

# Evaluating a START Program's Role in Diverting Emergency Service Utilization

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NYSTART Region 5 has been in operation since 2017, supporting 469 individuals since that time. All members of the region 5 team are trained by the National CSS for fidelity to the model. The mission of the START model is to improve the lives of individuals with intellectual/developmental disabilities and behavioral health needs and their families through fidelity to the START model with exemplary services and supports that emphasize local, person-centered, positive, multidisciplinary, cost-effective and evidence-informed practices.

START Coordinators use a systemic approach to support the current system of support build their capacity in managing the triggers and vulnerabilities of an individual. The START team does not replace any member of the team, rather it provides a consultative support. Through a Cross-Systems Crisis Prevention and Intervention Plan (CSCPIP), clinical trainings, referrals/linkages, in-home therapeutic coaching, resource center admissions and systems meetings, the START team hopes to build the capacity of those supporting the individual to increase their stability.

Of the 469 cases START region 5 has supported, 74% of them are diagnosed with autism spectrum disorder, 72% of them live with family in the community, and 82% indicate aggression as a presenting problem. In reviewing the 469 cases that START Region 5 has supported, START has impacted a significant decrease in emergency service usage. In looking at adult individuals (77% of enrollees), 96 individuals had psychiatric hospitalizations prior to START enrollment, while only 48 individuals did post enrollment. For Psychiatric emergency rooms visits, 152 individuals had visits prior to enrollment, while only 96 individuals had visits post-enrollment.

The services START provides focus not only on the individual, but on the system as a whole, in building their capacity to support the individual, doing training, education, use of the cross-systems crisis prevention and intervention plan (CSCPIP), as well as opportunities for medical and clinical consultation with the Medical Director and Clinical Director. Another important aspect of the START program is our 24/7 crisis line, which is available to enrolled individuals from the moment of intake. For the year 2021 through February 2022, there were 774 crisis calls, of those calls, settings were maintained for 616 of them, which means they did not require any change in setting, including an ER visit or psychiatric hospitalization.

## Case Review: Bill

At the time of referral to START services, Bill was living in an ICF supported by an agency that was struggling to meet his needs. In the two weeks that Bill lived in the ICF, he had attempted to jump out of his 3rd story window. Bill was brought to a local hospital, where he would remain until the agency could find alternative placement. Initial referral described Bill as exhibiting "breakthrough psychotic symptoms" and "full blown psychosis", often blurring the boundaries between fantasy and reality. It was evident that diagnostic clarity was needed, however historical documentation was limited. Bill was being defined by his current presentation at the ICF which was also noted at the time to include physical aggression, property destruction, verbal aggression and threats, homicidal threats and gestures, as well as suicidal ideations and gestures. It was noted at the time of referral that Bill also struggled with impulsivity, frustration tolerance, and "intermittent explosive outbursts". Additionally, incident reports from his residential providers include bouts of aggression, elopement, and disrobing in public.

Conceptualizing Bill's case in terms of the biopsychosocial model was paramount in understanding who he was as a person, and why he was functioning in the manner. It is START's philosophy that when an individual is understood in terms of their underlying vulnerabilities that make them more susceptible to entering into crisis, the root cause of crisis can be addressed more readily. Subsequently, when an individual is understood in terms of their vulnerabilities and triggers, it typically promotes a treatment approach more rooted in compassion and understanding. It was clear that up to this point, Bill was not being humanized by his circle of support.

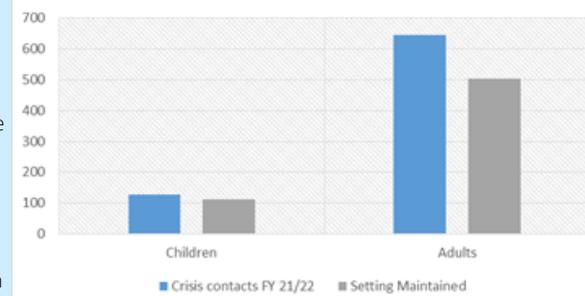
Bill was struck by a car in 2008 which left him in a coma for two months, and resulted in a traumatic brain injury and trauma to his lower extremities, rendering him unable to walk independently. He was first hospitalized psychiatrically in 2011 and then again in 2012 due to depressive symptomology and a lack of appropriate coping skills. Raised by his grandmother, Bill was placed in the care of Department of Social Services due to his grandmother's inability to support his needs with the level of aggression and self-injurious behavior he exhibited in the home. In 2013, he was placed in a Children's Residential Facility, where he remained until 2017 when he aged out.

It was evident upon initial assessment that Bill's poor impulse control was potentially related to larger issues that were not adequately being addressed, as his ADHD symptomology appears to have exacerbated after his accident. Executive functioning deficits related to TBI also significantly impaired Bill in such a way that was not being identified by the service providers. Diagnoses secondary to his TBI included tremors, a significant personality change, and emergence of bipolar and related disorders. It was identified that trauma also played a significant role in Bill's presentation, as PTSD, Mood Disorder Psychosis, and major Depressive Disorder were all previously noted on evaluations. The team identified that Bill struggled with abandonment related to being uprooted from his grandmother, as feelings of rejection from various residential teams whom could not support him were always met with grave disappointment. Another major aspect of Bill's presentation included struggles with gender identity, and preoccupation with finding a sexual partner, which oftentimes was projected onto staff and hospital providers. Bill was known to make false allegations against staff in hospitals or family that they are presently abusing him in an effort to get needs met. This could be understood in the context of his unmet wishes for love and intimate contact, which is understandable for a young man with intact socialization skills whom was restricted to the confines of a hospital bed. While hospitalized, NYSTART helped facilitate an IBR psychiatric and neuropsychological evaluation at Clinic for Bill in order to gain a clearer picture of his diagnostic profile and current presentation. This evaluation helped pave the way for future providers and a hopeful successful placement post discharge.

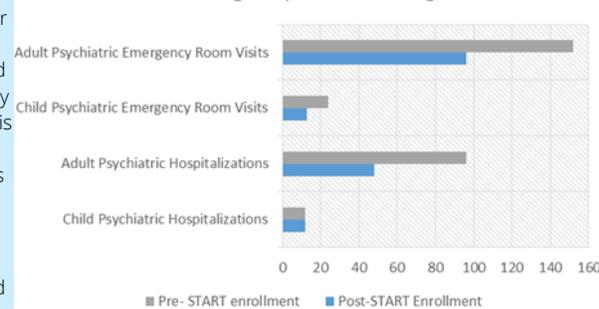
NYSTART Therapeutic Coaches and Coordinators provided in-person outreach to the hospital multiple times per week, including weekends, in order to help increase PERMA and aid the hospital in reframing Bill's behavioral health challenges. Outreach was geared towards providing Bill with meaningful, positive engagement while he remained confined to a room on a medical floor for over 6 months, awaiting alternate placement within OPWDD. Coaches and Coordinators were able to uncover Bill's strengths, skills, and interests by providing therapeutic intervention, including bringing journals and drawing materials to engage him. On one particular visit, the nursing manager of the unit had showed the NYSTART team the "iPhone" they creatively rendered and made out of cardboard to engage in imaginary play while Bill was confined to his medical bed. Having a phone and social engagement and interaction was something identified to be of incredible importance to Bill, and the hospital staff were able to tap into that to help increase his sense of enjoyment.

A Cross Systems Crisis Plan was developed by the Coordinator, which helped centralize Bill's needs as well as provide a consistent approach to responding to him when he enters into crisis. Every hospital and residential system in direct contact with Bill was trained on the plan during his stay with them. Once the system supporting Bill was able to understand his diagnoses and underlying vulnerabilities more accurately, it was shown they were able to address him with more compassion and with a more clinically driven and appropriate approach. Since entering OPWDD as an adult, Bill has lived in three various unsuccessful placements supported by two different agencies before he was screened by Family Residences for a permanent placement, where he remains currently. Over the course of Bill's time enrolled in NYSTART beginning in 2018, his system engaged emergency services including contacting NYSTART crisis line, calling 911, or accessing local emergency rooms in response to his behavioral health symptoms over 37 times. During that time, collectively, he spent over 365 days residing in a hospital setting. At the current time, Bill has settled into his new residence and has stabilized significantly, with no emergency service utilization warranted since 2020. With the support of NYSTART, Bill's system is able to successfully support him within his residence, which has been his longest permanent placement since exiting children's residential placement. Bill is able to better manage his emotions, as well as engage in his day to day in more meaningful and positive ways. Bill is now able to pursue positive relationships with staff and peers, something he could not do previously while chronically accessing emergency services. This newfound level of stability has exponentially increased Bill's quality of life, which will hopefully lay the foundation for a more independent and healthy future for him for years to come.

### Crisis Contacts/Setting Maintained



### Emergency Service Usage



### Total Days Bill had contact with Emergency Services

