to EMPS for recommendations on crisis and short-term treatment planning.

All providers reported that it would be helpful for DCF to assist in building relationships with EDs that have historically collaborated little with EMPS and to make it clear to all EDs that collaboration with EMPS is vital to the success of diverting youth from being unnecessarily "stuck" in EDs.

Relationships with schools and other community organizations. Individual providers reported various strategies in working with other community organizations to accomplish the diversionary goals of the EMPS program. One provider reported that they have EMPS liaisons at each school district in their catchment area, which assisted in the referral process, and in maintaining regular communication with schools; a primary referral source to their EMPS team. Other providers noted similar school outreach efforts, but also stated that it is sometimes difficult to maintain a consistent connection with other professionals in the community due to high turnover in schools as well as in police departments and other referring agencies. In addition, some organizations may choose not to utilize EMPS for logistical reasons even though they are aware of the service. For example, one provider reported that schools in their area did not refer to their EMPS program late in the school day, especially on Fridays, because EMPS assessments take significant amounts of time, and assessments often ran past regular school hours. In such instances, schools were reported to be likely to call ambulances and have the child brought to the ED.

Community linkages and referral. One program reported that working closely with care coordinators helped to facilitate community linkages. Across all providers, however, the most common reason given for delays in establishing community linkages was long wait lists for other services, particularly during the school year when many social services experience long wait lists. Another site reported a strong focus on developing a long-term community-based plan instead of referring clients

into their own, or another agency's, outpatient department. Because of these wait lists, EMPS providers at times end up delaying discharge from their program until other services in the community become available. The program thus has evolved into somewhat of a "catch-all" service for youth in need of mental health services and who may experience a crisis as a result of not receiving services, but cannot access these needed services due to a lack of availability. Providers reported that enhanced access to crisis stabilization beds would be of critical importance in diverting from inpatient treatment and ED visits.

Model and assessment protocols. Providers gave very little information specifying a model of crisis intervention. All providers had phone screen and assessment protocols that assisted staff in decision-making, although these protocols varied by site, particularly in terms of the depth of information collected. For example, most assessment forms included documentation of child and family demographics, current and past mental health and physical treatment, presenting problems, and mental status. However, some providers' assessment protocols resembled full outpatient intake evaluations, whereas others were briefer and concentrated more on presenting problems and nature of the crisis. This variability in assessment tools seems to represent the variability in the services that EMPS provides. As previously mentioned, the service has evolved to function both as a crisis intervention and as a place to treat youth in place of other services that may have a waitlist or are not available in the community. EMPS providers also serve as consultants to the community services that receive program referrals and therefore can provide another source of information to community providers in formulating an effective long-term treatment plan.

Training. Providers also provided limited information on training. One program reported pre-service and in-service training, whereas another program reported that they only provided pre-service training and job shadowing to their EMPS staff members. In general, programs reported a desire for DCF to offer enhanced training opportunities to their staff and thought that state-sponsored training for all providers would be beneficial in establishing consistent requirements for providers.

Quality assurance and data collection. Programs reported that the primary means by which programs collected program-relevant performance data was through the number and characteristics of youth and families served, and by youth and family satisfaction surveys. The director of the program typically reviewed these data internally on a quarterly basis. EMPS providers believed that the data reported by DCF were problematic. Specifically, DCF's count of the number of calls received by their program was dependent on how each program defined a call, which was not consistent across contracted providers. Furthermore, providers reported that in tracking their services, DCF's data collection attended to the number of calls received by each program, but neglected to take into account the length or intensity of services provided to each family. Finally, EMPS providers expressed concerns that data were not consistently reviewed by DCF, and that their programs would benefit greatly from individualized performance feedback to guide a quality

assurance process. Currently, any concerns that are identified by DCF are brought to the group of providers as a whole, but each provider stated that their program might be better served through a more individualized review process.

Summary of Findings

Based on a review of the literature, discussions with program administrators of national emergency service programs, and site visits with current EMPS providers in Connecticut, a number of trends emerge. Most programs seek to implement a comprehensive, multi-phase crisis intervention service that is available 24 hours a day and 7 days a week, is based in the community, employs trained clinical and paraprofessional staff, has established connections with EDs, schools, law enforcement, and community-based organizations, and utilizes ongoing training and quality assurance. In addition, programs both nationally and within Connecticut contend with the challenge of diverting youth from EDs often without available community-based services for longer-term care. Efforts to counteract this interim need for services include employing paraprofessionals to assist with follow-up and to facilitate the transition to other community-based services, and utilizing stabilization units to provide immediate respite care for youth and families. The following recommendations for Connecticut's EMPS model enhancement incorporate these findings and provide specific recommendations for implementation.

RECOMMENDATIONS FOR EMPS MODEL ENHANCEMENT

1) Implement a Consistent, Clearly Defined EMPS Model

Connecticut's EMPS programs should adhere to a clearly defined model that is consistently implemented statewide. Based on the available literature describing emergency mobile psychiatric programs nationwide, consultation with two nationally recognized programs, and data from currently implemented programs in Connecticut, the following components are recommended for Connecticut's EMPS model:

- **24/7 Statewide Call Center** that documents and routes calls to the appropriate region
- **Regional catchment areas** could be defined by considering a combination of population demographics, geographical area, and neighborhood or community ecology. One primary EMPS provider should be designated to serve equivalent population density and land areas.
- **Triage and decision-making protocols** conducted by trained staff that assess for lethality, collect brief information about the nature of the crisis, provide information and referral if appropriate, and document the nature of the call based on clearly defined definitions of crisis and mobile response
- **Comprehensive mobile assessment protocol** for all crisis calls that allow for crisis plan formulation, collateral contact with community providers, and discharge planning
- **Training and certification**, both initially and ongoing, for triage staff, mobile crisis staff, and paraprofessional support staff
- **Distinguish two functions of EMPS teams**, consisting of crisis response and follow-up, and ensure that staff clearly define and transition from crisis to follow-up in a specified time frame
- **Crisis stabilization units** that allow for brief crisis recovery and/or respite care
- **Clear follow-up guidelines** that account for the availability of community-based services and the needs of the youth and family
- **Contracts and/or MOU's with EDs, community providers, local law enforcement, and area schools** that allow EMPS staff to serve as a liaison that provide information and training on EMPS services and the needs of the community as well as respond to referrals, conduct assessments, and make clinical recommendations
- **Quality Assurance** provided by DCF or another qualified organization that includes regular, in-depth, and individualized reviews of each program as well as providing consultation to programs regarding how they are achieving model adherence and how they can improve implementation
- **Marketing and Outreach** should be conducted by the call center and provider staff to increase utilization and call volume

The recommendations that follow further highlight specific elements of the Connecticut EMPS model and provide suggestions for improvements in statewide implementation.

2) Recognize and Support the Diversionary and Short-Term Intervention Roles of EMPS

It is recommended that the diversionary and short-term intervention roles performed by EMPS be recognized and supported in Connecticut.

The most recent version of EMPS practice standards suggest that the service originally was designed with a "front end" purpose of diverting inpatient and residential treatment admissions and ED visits to less restrictive community-based services. However, EMPS currently serves an additional, vital function within the service array in Connecticut by providing short-term intervention and supports at the "back end" of the service continuum. This function is arguably a vital component of Connecticut's system of care for children and youth.

By supporting both the diversionary and short-term intervention roles of EMPS, the Connecticut EMPS model would be consistent with the approaches of the Mobile Urgent Treatment Teams (MUTT) of Wraparound Milwaukee, the Children's Crisis Outreach Response System (CCORS) in King County, Washington, and with recommendations for the re-procurement of the emergency services program network in Massachusetts. Results from our site visits indicated that delayed linkages usually are due to long waitlists in Connecticut's outpatient and intermediate levels of behavioral health care, such as extended day treatment, partial hospitalization, and intensive outpatient programs. Despite efforts to improve access through enhanced care clinics, it is likely that a more widely "marketed" EMPS system will result in even greater system backlog. Thus, EMPS should continue to provide follow-up services to youth and families that experience barriers and delays to community-based treatment. In addition, EMPS should continue to address the high volume of ED visits for behavioral health care by enhancing the diversionary aspect of EMPS services.

To support both roles of EMPS, contracted providers should be held to standards that emphasize the importance of mobility and linking youth and families to community-bases services in a timely manner while also continuing to provide follow-up services and fill in for gaps in the mental health service array.

3) Establish Guidelines for Follow-up Services

Guidelines should emphasize the short-term nature of follow-up services (6 weeks maximum) so that EMPS programs maintain their mobile capacity and their role of diverting youth from unnecessary ED admissions.

The addition of a more formalized crisis stabilization and follow-up function for EMPS has the danger of shifting focus of the service away from mobility and diversion, resulting in a service that resembles too closely an extended outpatient service. Results from our interviews with sites and stakeholders revealed that this already is a concern for many EMPS programs. As mentioned earlier, the CCORS team in King County, Washington currently utilizes an approach that allows their emergency mobile clinicians to follow a case for up to eight weeks, and will soon implement a new level of care in which mobile teams can petition to provide follow-up stabilization services for up to 90 days.

We recommend the following measures:

- Maintain and **strictly enforce the six-week follow-up** for providing short-term EMPS services and linking cases to appropriate community-based services (despite the Enhanced Care Clinic criteria for access that should limit wait lists to two weeks, current feedback from providers suggests that sufficient capacity does not exist to meet increased needs within the outpatient system of care)
- **Adherence to follow-up guidelines**, including documentation of length of service since intake, should be integrated into a comprehensive quality assurance plan
- Providers should **begin treatment planning at the time of initial assessment** and should help youth transition to active treatment services within 6-weeks of initial crisis call
- However, given the current gaps in the service system, it is recommended that EMPS providers have the option to request up to **four to six additional weeks of services** (from DCF or the BHP) to continue crisis stabilization when the appropriate community-based referral is not available, due to long waitlists or unavailability of specialty care.

Implementation of these recommendations will allow Connecticut to establish consistent guidelines for follow-up services, which will facilitate effective oversight and quality assurance.

4) Distinguish Two Functions of EMPS Providers in Each Contracted Agency

It is recommended that EMPS staff clearly define the two main functions of the service (crisis response and follow-up) and document the transition between these two services with each case.

Changes to the EMPS model would be useful in supporting the diversionary and short-term intervention functions of EMPS. Based on our literature review and consultation with national emergency service providers, the structures and policies of national programs support the follow-up service role provided by mobile crisis teams. For example, the CCORS team in King County, Washington currently allows their emergency mobile clinicians to follow a case for up to eight weeks, and will

soon implement a new level of care in which mobile teams can petition to provide follow-up stabilization services for up to 90 days.

Specific recommendations include the following:

- Each regional contracted EMPS provider should define and document these two functions of the service while providing continuity of care to youth while they transition from crisis, to follow-up, to community linkage
- All team members should contribute to both functions so that they spend some time during the week responding to crisis calls in the community and part of the week following up with families and arranging for appropriate, longer-term community linkages
- It is recommended that staff providing follow-up services also provide back-up mobile response capacity. This will allow for concurrent mobile response should two crisis calls be received at the same time in the same catchment area

5) Establish Realistic Expectations for Mobility among EMPS Providers

It is recommended that Connecticut:

- **Clearly define what constitutes a "call"**
- **Document actual call rates based on clear criteria**
- **Establish realistic expectations (i.e., 80-90%) for mobility**
- **Establish a formal linkage with 211 through EMPS for additional follow-up services as needed**

Connecticut should develop a consistent standard for defining what constitutes a call to the EMPS system. For example, a sizeable percentage of calls come to EMPS seeking only information and referral to community services. Such calls should be recorded, but because they are not emergency calls, should not be considered in analyses that calculate mobility rates.

Interviews with key stakeholders including DCF and contracted EMPS providers reveal a discrepancy in their perception of the appropriate standards for mobile response. A goal of 100% mobility for all calls received may not be realistic or consistent with best practices, based on our consultation with national programs and with Connecticut's EMPS providers. The MUTT and CCORS teams each include a disposition level for "information and referral" that does not require a mobile response, and the CCORS team includes an additional disposition level that calls for a non-emergent mobile or office-based visit within two days of the initial crisis call. However, if EMPS in Connecticut is to accomplish its goal of diverting from ED admissions and being responsive to crises as they occur in the community, then there must be an expectation for high rates of mobility. Therefore, expectations for mobility should be high (perhaps 80-90%), but a mobile response to 100% of calls received is not recommended.

6) Increase the Availability and Utilization of Crisis Stabilization Units

It is recommended that Connecticut invest in more crisis stabilization beds, and give priority to EMPS services in filling these beds in order to prevent ED visits.

Our review and consultation with national providers consistently identified the availability of crisis stabilization beds as a best practice in diverting from inpatient and residential stays as well as ED visits. The MUTT team of Wraparound Milwaukee currently operates their own 8-bed crisis stabilization group home, and the CCORS team in Washington has a contract that affords their program immediate, dedicated access to crisis stabilization beds. Both programs report that this is a key element in diverting youth from ED admissions. EMPS providers reported that sometimes parents expect that EMPS teams will be able to provide their children with crisis respite beds in the midst of a crisis. Although this represents parents' misconceptions about the role and scope of EMPS services, it also speaks to a gap in the service array in Connecticut. In addition to the use of crisis stabilization units, EMPS staff also may provide a link to 211 for referral to other available services in the state.

7) Establish Regional Catchment Areas

Connecticut should consider establishing regional catchment areas across the state, with each contracted provider responsible for a geographical region of the state corresponding to DCF-established zones.

Regional catchment areas could be defined by considering a combination of population demographics, geographical area, and neighborhood or community ecology. One primary EMPS provider should be designated to serve equivalent population density and land areas. This would be consistent with recommendations for re-procurement of the Massachusetts Emergency Service Provider network. However, this recommendation comes with potential challenges. A reduced number of contracted providers and an increased geographical size of each catchment area could result in increased time frames in which calls receive a mobile response. This would likely contribute to increased consumer dissatisfaction with the degree of mobility of the EMPS service. It is recommended that:

- Dedicated staff are complemented by per diem staff, located throughout the state, who can respond to crises in smaller sub-sections of a larger region
- Contracted EMPS providers have "outposts" in order to decrease mobile response times

In addition, staff that serve as liaisons with area hospitals and school districts should be located nearby in order to maintain regular contact and increase ongoing collaboration and referrals to EMPS.

8) Establish a Centralized Statewide Call Center

It is recommended that Connecticut establish one centralized statewide call center for incoming crisis calls, and that this call center should retain the responsibility for data tracking and reporting.

Providers and stakeholders have reported that data collection and reporting is a growing concern, and that inconsistent operational definitions of data elements and inconsistent reporting and feedback has resulted in misconceptions and misunderstanding between providers and DCF. Establishing one centralized statewide call center will help to alleviate much of this problem. Advantages of a statewide call center include improved consistency in defining a "crisis call" and tracking the types of calls that are received, as well as tracking demographic and referral source information. The call center should have a toll-free statewide line that can be easily marketed. However, certain guidelines will help the call center staff to support the myriad functions of EMPS. It is recommended that the call center:

- Receive ongoing training for appropriate triage of incoming calls, including establishing protocols and decision-making tools
- The call center should demonstrate capacity and a plan for data tracking and quality assurance
- Phone staff should have access to as-needed clinical consultation and supervision 24 hours a day and 7 days a week in order to assist with appropriate referrals and decision-making
- Implement a marketing strategy to promote the centralized phone line – marketing tools should include information that educate families on what EMPS services can provide and what they cannot (e.g., respite care)
- Receive incentives for increased call volumes

9) Engage in Relationship-Building with Community Providers

It is recommended that EMPS programs establish effective memoranda of understanding to strengthen their relationships with community providers, including emergency departments, schools, law enforcement agencies, and foster care/group homes, and that Connecticut DCF facilitate and support this process.

Our findings suggest that strong relationships with community agencies such as emergency departments, schools, law enforcement, and foster/group homes is likely to reduce rates of ED admission, and represents best practice nationally.

Emergency departments. **EMPS should continue to provide discharge planning services for EDs in their region to ensure that youth receive follow-up and crisis prevention services. However, relationship building with EDs should focus on utilizing EMPS to conduct assessments when youth and families**

present to EDs in order to prevent admissions to EDs and link youth and families to appropriate community-based resources.

Our findings from consultation with national providers of emergency services determined that effective relationships and memorandum of understanding with emergency departments resulted in higher rates of diversion from ED admissions and consistent utilization of mobile psychiatric services for emergency assessments of youth. Results of our site visits determined that EMPS programs currently are utilized to conduct assessments and determine appropriate treatment decisions *at the time youth present* to emergency departments. However, it also is common for hospital EDs to utilize EMPS *after* hospitals have admitted youth to assist youth and families with crisis prevention, discharge planning, and linkage to community-based treatment services. Discharge planning after inpatient admission is a valuable use of EMPS in the service array and assists youth and families in establishing ongoing treatment linkages in the community following an inpatient stay.

Schools. **It is recommended that EMPS teams collaborate with school districts in their catchment areas to establish procedures that clearly specify the appropriate use of EMPS services.**

Findings from our site visits suggested that schools are a common referral source to EMPS programs and EDs, and that providers' share a collective perception that Connecticut's schools have a low threshold for referring emergent psychiatric issues due to their adherence to a "zero-tolerance" policy regarding school violence. Similar issues were reported during our consultation with national providers. The CCORS team in King County, Washington reported that they identified one school official to act as the official liaison with the EMPS program in their region. The MUTT team of Wraparound Milwaukee established contracts with the local school district to provide crisis assessment services for youth in the local school district.

Consistent communication between EMPS providers and school districts is likely to have an impact on diverting youth away from law enforcement involvement and ED admissions as solutions to emergent mental health concerns. Therefore, MOUs should be established with the superintendent offices of the school districts within each provider's catchment area. These MOUs should focus on clearly identifying when it is appropriate to engage EMPS, and the appropriate use of EMPS services. As one part of developing MOUs, it is recommended that Connecticut adopt the approach of the CCORS teams by identifying one school official to act as the liaison to the EMPS program.

Law enforcement. **It is recommended that EMPS teams collaborate with law enforcement agencies in their catchment areas to establish procedures that clearly specify the appropriate use of EMPS services. MOUs should focus on developing clearly defined goals and procedures for ensuring that mental health professionals assess youth and link them to appropriate mental health**

services when this option is more appropriate than entering youth into the juvenile justice system.

Many youth who are arrested during behavioral health emergencies would be more appropriately routed to the mental health rather than the juvenile justice system. EMPS providers in Connecticut report that working collaboratively with law enforcement has been beneficial to both diverting youth from EDs and providing an extra measure of safety to staff going to family's homes in potentially unsafe circumstances. In addition, national providers of emergency services such as the CCORS team in King County, Washington report that they meet regularly to educate law enforcement on the nature of behavioral health crises in children and families, the availability of community resources for mental health treatment, and the services provided by their mobile crisis teams. They report that this has helped prevent youth from inappropriately being entered into the juvenile justice system by assuring that youth and families receive the mental health services they need.

Foster care and group homes. **It is recommended that EMPS programs and foster care and group home providers work together to identify strategies for responding to the needs of this population, and utilize EMPS as a primary means of crisis assessment.**

Foster and group homes serve a high-risk population of youth and families that may seek out crisis services for a variety of reasons including information and referral, respite care, and crisis de-escalation. Results from our site visits revealed that youth placed in foster care and group homes are common referrals to hospital EDs. Similar experiences were reported during consultation with well-known national providers of emergency services. The MUTT team of Wraparound Milwaukee established contracts with foster care and group homes in the area. While contracting with the state to provide services to the foster care and group home population could be difficult, there should be a stronger emphasis on diverting these youth from high utilization of EDs for mental health treatment. One strategy for accomplishing this is for EMPS teams to work closely with their regional DCF offices to identify high-risk youth in foster care and group homes and provide crisis assessment services to these youth.

10) Use Paraprofessional Staff/Family Advocates to Assist in Program Implementation

It is recommended that Connecticut utilize paraprofessionals/family representatives in their service delivery model as partners in responding to initial crisis calls and linking families to community-based services.

The MUTT team of Wraparound Milwaukee and the CCORS of King County, Washington utilized paraprofessionals in their service delivery models. For example, in the CCORS model, teams consisted of one mental health professional who was a certified crisis responder (typically a Master's level clinician) paired with a

paraprofessional staff member (typically a qualified community member and/or former parent who had utilized the service). Paraprofessionals worked in partnership with EMPS staff members in responding to the initial crisis call, attending follow-up appointments, and ensuring linkages to community-based treatment resources. The CCORS team reported that they were examining issues related to Medicaid reimbursement for peer support services.

In Connecticut, it is recommended that EMPS collaborate with the FAVOR network of parent advocates to establish a collaborative approach to responding to crises and linking families to community-based services. It is recommended that Connecticut pay paraprofessionals for this work.

11) Ensure Training and Certification of EMPS Staff

It is recommended that Connecticut conduct a series of pre-service and in-service EMPS staff trainings to ensure the acquisition of core clinical competencies. It is recommended that EMPS staff members who complete the required training elements receive certification as Crisis Intervention Specialists in the state of Connecticut.

DCF and EMPS providers consistently recognized a need for enhanced training of EMPS staff to ensure that EMPS staff members possess the necessary range of core clinical competencies for crisis intervention work. Specific recommendations for training modules include:

- Basic foundation in understanding Connecticut's system of care philosophy
- The enhanced model for EMPS services (based on these recommendations)
- Crisis intervention theories, prevention, intervention, and de-escalation techniques
- Child and adolescent mental health, with particular emphasis on the most common EMPS presenting problems of suicidality, oppositional/defiant behavior, depression, and traumatic stress
- Foster care and group home populations
- Child and family assessment
- Clinical decision-making protocols
- Available community mental health services and resources
- Quality Assurance training
- Call center screening, decision-making, and clinical consultation

12) Develop Effective Triage and Assessment Protocols

We recommend that the re-procurement of EMPS include a revised triage and assessment protocol that is used by all providers statewide and collects consistent intake information that informs both immediate crisis intervention needs and recommendations for further treatment.

In addition to providing mobile assessment and crisis response as well as short-term intervention, EMPS providers should serve as consultants to community-based mental health services as they formulate effective long-term treatment plans for youth and their families. Over time, EMPS has gradually shifted to providing longer-term services and supports to youth, and consequently, has developed assessment procedures and treatment plans that focus too heavily on long-term intervention rather than brief intervention and referral.

Four areas of practice in particular would benefit from regular, standardized assessment and documentation. These include initial call triage, mobile assessment, crisis prevention planning, and follow-up services. A full outline of the recommendations for elements of assessment for each of the four areas can be found in Appendix D.

13) Develop and Implement an Effective Quality Assurance Plan

It is recommended that DCF provide individualized feedback to all contracted providers, and facilitate an action planning and continuous quality improvement plan with each provider.

Connecticut DCF and EMPS providers consistently recognize the need for developing an effective quality assurance plan with site-specific feedback. In order for the EMPS model enhancement to be effective, a comprehensive QA plan must be implemented. It is recommended that DCF dedicate a minimum of 10% of the total EMPS budget to development and implementation of a comprehensive QA plan. QA can be conducted either internally by DCF or through an independent organization that responds to a separate RFP to procure these services.

In addition, respondents to the RFP for operating the statewide call center should demonstrate the capacity to collect, analyze, and develop monthly reports on these data. The full set of recommendations can be found in Appendix E. A summary of the recommendations for quality assurance elements appears below.

Data should be collected at the time of the initial call (by the call center staff). These data include, but are not limited to demographic and identifying information of the child and the caregivers, the reason for referral, the disposition of the phone call, and the time at which calls were received and various decisions were made (e.g., time at which the phone call was received, ended, and was dispatched to the appropriate regional EMPS provider). In addition, EMPS providers must track other indicators once calls are dispatched. Information to be tracked by providers includes the time the phone call was received, the time at which contact was made with the referral source, the disposition decision (e.g., information and referral, immediate mobility), and the time at which a mobile assessment team was dispatched and arrived on-site.

Service indicators include, but are not limited to the diagnosis of the child and the services provided (e.g., immediate crisis response and referral only, follow-up services up to four weeks, extended follow-up services for up to six additional weeks), and the type of intervention delivered to children and families.

Outcome indicators include information on the amount of time to mobility, mobility rates, diversion from EDs and juvenile justice, duration of follow-up services, and rates of community-based service linkage (e.g., type of service referrals made, time to referral, time to family engagement, barriers to service linkage).

Individual providers should use program-level data to identify a set of 2-3 key performance indicators to target for continuous quality improvement. Action plans then will be developed that specify the targeted performance indicator, the plan of action for improving performance on that indicator, the time frame for the plan of action, and the expected outcome at the end of the specified time frame. Results of these action plans will be reviewed internally and with key DCF staff, and the degree of success will be determined. If the goals were accomplished sufficiently, a new action plan identifying another set of 2-3 performance indicators will be identified, and the process will be repeated. Finally, feedback between DCF and providers should be bidirectional such that providers are able to seek out consultation with DCF to improve their quality of implementation and adherence to the EMPS model.

14) Utilize a Phased Implementation Approach

It is recommended that Connecticut phase in the implementation of the new enhancement recommendations by first implementing new model requirements in the highest-need areas of the state.

The enhanced model of care for EMPS represents a significant shift from current practice. The redesign of the Massachusetts Emergency Services Program Network made clear that rich data can be gathered as a result of re-procuring one region of the state, and the lessons learned from that experience can be used to implement changes to the statewide service system. Therefore, analysis of past utilization rates for EMPS in the new catchment areas should be conducted and the phased implementation should begin with areas with the highest need. Based on the lessons learned during that implementation process, Connecticut then should move forward with a broader statewide implementation of the enhanced EMPS model.

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Appendix A: EMPS Site Visit Interviews
Questions for Providers

- What are the hours of operation of your program?
- What is your call volume like? What are the high volume times of year and times of day?
- Where are calls coming from? Who is served?
- Triage – how does this happen?
- Describe the assessment protocols in your EMPS program.
- Who makes up your EMPS staff? What are their roles? Are they shared with other programs in your agency?
- Continuity of care – who is involved in the case from intake through stabilization?
- What do staff members do during slower periods? Are staff under-utilized or shifted to other clinic tasks?
- How much training do staff members receive? What is the content of that training?
- What is the nature of your relationship with EDs and inpatient units?
- What is the relationship with law enforcement and schools?
- How does EMPS coordinate follow-up services with community agencies?
- Do you get parent feedback?
- What's working well at EMPS?
- What needs improvement?

Appendix B: Findings from Consultation with National Models

	CCORS	MUTT
Site Name	○ Community Crisis Outreach Services	○ Mobile Urgent Treatment Team, Wraparound Milwaukee
Region served/ Total Population	○ King County, Washington ○ Over 1 million residents	○ Milwaukee County, Wisconsin ○ Over 1 million residents
Call Centers	○ 24/7 crisis phone line ○ Calls routed to region in county where child lives	○ 24/7 crisis phone line ○ Calls routed to region in county where child lives
Hours of Operation/ Mobility	○ 24/7 mobility ○ Overnight crisis staff carry pagers and laptops ○ Overnight "non-emergent" cases receive next-day appointments	○ 24/7 mobility ○ 9am-10pm M-F, 1:30-10pm S-S - full staff availability ○ 10pm-7am – designated staff carry pagers
Staffing	○ 2 staff member response teams – 1 MA level and 1 paraprofessional (former consumer or community member) ○ 1 active and 1 back-up mobile team	○ 2 staff member response teams – 1 MA level and 1 paraprofessional (former consumer or community member) ○ 1 active and 1 back-up mobile team
Diversion from EDs	○ Community outreach and training ○ Relationships and/or contracts with schools, law enforcement, EDs ○ Operates own crisis/respite home (3-14 day stays)	○ Community outreach and training ○ Relationships and/or contracts with schools, law enforcement, EDs ○ Access to crisis/respite beds
Call Volume (6000 calls/year statewide)	○ 600 calls/year ○ After-hours calls increased past 6 months ○ Est. 30% of calls are repeats ○ Infrequent night calls	○ 1100 calls/year ○ Tuesday mornings busiest ○ 10 am and 2-4 pm busier ○ Infrequent night calls
Community Linkage	○ Policy to link youth to community-based provider within 8 weeks ○ Crisis team handles all discharge planning for ED referrals	○ Policy to link youth to community-based provider within 30 days
Mobile Crisis Model	○ Assessment ○ Crisis Intervention ○ Community Linkage ○ Follow-up ○ Petition for extension past 8 wks	○ Assessment ○ Crisis Intervention ○ Community Linkage ○ Follow-up
Training	○ System of care ○ Crisis stabilization	○ 40 hours pre-service training for little or no experience and 20 hours for staff with experience
Quality Assurance	○ Satisfaction surveys	○ Comprehensive initial youth data and tracking

Appendix C: Findings from Site Visits

	UCFS – Norwich	Waterbury	Bridgeport	Wheeler – New Britain
# Staff	○ 5 full, 2 shared with care coordination	○ 4 full-time staff, 1 supervisor, 1 director, 1 shared with care coordination ○ Danbury some split; Torrington all dedicated ○ Some triage positions	○ 5 full-time staff, 1 director, 1 community policing ○ 1 phone screener	○ 5 full-time staff, 1 supervisor ○ 1 FTE service effectiveness coordinator ○ Subcontract Hartford Catholic Charities
Training	○ Initial ○ Job shadowing	○ Orientation ○ Hands-on	○ 6-month initial & bi-weekly clinic-wide training ○ Low turnover, completed 1 on 1 with director	○ Initial and ongoing ○ Variety of mental health and crisis-related topics
Hours of Operation	○ 9-8 Mon - Fri ○ 1-7 Sat - Sun ○ Will go to ER after hours if needed	○ 10-8 Mon - Fri ○ 1-7 Sat – Sun	○ Both crisis line and mobility are 24-7 ○ Clinicians paid slightly more for night mobility	○ 8-8 ○ 2 shifts with 1 team each (8-4, 12-8)
Approximate Call Volume (6000 calls/year statewide)	○ Approximately 600 calls/year ○ After-hours calls increased past 6 mos. ○ Approximately 30% of calls are repeats ○ Infrequent night calls	○ Approximately 1,100 calls/year ○ Tuesday mornings busiest ○ 10 am and 2-4 pm busier ○ Infrequent night calls	○ Approximately 900-1000 calls per year ○ Increase from past years ○ Infrequent night calls	○ Approximately 600-700 calls per year ○ No other discernable pattern in volume ○ Infrequent night calls
Utilization/ Region	○ Eastern CT - Plainfield to Old Lyme (North to South) ○ Urban areas (Norwich) speak 29 languages	○ 43 towns in Waterbury area ○ Subcontracts with Danbury and Torrington	○ Bridgeport accounts for 83% of calls despite 6 town coverage area	○ New Britain – 15 towns from Rocky Hill to Terrytown ○ Hartford & W. Hartford – subcontract ○ Similar volume but NB is a much larger region

	UCFS – Norwich	Waterbury	Bridgeport	Wheeler – New Britain
Triage	○ 10% of parents prefer non-mobile service ○ Off-site call center records phone number and presenting problem	○ Outpatient easiest to refer ○ Much fewer openings for inpatient or higher level services ○ Some parents want respite or to be seen in clinic	○ Therapist who takes call typically goes mobile ○ Some parents want respite or to be seen in clinic	○ All calls are routed to staff from call center in same building ○ 92% mobile – the New Britain service does not see clients on-site
ED relationship	○ Strong with one of the two local hospitals	○ All sites have MOU's with area hospitals	○ No current contracts ○ Relationship with 2 local hospitals are good, but no psychiatric unit – cases sometimes transferred out of Bridgeport area	○ Each site has MOU ○ Hospitals defer to EMPS for case recommendations
Other relationships	○ Liaison in every school ○ Strong with area DCF office & community agencies	○ Very good relationship and MOU's with all EDs ○ Strong school relationships	○ EMPS & care coordination staff work closely together – this seems to help discharge and referral	○ Consistent turnover in school, police, EDs, etc. ○ Makes it difficult to maintain consistent relationships ○ Good relationship with area DCF office
Parent feedback	○ Generally positive ○ Any negative feedback used to improve program	○ Generally positive ○ Parents report on occasion only wanting Information & Referral (I&R), respite care, (especially foster parent), or to be seen in clinic	○ Generally positive feedback	○ Generally positive feedback

	UCFS – Norwich	Waterbury	Bridgeport	Wheeler – New Britain
What works well at your site?	○ Community needs are priority over agency needs ○ A good program should "not just serve as a feeder into outpatient" but keep kids in community with a long-term plan	○ Mobility ○ Quality of care	○ Responsiveness (within 30-minute window) ○ Low staff turnover ○ Cohesive team atmosphere and collaboration ○ Local call center	○ Local call center – staff in building & immediately transfer to crisis staff ○ Mobility ○ Relationship with local hospital ○ Training ○ Collaboration with other EMPS providers
What needs improvement? (Consistent provider feedback across sites)	○ Clarification of statewide model – (e.g., what are the specific and concrete goals for each provider?) ○ Providers across the state have different definitions of crisis and thresholds for risk ○ Need consistent definition of data (e.g., "call") ○ Data does not track case management, length of call, or follow-up sessions ○ Core competency and hands-on training ○ Individualized feedback on data from DCF and how each site is doing ○ DCF no longer collects satisfaction survey data, so not all sites consistently collect this data ○ Some hospitals won't admit high-risk, high-need cases (homicidal, fire setting) ○ Availability of other services in the community ○ Formal complaint process for parents directly to providers ○ 24-hour crisis stabilization beds			

Appendix D: Recommendations for Assessment and Triage

Initial Call Triage

- Document type of call
  - Information & Referral (I&R)
  - Request for other services, such as respite care
  - Crisis – mobile
  - Crisis – non-mobile
- Name, age, phone number
- Presenting problem
- Lethality of crisis (assess degree of intention to harm self or others)

Mobile Assessment

- Time to assessment
- Length of assessment
- Nature of crisis
- Mental status
  - Physical, psychomotor, affect, mood, hygiene, grooming, relatedness, speech, intelligence level, insight, judgment
  - Suicidal ideation
  - Self-injurious behavior
  - Homicidal ideation
  - Hallucinations
- Problem areas
  - Relational (family, friends)
  - Physical (eating, sleeping, medications)
  - Educational
  - Trauma
  - Abuse/neglect
- Symptom correlates
  - Problem behaviors
  - Antecedents and consequences of problem behaviors
  - Environmental triggers
  - Family and social supports
  - Youth strengths
- Current and past treatment, including collateral providers
  - Medications
  - Medical history
  - Educational history
  - Family current and past treatment
- Family supports and family needs, including parenting

Crisis Plan

- Immediate safety plan
  - Identify goals, interventions, and verbal contracts, if necessary
  - Include assessment of family ability to implement safety plan

- Short-term crisis plan
    - Identify problem areas, crisis intervention goals, and individuals responsible for achieving goals
    - Identify youth and family coping strategies
    - Include family or other supports in crisis plan
- Recommended long-term service needs
    - Immediately begin discharge planning
    - Assess both youth service needs and service availability
    - Document estimated time to discharge and linkage with community services

Follow-up

- Ensure immediate service needs are met
- Monitor crisis intervention goals during follow-up and adjust as needed until discharge from EMPS
- Focus treatment on immediate service needs and issues related to transfer to likely referral site
- Document all recommended services, available services, and attempts to link youth with recommended services

Appendix E: Recommendations for Quality Assurance

Referral Information
To be collected by call center staff during initial call

- Demographic and identifying information (e.g., age, gender, race/ethnicity of the child, referral source)
- Family socio-demographic information (e.g., age, gender, race/ethnicity of caregivers, address, family composition, socio-economic indicators)
- Reason for referral (e.g., oppositional behavior, suicidal/homicidal ideation, depression)
- Disposition of phone call
    - Screened out (inappropriate call)
    - Provided information and referral only
    - Sought expert consultation
    - Dispatched to regional EMPS provider
- Time phone call was received, time phone call ended, time at which the phone call was dispatched to regional provider (if applicable)

These indicators will allow the call center to report monthly on quality assurance information at an aggregate and site-specific level, including:

- Total number of calls received (monthly) and duration of phone calls
- Volume of calls dispatched to each region
- Volume of calls received at various time intervals throughout the day (e.g., 8-10am, 3-5pm,etc.)
- Referral sources
- Frequency of various presenting issues
- Frequency of various dispositions

Referral Information
To be collected by EMPS providers during initial referral and first visits

- Time phone call was received
- Time contact was made with referral source
- Disposition decision
    - Information and referral
    - Immediate mobile response
- Time of mobile response (when applicable) and time at which mobile assessment team arrived on-site

These indicators will allow site-specific information to be reported including:

- Time elapsed from initial referral to EMPS follow-up call
- Mobility rates

- Time to mobile response.

Service Indicators

- Diagnosis of child
- Services provided
    - Immediate crisis response and referral
    - Follow-up services (up to four week limit)
    - Extended follow-up services (up to six additional weeks, with DCF/BHP authorization)
- Type of intervention employed
    - Case management
    - Individual therapy
    - Family therapy

Outcome Indicators

- Time to mobility and mobility rates
- ED and juvenile justice diversion
- Duration of follow-up services (e.g., number of visits)
- Community-based service linkage (type of service, time to linkage, barriers to service linkage)

Additional quality assurance elements should be collected that would form the basis of program-specific action planning and continuous quality improvement. Recommendations for additional indicators include:

- Staff training activities
- Outreach activities to community agencies (e.g., emergency departments, schools, law enforcement, foster and group homes)
- Number of MOUs developed with other community providers
- Intake and decision-making protocols developed
- Child and family satisfaction measure that is collected from all consumers within 30 days of termination of the case