Sequential Intercept Model Mapping Report for Potter and Randall Counties

SAMHSA's GAINS Center Policy Research Associates, Inc.

Sequential Intercept Model Mapping Report for Potter and Randall Counties

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ACKNOWLEDGEMENTS

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RECOMMENDED CITATION

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CONTENTS

Background

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

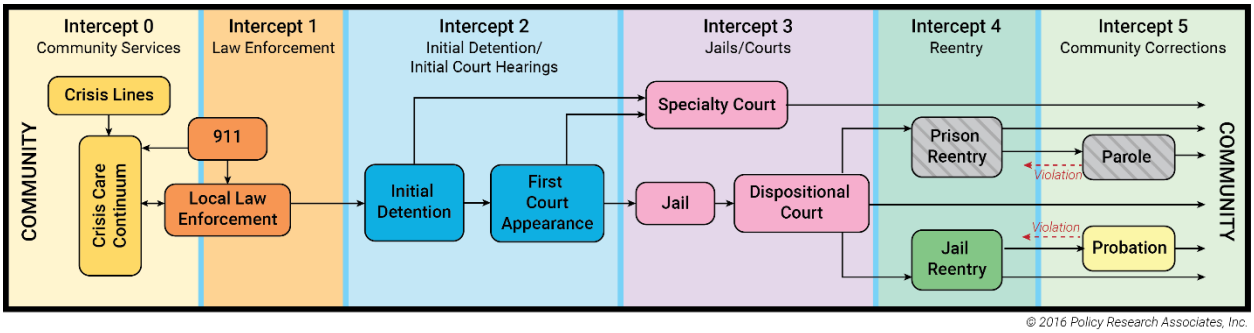
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

AGENDA

SAMHSA's GAINS CENTER

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Sequential Intercept Mapping Workshop

Potter-Randall Counties, TX

May 1, 2019

AGENDA

8:00 **Registration and Networking**

8:30 **Openings**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review
- Setting the Stage for Day 2

4:30 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

SAMHSA's GAINS CENTER

SAMHSA

Sequential Intercept Mapping Workshop

Potter-Randall Counties, TX

May 2, 2019

AGENDA

8:00 **Registration and Networking**

8:30 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

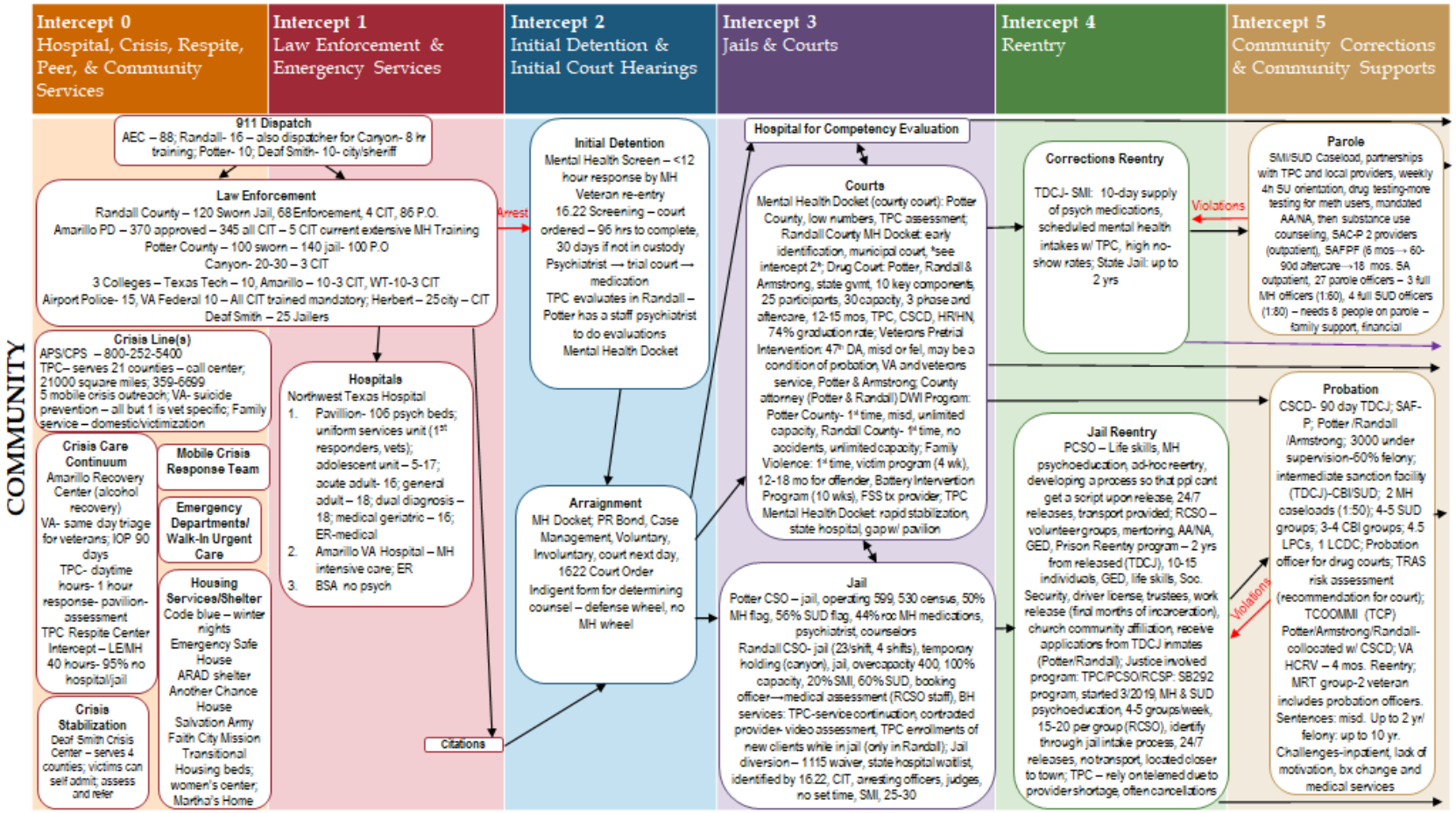
Next Steps

Summary and Closing

12:00 **Adjourn**

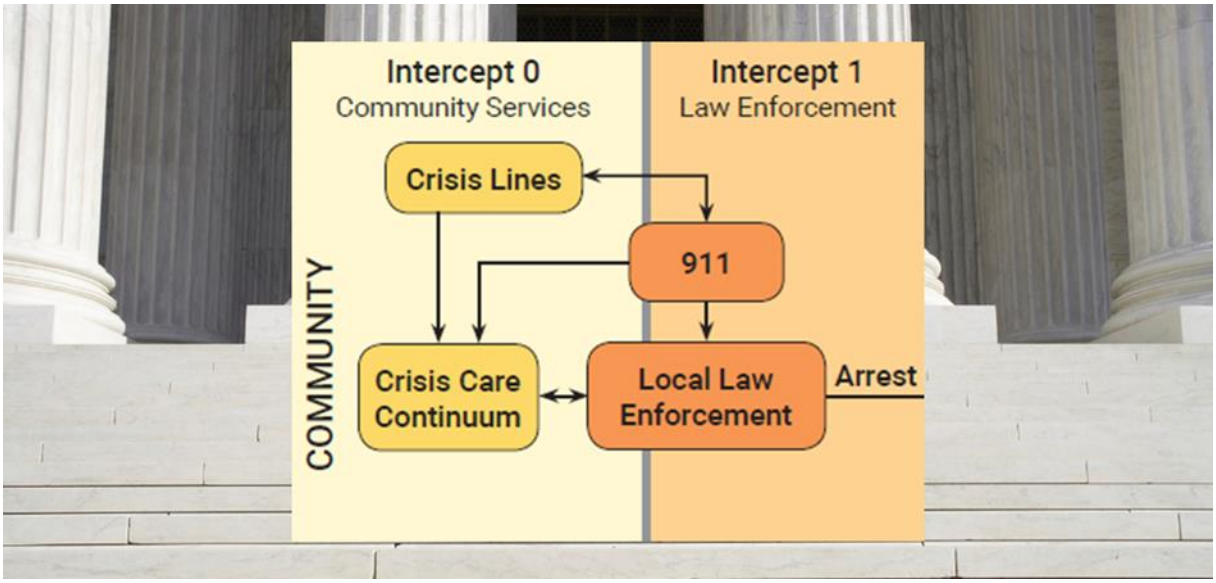
There will be a 15 minute break mid-morning.

Sequential Intercept Model Map for Potter and Randall Counties



Resources and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the workshop participants to identify resources and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the resources and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing resources.



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

Crisis Lines

- Texas Panhandle Centers serves 21 counties and operates a call center that covers 21,000 square miles. They also offer five mobile crisis outreach team members and can be reached at 806-359-6699. Texas Panhandle Centers provides telehealth at nine local jails and in eight hospital emergency departments.
    - Crisis hotline: 806-359-6699 or 800-692-4039

- The Pavilion at Northwest Texas Healthcare System is a psychiatric hospital which operates a crisis line.
    - Phone: 806-354-1810 (Ext. 3) or 800-537-2585

- Adult Protective Services and Child Protective Services provides crisis response for assistance with shelter and food.
    - Phone: 800-252-5400

- U.S. Department of Veterans Affairs offers a suicide prevention line that is available to the general public through an extension of the National Suicide Prevention Hotline.
    - Phone: 800-273-8255 (Ext. 1)

Crisis Care Continuum

- Deaf Smith Crisis Center serves victims of domestic assault and sexual abuse in four counties. Victims can self-admit and are assessed and referred out.
    - Phone: 806-363-6727

- Texas Panhandle Centers offers behavioral and developmental health services to include outpatient behavioral health, a mobile crisis outreach team, psychiatric services, respite and recovery, homeless services, jail diversion services, rapid crisis stabilization, veterans services, substance abuse services, and peer support.

Hospitals with Psychiatric Services

- The Pavilion at Northwest Texas Healthcare System operates 106 psychiatric beds, a uniform services unit designed for first responders, an adolescent unit for 15-17 year olds, 16 acute adult beds, 18 general adult beds, 18 dual diagnosis beds, and 16 medical geriatric beds. The average length of stay is five days for inpatient mental health.

- Amarillo Veterans Hospital provides mental health intensive care and an emergency room.

- The nearest State Hospital is in Wichita Falls. The hospital has a growing proportion of forensic beds and no dedicated beds for Randall or Potter counties. There is also a significant wait time to access services.

Community Resources

- Yellow City Community Outreach has 30 volunteers and provides housing support and offers Narcotics Anonymous and Alcoholic Anonymous meetings.

- Another Chance House provides 57 beds with a significant proportion that are veteran specific. It offers dormitory style living for 60-90 days with private rooms and then transition to a house.

- Code Blue is a winter nights seasonal emergency shelter

- Panhandle Behavioral Health Alliance (PBHA) provides supports systems change for improving services and outcomes by looking at culture, policies and practices. They do not provide direct services. Focus areas are access and alignment, prevention and early intervention and workforce recruitment and retention.

- There is a pilot program working with veterans that provides Uber services utilizing veteran drivers to pick up individuals from jail to transport from release and provide assistance with picking up medications and getting to appointments.

- Workforce Development helps connect people with employment services and supports access to temporary assistance.

- Community Development is the housing authority. They are the lead COC agency in Amarillo and started a Housing First pilot in November 2018 that serves 32 households. They also have 1500 housing choice vouchers.

- ARAD/Cenikor Foundation assist in providing placements for the homeless population and coordinate with chemical dependence providers.

- National Association for the Mentally Ill (NAMI) works to educate family members of individuals struggling with mental health issues. They offer weekly support groups and provide education with In Our Own Voice presentations.

- AGAPE provides peer support services, social support training and partners with TPC.

Dispatch/911

- There are four dispatch centers that cover Potter and Randall Counties: the Amarillo Emergency Center (88 dispatchers), Randall County (16 dispatchers), Potter County (10

dispatchers), and Deaf Smith County (10 dispatchers). Dispatchers attend an 8 hour mental health training.

Law Enforcement

- Randall County Sheriff's Office has 120 sworn corrections officers and 68 in enforcement. Four of those officers are identified as CIT officers and 86 are certified peace officers.

- Potter County Sheriff's Office has 100 sworn enforcement officers and 140 corrections officers.

- Amarillo Police Department is the largest law enforcement agency in the region with 370 approved positions. Current staffing is at 345 officers. All officers are CIT-trained but five officers comprise a CIT unit.

- Canyon Police Department has 20-30 officers, with three trained in CIT.

- The Veterans Administration has 10 officers, all of whom have received CIT training.

- Texas statute provides a Peace Officer Certification which is a 40 hour training. In addition the 40 hour CIT training is offered as well as an 8 hour CIT refresher that is offered every 4 years. SB 1849 (commonly referred to as The Sandra Bland Act) impacts jail standards and timelines related to an individual identified with a mental illness or an intellectual disability which impacts officer response pre and post arrest.

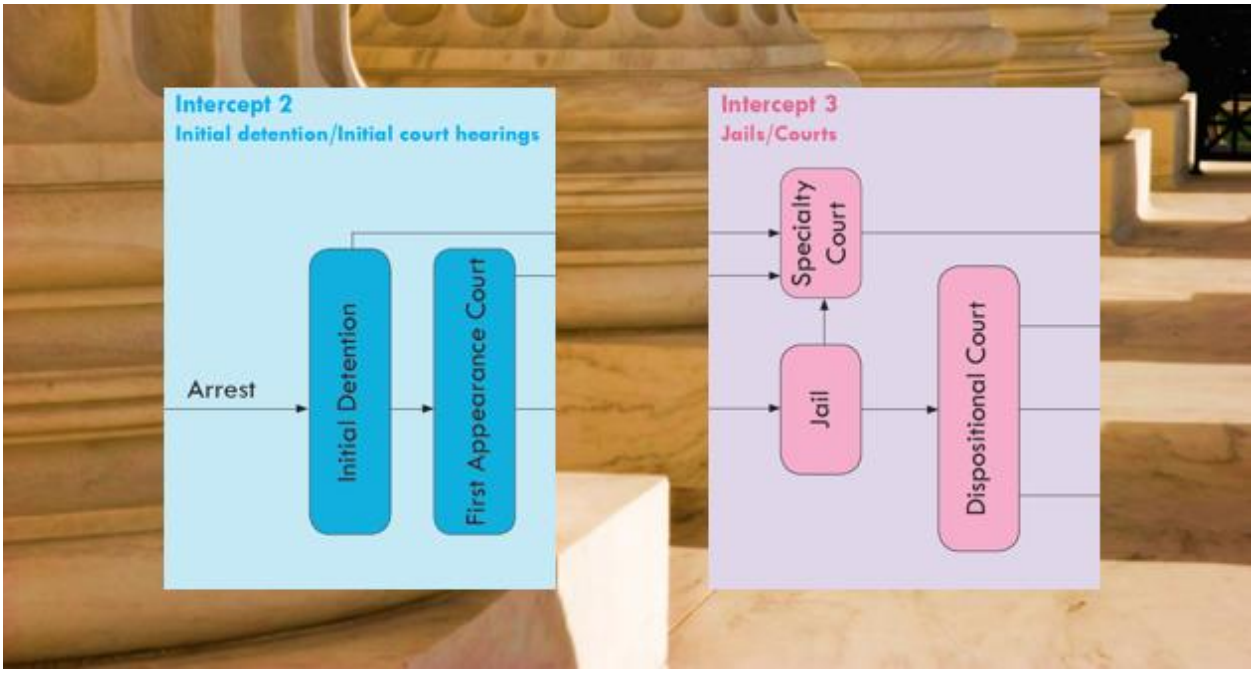
GAPS

- State-mandated Mental Health Peace Officer training and CIT trainings have redundant content.

- Officers must transport to Pavilion for assessment and remain for the duration.

- Officers who transport to one hospital may have to then transport again to the Pavilion for another assessment.

- Officers may transport to an emergency department for medical clearance before they bring an individual experiencing a mental health crisis to Pavilion. The wait for medical clearance is a long time.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

Arrest to Initial Detention

- A mental health screening is completed by jail staff. A positive screen for mental healthrisk requires that the magistrate is notified within 12 hours. Magistrations occur daily in the jail where hearings occur in the morning and afternoons. A Continuity of Care Query (CCQ) search is then completed to determine of the defendant has ever been served by the Texas public mental health system.

- Texas Code of Criminal Procedure article 16.22 details a procedure in which early identification of individuals with possible mental illness or intellectual disability can occur at the earliest stages of arrest, booking, and when identified by the magistrate. A collection of information can be ordered by the magistrate to a qualified mental health professional. If the defendant has been arrested within the previous 12 months this step is not required if it has already been completed, if not then the magistrate will order a mental health assessment to be completed. The completed report is due to the magistrate within 96 hours if the defendant is still in custody and within 30 days if the defendant was released on bond. Detainees can post bonds for misdemeanor charges prior to being arraigned.

- Texas Panhandle Centers completes 16.22 court-ordered evaluations in Randall County (approximately 6 per week).

- Potter County employs a staff psychiatrist to complete the 16.22 court-ordered evaluation.

- Currently there are 14 individuals in custody for competency restoration in Potter and Randall County and there are a total of 18 individuals from the top 21 counties also served by Texas Panhandle Centers on the statewide list. There are approximately 460 total individuals on the statewide maximum security state hospital waitlist.

- When an officers makes a class c misdemeanor on-view arrest in the city limits of Amarillo that person is seen by the Amarillo Municipal court in Randall County. If it is a higher misdemeanor charge a sheriff's bond may be issued or it may go to the magistrate who can issue a bond through the County Court. If it is a felony an indictment or additional information is provided to the District Court. If the person is picked up on a misdemeanor warrant a bond can be issued at the time of booking.

Initial Court Hearing

- The Municipal Courts of Amarillo can place an individual on the mental health docket program utilizing information gathered from the initial mental health screening completed in booking or a 16.22 court order. Texas Panhandle Centers has case managers available at these arraignments. An individual can then get a personal recognizance bond in which they are required to attend court the next day with a mental health case manager. Individuals are offered mental health and case management services on an outpatient basis with Texas Panhandle Centers. Individuals who have a mental illness and participate in services with Texas Panhandle Centers can get credit towards their fines if agreed by the Municipal Judge.

Courts

- Mental Health Court. Potter and Randall County both operate a mental health court. Both programs use the Texas Panhandle Centers for the assessment, supported through

a two-year grant through Texas HHSC. The goal is rapid stabilization. In Randall County the focus is on early identification and follows 16.22.

- Drug Court. Potter, Randall, and Armstrong counties operate a drug court supported by a state grant. It has 25 participants enrolled with a 30-person capacity. It consists of 3 phases and aftercare with an average length of stay of 12-15 months. The program has a 74% graduation rate.

- Veterans Pretrial Intervention. Potter and Armstrong counties operate a pretrial intervention for veterans arrested for misdemeanor or felony offenses. The program is a collaboration between Veterans Services, the U.S. Department of Veterans Affairs, and the Probation Department.

- County Attorney DWI Program. The Potter and Randall county attorneys' offices operate DWI programs. The programs are for first time offenders and have an unlimited capacity. The Potter County program serves misdemeanors. The Randall County program excludes individuals involved in traffic accidents associated with the DWI offense.

- Family Violence Court. The court program serves first-time offenders. The victim component runs for four weeks. The offender program runs for 12-18 months. A batterer intervention component runs for 10 weeks.

Jail

- The Potter County Jail has 160 sworn staff and 40 support staff. Operating capacity is 599 and current census is 530. Half of the population is flagged for mental health and 56% are flagged for substance used disorders. Forty-four percent of the population are on mental health medications.

- The Randall County Jail has 23 staff per shift and operates four shifts. A facility in Canyon is used for temporary holding of inmates. The primary facility's operating capacity is 400 and they are currently at 100% capacity.
    - 20% of the population has mental health concerns
    - 60% have substance use concerns.

The booking officer completes a screening and trained CIT officers do a mental health assessment. Texas Panhandle Centers completes all court ordered 16.22 evaluations. The jail staff complete a medical assessment. Behavioral health services are provided by TPC under three different grants and programs, Jail Diversion, Mental Health Docket, and the Justice Involved Co-Occurring Psychiatric and Substance Use Disorder (COPSD) Program. Randall County also contracts with a psychiatrist for their forensic evaluations and other prescribers for mental health medication management services.

- Jail diversion occurs under the 1115 waiver for individuals up to a third degree felony charges and the state hospital waitlist. These individuals are identified by 16.22, CIT, and feedback from the arresting officer and judges. People coming out of the state hospital regularly decompensate and come back into contact with the justice system. It can take up to 15 months to get into the state hospital for an individual who is on the maximum security waitlist. If the waiting time for the state hospital is less than the maximum sentence, then the inmate can be released.

GAPS

- Article 16.22. A major gap relates to the interpretation of Article 16.22 and the lack of a standard process across the counties for the implementation of the Sandra Bland Act. Implementation of Article 16.22 is also an unfunded state mandate. Not everyone knows about services and there is a lack of communication on procedures (i.e., what can and cannot be done).

- Competency restoration waitlist is currently at 18 defendants. There is no single point of contact for who places a defendant on the competency waitlist in each county. Most of these cases wait in the jail for competency restoration. Additionally, defendants can only be held up to 90 days for misdemeanor charges and 2 years for felonies.

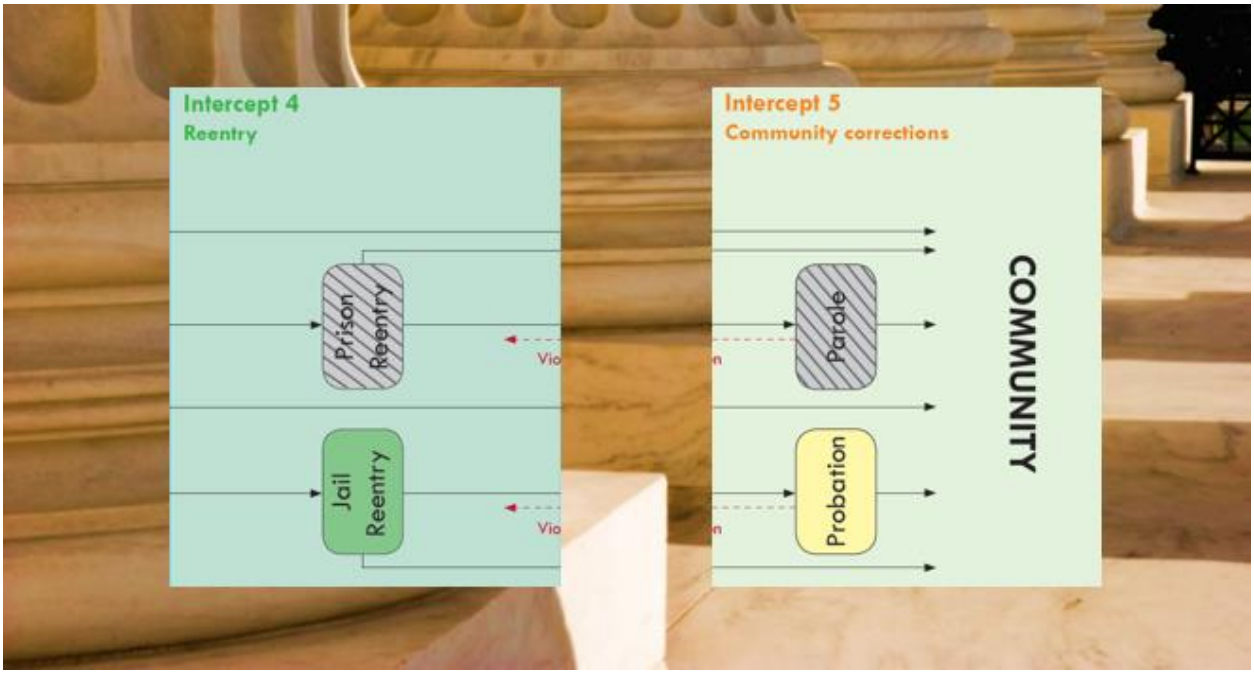
- Defense attorneys do not receive any of the mental health screening information mandated by 16.22 even though this information is shared with other parties.

- Defense counsel for indigent defendants is not provided by a mental health wheel. There have been discussions about establishing a mental health wheel among private practice defense attorneys for those defendants.

- Protected health information: Jail mental health evaluations are classified differently in Randall County (protected medical) as opposed to Potter Counties (not protected).

- Shared offenders: Due to the layout of the counties, with the city of Amarillo situated along the county line, people routinely have cases in Randall and Potter counties. These cases are in the same court system but cannot be consolidated.

- Treatment Courts in Potter County. The Mental Health treatment program is underutilized, lacks consistency on who qualifies, and has a shortage of case managers. Potter County does not have a DUI Court and also does not have a Family Treatment Court.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

Prison

- The Texas Department of Criminal Justice (TDCJ) releases inmates with severe mental illnesses with a 10-day supply of psychiatric medications. TDCJ schedules mental health intakes with TPC but there is a high rate of no-show appointments. TDCJ has a reentry program for inmates with SPMI that are two years from release. The program can serve 10-15 individuals and focus on life skills, GED, social security, obtaining a driver's license, church/community affiliation, and work release.

Jail Reentry

- Texas Panhandle Centers works with the both jails to coordinate releases on current clients and to match inmates to families. TPC along with Randall and Potter counties operate a Justice-Involved Program that started in March 2019. The program is supported through SB292 program that provides psychoeducation for mental and substance use disorders. The program offers 4-5 groups a week with 15-20 inmates per group. Inmates are identified for participation through the jail intake process and through screening inmate requests. *This program no longer exists in Potter County, but continues in Randall County.*

- Potter County Jail offers life skills classes, mental health psychoeducation, and is developing a process so people can obtain the necessary prescription(s) upon release. The jail releases inmates on a 24/7 basis and provides transportation to released individuals.

- Randall County Jail offers groups run by volunteers, mentoring, AA/NA groups, and GED classes. The jail releases inmates 24/7 but do not provide transportation at release as they are located closer to town.

Parole

- Texas Department of Criminal Justice – Parole Division. There are 27 parole officers that include 3 full time mental health officers with a caseload of 1:60 and 4 full time substance use-specialized officers with a caseload of 1:80. The agency has partnerships with Texas Panhandle Center and local providers to deliver a weekly 4-hour substance use orientation class and drug testing. More frequent testing is required for methamphetamine users. That have mandated AA/NA meetings and then substance counseling. The TDCJ Parole Division has a Substance Abuse Counseling Program operated by two outpatient providers and parolees may be sent to a Substance Abuse Felony Punishment Facility for 6 months followed by 60-90 days of aftercare.

Probation

- Community Supervision and Corrections Department of the 47th Judicial District Adult Probation supervises 3,500 individuals in Randall, Potter, and Armstrong counties. A majority are under supervision for felony offenses. The department has 55 probation officers, 10 support staff, and 5.5 counselors. Individuals convicted of misdemeanor offenses can be supervised for up to 2 years and individuals with felony offenses for up to 10 years. The department has two mental health probation officers who carry a caseload of 1:50. The department offers 4-5 substance use groups, 3-4 cognitive behavioral intervention groups, and 3-4 domestic violence groups.

GAPS

- Medications at release. Inmates do not receive medications upon release, but a policy to permit release with medications or a prescription is being worked on by stakeholders.

  Unscheduled releases. Most of the releases from the jails in Potter and Randall counties are unscheduled. This reduces the potential for any reentry planning to succeed, since

warm hand-offs to providers and medications or prescriptions at release (once the policy is instituted) are frustrated when inmates are released unannounced during all hours of the day. To facilitate reentry and linkage to services, individuals should be released at scheduled times during business hours. Providers should have foreknowledge of expected released dates.

- Family support. Many individuals with mental and/or substance use disorders involved with the justice system lack family support.

Priorities for Change

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place on May 2, 2019. The top priorities are highlighted in bold text.

Rank	Priority	Votes
1	Coordinating group for mental health/criminal justice. • Establish a strategy/philosophy across jurisdictions and agencies to address justice-involved individuals with mental and substance use disorders.	23
2	Crisis diversion center (with sobering unit).	20
3	Improved information sharing on individual clients shared among providers and criminal justice agencies	19
4	Strategy to recruit and retain direct service providers and physicians/prescribers.	11
5	Community education on mental health and substance abuse.	10
6	Improve trauma-informed care practices.	8
7	Reduce the time that officer spend waiting for individuals to receive assessments at hospitals (voluntary and involuntary).	8
8	Develop capacity for co-occurring inpatient services.	6
9	Resource directory of services in the area.	5
10	Improve notification process to defense bar when a defendant flags for mental health at booking.	4

Rank	Priority	Votes
11	Early identification of people need mental health and substance use services.	3
12	Revised legislation to align mental health peace officer and CIT requirements.	2
13	More post-crisis follow-up work to help people get engaged in services.	0
14	Resource coordinator	0

Action Plans

PRIORITY 1:
COORDINATION OF SUBSTANCE USE/MENTAL HEALTH COURT INTERACTIONS

Objective	Action Step	Who	When

1. Open minded membership and creation of direction	• Invitation
	  • Probation
	  • Prosecutors
	  • Defense
	  • City PRPC
	  • Judicial
	  • Treatment – TPC, VA
	  • Law Enforcement
		• District Attorneys from Deaf Smith, Randall, and Potter counties	• May 31, 2019
			• Send out invites

2. Philosophy/Focus: Expansion to Panhandle Region	• Public safety community integration unified for counties
	  • MH/SA
	  • General public
	  • Amarillo
		• Membership group	• First quarter

3. Funding	• Grant writers (City, PRPC)	• Membership group	• Within six months of court possibilities
4. Research	• Site visits • Accountability Courts (GA) • Legal/Community/Funding • Best practices • Create uniformity	• Members	• Ongoing

PRIORITY 2:
CRISIS DIVERSION CENTER

Objective	Action Step	Who	When
1. Sobering unit vs. crisis unit	• Research existing facilities	• Justice League	• 6 months
	• Demand data	• Law enforcement agencies	• 30 days
	• Civil/criminal issues	• Attorneys	• 90 days
	• Funding	• PBHA • Local government • Hospital district	• End of year
	• Case management	• United Way/PBHA referrals	• End of year
	• Location	• Justice League	• End of year

PRIORITY 3:
IMPROVED INFORMATION SHARING (WITH TIE-INS TO #9 AND #14)

Objective	Action Step	Who	When
1. Share communication across all agencies	• Create uniform release of information	• Law enforcement, Criminal justice agencies, Social services, Shelters, Treatment providers, TUFS	• 90 days
2. Create steering committee	• Informational meeting • Invite agencies to collaborate	• See above	
3. Create a system where all agencies can share information regarding all offenders/clients	• Develop MOU among all agencies		
	• Funding	• PBHA • Local government • Hospital district	• End of year
	• Case management	• United Way/PBHA referrals	• End of year
	• Location	• Justice League	• End of year

PRIORITY 4:
RECRUIT AND RETAIN PROVIDERS

Objective	Action Step	Who	When
1. Create a shared job shadowing or educational experience amongst mental health providers.	• Invite community providers to develop a joint job shadow/education experience • Invite educational institutions	• Pavilion, TPC, PCSO, FSS, APD, RCSO, Legal offices, Shelters, Emergency services, HR • Pro, AC, WTAMU, Tech, Frank Phillips, Clarendon, AISD, CISD, RRISD, HPISD, BISD	• Summer – End of June 2019 • By end of May 2019
2. Mental health professional opportunities	• Mental health job fair – AACAL, AC, WT • Shared booth at other job fairs	• Health professionals • AHEC (Panhandle Area Education Center)	• October – Amarillo job fair
3. Self-care	• Peer support certifications • Joint trauma informed training • Team building among partnering providers • Conduct employee satisfaction surveys • Stay interviews		• Quarterly • Color Run (06/08/19) • Mental Health Walk (October 2019) • Biannually
Goals and measures: Reduced wait times for patients, reduced turnover, increased number of interns, increased job opportunities, increase outreach about behavioral health professions			

PRIORITY 5:
COMMUNITY EDUCATION ON MENTAL HEALTH AND SUBSTANCE ABUSE

Objective	Action Step	Who	When
1. Reaching a larger audience.	• PSA, Billboard, social media, flyers, speakers bureau, talking points.	• Work with PBHA Community Awareness Group, resource directory group.	• Monthly meetings on Tuesdays.
2. Changing the conversation.	• Personal testimony, Doppler Dave "Good News"	• Work with PBHA Community Awareness Group, resource directory group.	• Monthly meetings on Tuesdays.
3. Identify the program in the community for those needing services.	• Brochures – bond companies, jails, courthouse, hospitals, victim services agencies, all 26 counties, lawyers, offices, social media	• Work with PBHA Community Awareness Group, resource directory group.	• Monthly meetings on Tuesdays.

RECOMMENDATIONS

RECOMMENDATION 1

ESTABLISH A MENTAL HEALTH CRISIS SERVICES COMMITTEE TO EXAMINE THE SERVICE NEEDS AND RESOURCES NEEDED TO IMPLEMENT THE NECESSARY CRISIS RESPONSE STRATEGIES IN POTTER AND RANDALL COUNTIES

The development of a crisis center in would provide individuals experiencing a mental health crisis with access to short-term stabilization and triage to other services to assist with engagement in the appropriate behavioral health services. See the Crisis Now website for a community self-assessment and bed calculator to assist in determining the recommended service capacities in Potter and Randall counties.

A 23-hour crisis stabilization unit can serve as the hub which connects a community's crisis care continuum between front-end responses on one side and higher levels of care on the other (e.g., crisis residential programs, psychiatric inpatient settings). Crisis stabilization units provide 23-hour observation and stabilization with an opportunity to triage, monitor, and refer individuals to a follow-up level of care. These units may be a standalone service or co-located with other services such as sobering units, crisis residential programs, or on hospital campuses.

Some of the major questions in designing a crisis service, apart from the various types of care and levels of care, are as follows:

- How can the crisis service serve as an integrated hub for other crisis care components?
- What mental health and substance use crisis care gaps exist in the community that a crisis service could help ameliorate?
- Where can a crisis service be located so that it is positioned for equitable access to all residents?

- What are the pathways into the crisis center? Can people be diverted from the emergency department to the crisis center?
- How can the crisis center assist individuals? Become connected with treatment? Access support services and housing? Obtain health coverage and entitlements?
- Moving forward, it is essential to design the crisis diversion center with the user in mind. A 2016 paper by mental health crisis professionals established the Crisis Reliability Indicators Supporting Emergency Services (CRISES) performance measurement framework for ensuring high-quality services responsive to the needs of people experiencing crises (Appendix A). The CRISES framework for excellence in crisis services set forth seven principles with the understanding that a person in crisis should receive services that are…

RECOMMENDATION 2

REVIEW AND ADDRESS PROBLEM-SOLVING COURT CRITERIA TO ALIGN WITH NATIONAL BEST PRACTICE STANDARDS

Problem-solving courts are an integral diversion strategy that should target high risk and high needs populations. They can provide access to treatment, encourage treatment engagement and reduce recidivism. The county has several problem-solving courts all with very limited eligibility criteria. Consider a routine review and evaluation of the problem-solving courts including: eligibility criteria; population demographics of who is included, screened out, or

determined to be ineligible; completion criteria and rates of completion by population demographics; client costs for involvement; technical violations; use of graduated incentives and sanctions; completion rates and recidivism for all problem-solving courts.

RECOMMENDATION 3

PROVIDE SHORT-TERM MEDICATIONS OR PRESCRIPTIONS UPON RELEASE FROM JAIL TO BRIDGE THE GAP BETWEEN RELEASE AND AN APPOINTMENT WITH A PRESCRIBER

Individuals with serious mental illnesses who are released from jail with a transition plan often experience a significant gap of several weeks to months before being able to see a prescriber. Continuity of care related to psychotropic medications, particularly for those living with serious mental illness, is crucial for helping to maintain stability once a person returns to the community. A 30day supply of medication for individuals leaving jail can help to reduce gaps in continuity and provide a window during which the individual can get an appointment with a community prescriber and a new prescription. In the event that an individual is released without a short-term supply, they should be provided with a prescription sent to a pharmacy of their choice.

Bridge medication policies are only effective if individuals are not subject to unscheduled releases since the medication has to be placed in their possessions prior to release. Implementation of this recommendation should occur in tandem with changes to jail release policies for inmates receiving reentry coordination.

RECOMMENDATION 4

IMPROVE JAIL TRANSITION PLANNING TO REDUCE RECIDIVISM AND IMPROVE HEALTH AND SAFETY OUTCOMES

Public safety and public health outcomes can be improved by providing transition planning and coordinated continuity of care of inmates with mental and substance use disorders. The terms “transition” and “reentry” are used interchangeably in this recommendation. It may be helpful to think of jail services and reentry in terms of a “hub-and spoke” model where the jail is the hub and responsible for specific actions such as identification of needs, care that increases stabilization, and coordination with spokes or strategies for continuation of care and access to services in the community.

Various models are used to deliver jail transition services. Some facilities have dedicated jail staff, others use community-based providers who reach into the jail. Some facilities allow only a very limited number of non-sheriff department staff into the facility. Ideally, to build continuity of services, the same providers who provide services in jail, continue services into the community. At the very least, there should be a coordinated and streamlined process. Appropriately, most jails use volunteers to deliver

some services, however, it can result in inconsistent delivery and availability of services. Generally, evidence-based programs require trained and dedicated staff to increase program fidelity.

Ideally, planning for reentry should begin as soon as the individual is incarcerated and should include risk and need assessments, targeted services in the jail, and reentry planning to meet core needs during the first day, week, month, and up to 6-9 months. Examine the strategies provided through the National Institute of Corrections *Transition from Jail to Community* initiative.

RESOURCES

Competency Evaluation and Restoration

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APPENDICES

APPENDIX A

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ORIGINAL PAPER

Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs

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Abstract Crisis and emergency psychiatric services are an integral part of the healthcare system, yet there are no standardized measures for programs providing these services. We developed the Crisis Reliability Indicators Supporting Emergency Services (CRISES) framework to create measures that inform internal performance improvement initiatives and allow comparison across programs. The framework consists of two components—the CRISES domains (timely, safe, accessible, least-restrictive, effective, consumer/family centered, and partnership) and the measures supporting each domain. The CRISES framework provides a foundation for development of standardized measures for the crisis field. This will become increasingly important as pay-for-performance initiatives expand with healthcare reform.

Keywords Mental health services/standards · Outcome and process assessment · Quality improvement · Emergency psychiatry · Crisis services · Behavioral health

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Introduction

Crisis and emergency psychiatric services are an integral part of the behavioral health system of care, yet there are no standardized quality measures for programs providing these services (Glied et al. 2015; Substance Abuse and Mental Health Services Administration 2009). In an era increasingly focused on outcomes, healthcare organizations require standardized frameworks by which to measure the quality of the services they provide. Standardized measures are needed for comparisons and benchmarking between programs and to assist organizations in defining goals for internal quality improvement activities. This will become increasingly important as pay-for-performance initiatives expand with healthcare reform. In addition, standardized measures and terminology are needed to support research efforts in crisis operations and quality improvement. In response to these needs, we developed the Crisis Reliability Indicators Supporting Emergency Services (CRISES) framework to guide the creation of a standardized measure set for the programs providing emergency psychiatric and crisis care within our organization, which is the largest provider of facility-based emergency psychiatric care for adults and children in Arizona. We will describe the method used to develop the CRISES framework and the resulting measures. The CRISES framework is a method rather than a static measure set; thus some measures are designated provisional as we continue to evolve improved measures or respond to new customer needs. This framework provides a starting point for the development of standardized measures for the crisis field as a whole.

The term "crisis services" encompass a wide variety of programs and services. These include facility-based psychiatric emergency services, 23-h observation, crisis stabilization beds, crisis respite beds, mobile crisis outreach

teams, crisis hotlines, warm lines, peer support, and others. In this work, we use the term "crisis program" to refer to facility-based psychiatric emergency services and 23-h observation. Such services may be delivered in a free-standing behavioral health facility or within a medical ED.

Crisis programs share features in common with emergency departments, urgent care clinics, inpatient psychiatric facilities, and outpatient mental health clinics, yet they are distinctly different. Standards and measures designed for these settings have been variably applied to crisis programs, but they are an imperfect fit. For example, in our own organization, two programs providing identical 23-h observation services have different licenses due to differences in their respective facilities' physical plant specifications. One is licensed as an inpatient psychiatric unit and the other as an outpatient clinic. As a consequence, the two programs are held to different regulatory and quality standards, neither of which is the best fit for the services provided. This illustrates the need for an independent set of crisis measures that supports a common definition of quality crisis services and allows comparison between similar programs.

We endeavored to develop a measure set that remained under the sphere of influence of an individual crisis program while also reflecting the desired contribution of the crisis program to the functioning of the behavioral health system as a whole. Thus our measures focus on the experience of the individual from the time of arrival to discharge and the interface between the crisis program and its community partners. Such measures have a more narrowed scope than those of managed care organizations (MCOs) and state/local behavioral health authorities (BHAs). At the MCO/BHA level, measures are often designed to assess the functioning of the crisis system as a whole and may not be directly transferable to an individual service provider. For example, it is common for a behavioral health system to measure whether patients discharged from a crisis program are seen by their outpatient behavioral health provider within a certain timeframe, such as 7 days. This measure is designed to incentivize the MCO/BHA to influence the behavior of its contracted providers—both the crisis program and outpatient clinic—in order to meet this metric. While this is a worthwhile measure and all parties should collaborate to ensure that it is met, it is not feasible for a crisis program to be solely responsible. Rather, the crisis program and outpatient clinic should select internal process metrics that facilitate the attainment of this shared goal, such as ensuring that appointments are made and communication occurs between the crisis program and clinic. Then the MCO/BHA can focus on systemic issues that hinder attainment the larger goal.

Methods

CTQ Tree

We began by employing a quality improvement tool called a Critical To Quality (CTQ) Tree. This tool is designed to help an organization translate its values into discrete measures (Lighter and Lighter 2013). When building a CTQ Tree, the first step is to define the value we are trying to accomplish, in this case "Excellence in Crisis Services." The next step is to define the key attributes that comprise excellent crisis services, from the perspective of the customer. Because a crisis program plays such a vital role in the community, it has many customers and stakeholders. These include the individuals receiving care, law enforcement, emergency departments, other healthcare providers, staff, etc. We defined our key attributes as Timely, Safe, Accessible Least Restrictive, Effective, Consumer/Family Centered, and Partnership (see "Results" section for a detailed description of each). The CRISES domains are consistent with the Institute of Medicine's six aims for quality healthcare: Safety, Effectiveness, Equity, Timeliness, Patient-centeredness, and Efficiency (Institute of Medicine 2001) while also focusing attention on goals unique to the crisis setting. The CTQ Tree and the resulting CRISES measures are depicted in Fig. 1.

Measure Selection

Next, we selected discrete measures to reflect the key attributes defined above. Many frameworks exist to inform the selection of quality measures. We employed the criteria described by Hermann and Palmer (2002) which require that measures are meaningful, feasible, and actionable. Some key considerations regarding each of these requirements are outlined below.

Meaningful

Does the measure reflect a process that is clinically important? Is there evidence supporting the measure? Compared to other fields, there is a paucity of research on crisis quality measures, so we must rely on face validity or adapt measures for which there is evidence in other settings. The emergency medicine field has put forth much effort in defining standardized measures (Welch et al. 2011), many of which are applicable to crisis services. When possible, measures should be selected or adapted from measures that have been endorsed by organizations that set standards for quality measurement such as the National Quality Forum (NQF), Centers for Medicaid and

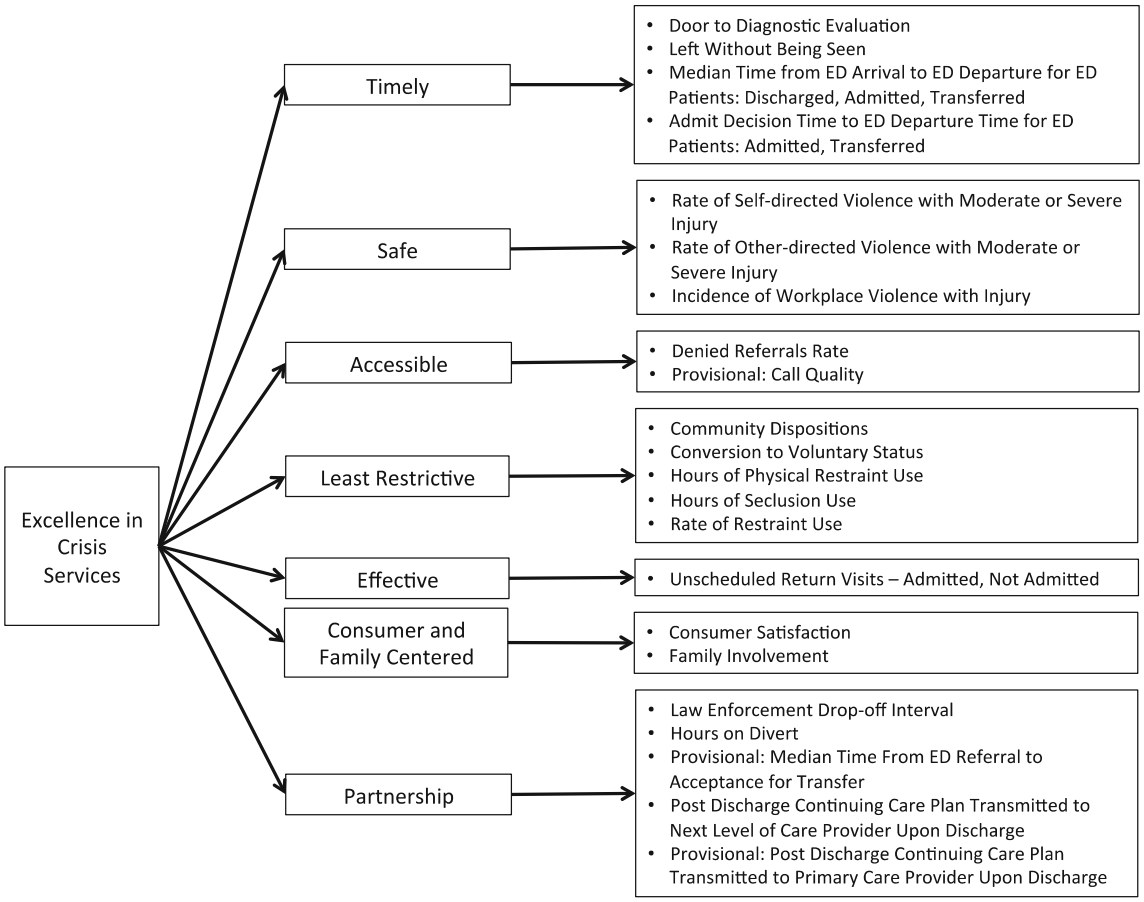

Fig. 1 CRISES framework

Medicare Services (CMS), The Joint Commission (TJC), Agency for Healthcare Research and Quality (AHRQ) etc.

Feasible

Is it possible to collect the data needed to provide the measure? If so, can this be done accurately, quickly, and easily? Data must be produced within a short timeframe in order to be actionable (see below). An organization's quality department staff should be able to spend most of its time addressing identified problems rather than performing time-consuming manual chart audits. With the advent of electronic health records (EHRs), it is now possible to design processes that support automated reporting, making it feasible to quickly obtain data that were previously too complex or labor intensive to collect via chart abstraction.

Actionable

Do the measures provide direction for future quality improvement activities? Are the factors leading to suboptimal performance within the span of control of the organization to address? A crisis program is in a position to identify problems in the community-wide system of care, and should collaborate with system partners to fix systemic issues. However, its own core measures must be within its sphere of influence to improve, otherwise there is the tendency to blame problems on external factors rather than focus on the problems it can address. Are there established benchmarks towards which to strive? There are few benchmarks for crisis services so we must often rely on internally developed goals, or attempt to benchmark against inpatient psychiatric services or emergency medicine.

Results

Descriptive Data

Descriptive data are needed for program and operational design, benchmarking between similar programs, and providing context for performance on quality measures. For example, the emergency medicine field stratifies

programs both by volume and by measures of acuity such as Emergency Severity Index (ESI) scores and Intensive Care Unit (ICU) admission rates. Table 1 contains suggested categories for describing the characteristics of crisis programs and the populations they serve.

CRISES Domains and Measures

The individual measures and their definitions are listed in Table 2. A description of each domain and the rationale for selection of the corresponding measures are below.

Timely

Timeliness is especially critical in the crisis setting. CMS has developed measures to assess throughput in emergency departments (Centers for Medicare and Medicaid Services 2015a, c) and performance on these measures is now publicly available on its Hospital Compare website http://hospitalcompare.hhs.gov. The CMS ED throughput measures are directly applicable to the crisis setting and we have adopted them with only minor modification.

Table 1 Descriptive data

Population characteristics
Age
Gender
Race
Ethnicity
Referral source: police, walk-in, child protective custody, etc.
Payer
Legal status: voluntary, involuntary, assisted outpatient treatment, etc.
Housing status
Diagnosis
Co-occurring substance use disorders
Acute substance intoxication or withdrawal
Trauma history
Chronic medical disease (e.g. diabetes, congestive heart failure)
Primary language
Program characteristics
Volume: number of encounters annually
Age range served: child, adolescent, adult, geriatric
Law enforcement referral rate: percentage of visits arriving via law enforcement
Involuntary referral rate: percentage of visits arriving under involuntary legal status
Level of care: urgent care, emergency services, 23-h observation, sub-acute crisis stabilization, crisis residential, etc
Locked versus unlocked: Does the program contain a locked unit?
Accessibility: Does the program accept involuntary law-enforcement drop-offs? Does the program require medical clearance at an outside ED or via EMS before arrival?
Hospital setting: Is the program a freestanding behavioral health facility, a program within a medical ED, other?
Community setting: Urban, rural, etc.?
Teaching status: Does the program serve as a training site for residents and medical students?

Accessible

A crisis program must be accessible to the community at all times and welcome anyone in need of services. However, many crisis programs are not subject to the Emergency Medical Treatment and Active Labor Act (EMTALA), and some have created barriers to access such as overly rigorous exclusion criteria. Thus we include a measure of the percentage of referrals that are denied admission for any reason other than overcapacity. In addition, we are developing a "mystery caller" assessment tool (O'Neill et al. 2012) to assess our customer service and determine whether callers to the crisis program get their needs met in a welcoming, respectful, and timely manner.

Safe

A core function of crisis services is to address potential dangerousness to self or others. Regulatory reporting requirements for incidents of self-harm within the facility often include vague qualifiers such as "serious suicide attempt" that leave much to interpretation. The Centers for Disease Control (CDC) has proposed a classification system for self-directed violence (SDV) that allows for more precise descriptions of the behaviors and resulting injuries (Crosby and Melanson 2011). Using this system, we measure incidents of SDV (suicidal or non-suicidal) with moderate or severe injury. For episodes of violence towards other persons receiving care, we include other-directed violence with injury using the classification system for SDV described above. In addition to the need for patient safety, there has been increasing awareness of the high prevalence of workplace violence towards healthcare workers, especially in EDs and behavioral health facilities (Anderson and West 2011; Gacki-Smith et al. 2009). For violence towards staff, we include a measure based on the methodology outlined by the Occupational Safety and Health Administration (OSHA) for measuring the incidence of workplace violence with injury (Occupational Safety and Health Administration).

Least Restrictive

A crisis program should strive to resolve the crisis in partnership with individuals and their supports such that the majority can continue their recovery in the least

Table 2 CRISES measures definitions

Measure	Definition	Adapted from existing measure
Timely		
Door to Diagnostic Evaluation by a Qualified Behavioral Health Professional	Median time (in minutes) from ED arrival to provider contact	NQF-0498 (CMS OP-20)
Left Without Being Seen	Number of patients who leave the ED without being evaluated by qualified personnel divided by the total number of ED visits	NQF-0499 (CMS OP-22)
Median Time from ED Arrival to ED Departure for Admitted ED Patients	Time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the emergency department	NQF-0496 (CMS ED-1)
Median Time from ED Arrival to ED Departure for Discharged ED Patients	Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department	NQF-0496 (CMS OP-18)
Median Time from ED Arrival to ED Departure for Transferred ED Patients	Time (in minutes) from ED arrival to ED departure for patients transferred to an outside facility from the emergency department	NQF-0496 (CMS OP-18)
Admit Decision Time to ED Departure Time for Admitted Patients	Median time (in minutes) from admit decision time to time of departure from the emergency department for patients admitted to the facility from the emergency department.	NQF-0495 (CMS ED-2)
Admit Decision Time to ED Departure Time for Transferred Patients	Median time (in minutes) from admit decision time to time of departure from the emergency department for patients transferred to an outside facility from the emergency department	NQF-0495 (CMS ED-2)
Accessible		
Denied Referrals Rate	Percent of referrals denied admission to the crisis program for any reason other than overcapacity	No
Provisional: Call Quality	Composite score on "mystery caller" assessment tool	No
Safe		
Rate of Self-directed Violence with Moderate or Severe Injury	Number of incidents of SDV with moderate or severe injury per 1000 visits	Uses CDC methodology
Rate Other-directed Violence with Moderate or Severe Injury	Number of incidents of violence to other persons receiving care with moderate or severe injury per 1000 visits	Uses CDC methodology
Incidence of Workplace Violence with Injury	Total number of incidents of workplace violence to staff resulting in injury divided by the total number of hours worked	Uses OSHA methodology
Least-Restrictive		
Community Dispositions	Percentage of visits resulting in discharge to community-based setting	No
Conversion to Voluntary Status	Percentage of involuntary arrivals requiring admission/transfer to inpatient care that are admitted/transferred under voluntary status	No
Hours of Physical Restraint Use	The total number of hours that all patients were maintained in physical restraint per 1000 patient hours	NQF-0640 (HBIPS-2)
Hours of Seclusion Use	The total number of hours that all patients were maintained in seclusion per 1000 patient hours	NQF-0641 (HBIPS-3)
Rate of Restraint Use	Total number of restraint episodes per 1000 visits	No
Effective		
Unscheduled Return Visits—Total	Percentage of discharges that resulted in an unscheduled return visit	No
Unscheduled Return Visits—Not Admitted	Percentage of discharges that resulted in an unscheduled return visit in which the return visit did not result in admission or transfer to an inpatient psychiatric facility	No
Unscheduled Return Visits—Admitted	Percentage of discharges that resulted in an unscheduled return visit in which the return visit resulted in admission or transfer to an inpatient psychiatric facility	No
Consumer and Family Centered		
Consumer Satisfaction	Likelihood to recommend	IHI Experience of Care

Table 2 continued

Measure	Definition	Adapted from existing measure
Family Involvement	Percentage of individuals for whom there is either a documented attempt to contact family/other supports or documentation that the individual was asked and declined consent to contact family/other supports	No
Partnership		
Law Enforcement Drop-off Interval	Time (in minutes) from law enforcement arrival to law enforcement departure	EMS Offload Interval
Hours on Divert	Percentage of hours the crisis center was unable to accept transfers from medical EDs due to overcapacity	No
Provisional: Median Time from ED Referral to Acceptance for Transfer to the Crisis Program	Time (in minutes) from initial contact from the referring ED to notification that the patient has been accepted for transfer to the crisis program	No
Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge	Percentage of discharges in which the continuing care plan was transmitted to the next level of care provider	NQF-0558 (HBIPS-7)
Provisional: Post Discharge Continuing Care Plan Transmitted to the Primary Care Provider Upon Discharge	Percentage of discharges in which the continuing care plan was transmitted to the primary care provider	NQF-0558 (HBIPS-7)

restrictive setting possible. Thus we measure the percentage of visits that result in discharge to a community setting and the percentage of involuntary arrivals requiring inpatient admission that are converted to voluntary status. Measures of restraint use are an important indicator of the use of less restrictive interventions within the facility. The Joint Commission Hospital Based Inpatient Psychiatric Services (HBIPS) measures (Joint Commission on Accreditation of Healthcare Organizations 2012a) include two items (HBIPS-2 and HBIPS-3) that reflect the duration of physical restraint and seclusion use expressed as hours of each per 1000 patient hours. State and national benchmarks for inpatient units are available at http://qualitycheck.org and CMS has incorporated the HBIPS measures into its Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program (Centers for Medicare and Medicaid Services 2015c). In contrast, there is no standard methodology for reporting the rate of restraint occurrences. We have defined an "event" as the single application of a restraint (e.g. physical hold, mechanical restraint, or seclusion) and an "episode" as the continuous restriction of a person's freedom of movement via the use of one or more restraint events and express the rate as episodes per 1000 visits.

Effective

Crisis services may be considered effective when the individual had his/her needs met and leaves with a plan that facilitates the continuation of recovery in the community setting. The most readily available proxy metric would then be unscheduled return visits (URV), based upon the assumption that the need to return to the crisis program represents a failure of the discharge plan. We measure URV within 72 h, as this timeframe is becoming more common in the ED literature (Trivedy and Cooke 2015) and is consistent with the Joint Commission's timeframe in which a hospital is held accountable for suicide post-discharge. There is emerging evidence suggesting that all URVs are not equal (Hu et al. 2012). One group is comprised of individuals who are discharged from an ED, return to the ED, and are then discharged again. For this group, the URV may represent opportunities for improvement within the crisis program but may also indicate problems with community services that it is unable to address without help from system partners. In contrast, individuals who are discharged from an ED, return to the ED, and are then admitted to an inpatient unit on their second visit may—but not necessarily—represent an error in decision-making. Thus we measure these two types of URV separately.

Consumer and Family Centered

We have adapted surveys from psychiatric inpatient and medical ED settings to measure consumer satisfaction at our programs and use the anchor question "likelihood to recommend" to serve as a proxy for overall satisfaction with the healthcare service received (Stiefel and Nolan 2012). In addition, families often play a critical role in crisis resolution (Substance Abuse and Mental Health Services Administration 2009) and thus we assess whether there is documentation that our staff attempted to involve family or other supports in the care of the individual in crisis.

Partnership

Partnerships with Law Enforcement Individuals with mental illness are disproportionately represented in the criminal justice system (James 2006), and we have worked very closely with law enforcement to divert individuals with behavioral health needs into more appropriate treatment settings. We have learned that in order to achieve this goal we must be as user friendly as possible to law enforcement; thus, we measure law enforcement drop-off time and strive for a target of 10 min. This measure is analogous to the ED process metric of EMS offload interval—arrival time to the time the patient is removed from the ambulance stretcher and care is assumed by the ED staff. Similarly, our goal is to transfer the individual from police custody to the care of the crisis center staff as quickly as possible.

Partnerships with EDs Boarding of psychiatric patients in medical EDs is an increasing problem for the healthcare system. Crisis programs are poised to help EDs mitigate the burden of psychiatric boarding (Little-Upah et al. 2013; Zeller et al. 2014) and should develop measures reflecting this value. The Joint Commission has recently required EDs to measure the time from decision-to-admit to the actual admission time (Joint Commission on Accreditation of Healthcare Organizations 2012c). Perhaps in the future it will be possible to use that data to construct a composite measure of a community's total psychiatric boarding. While such a measure could inform system planning, more feasible and actionable measures for a crisis program are those that reflect its accessibility to EDs. We currently measure the percentage of time the crisis program is unable to accept transfers from outside EDs due to overcapacity (i.e. diversion). We are also developing a measure assessing the time from ED request for transfer to the crisis program's communication that the patient has been accepted for transfer.

Partnerships with Other Care Providers We have adopted the HBIPS-7 measure regarding the transmittal of a post-discharge continuing care plan to the next level of care provider and are developing a similar measure reflecting transmittal of key information to the primary care provider.

Discussion

We developed the CRISES framework in response to our own organizational needs and have used it to guide the creation of quality measures that inform internal performance improvement initiatives and facilitate comparison of performance across programs. The framework is comprised of two components—the CRISES domains and the measures supporting each domain. The CRISES domains are consistent with the IOM's six aims for quality healthcare while also focusing attention on goals unique to the crisis setting, such as least-restrictive care and community partnerships. We attempted to limit the number of measures to a manageable number and thus some potentially useful measures were excluded. In particular, we did not include measures that track whether or not a particular type of screening or assessment was performed. Rather, we prefer to evaluate the content of clinical assessments and perform qualitative reviews on a random sampling of charts and then provide individual feedback via our clinical supervision and peer review processes. Other limitations of this work are that these measures have not been endorsed for use in the crisis setting by professional or healthcare quality improvement organizations and they have only been tested within our own crisis programs.

Implementation and Application

The CRISES measures form the foundation of the quality scorecards in use at our facilities. It took approximately 1 year to build our first scorecard due to challenges with EHR reporting capabilities that required repeated cycles of data validation via manual chart audits, changes to our documentation processes, and staff education. Having learned from this experience, we specified reporting capability for these measures as a contract deliverable with our EHR vendor as they transition another of our facilities to electronic charting.

We have hardwired ongoing assessment of the validity and utility of these measures into our routine quality and operational processes. For example, the scorecard is reviewed at monthly quality meetings. Specific measures such as URV are tracked and trended in monthly utilization management meetings; when indicated, individual cases are reviewed and referred for internal peer review or to the relevant outpatient clinic or system partner. Law enforcement drop-off time data is reviewed at monthly meetings with local law enforcement. Individual employee injuries and incidents of self/other directed violence are reviewed in daily operational huddles and tracked and trended in monthly restraint committee meetings.

We have successfully used CRISES measures as outcomes for process improvement initiatives within our organization. As an example, Fig. 2 depicts a control chart showing improvements in the Time from Arrival to Departure in one of our crisis urgent care clinics in response to two phases of process improvements. In addition, at that facility we have achieved a 78 % decrease in Door to Diagnostic Evaluation and a 60 % decrease in staff injuries (Balfour et al. 2014). The CRISIS measures have

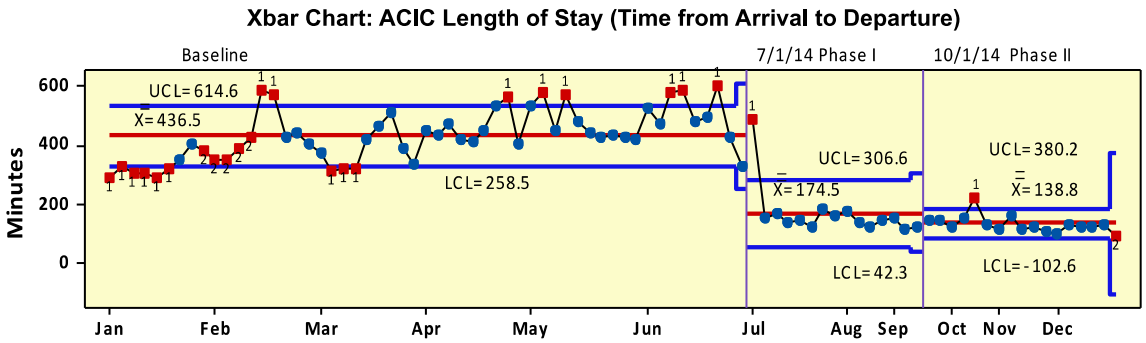

Fig. 2 Improvement in time from arrival to departure. Change in time from arrival to departure in response to two phases of process improvements. ACIC, Adult Crisis Intervention Clinic; Xbar, sample mean; UCL, upper control limit; LCL, lower control limit

also proven useful in discussions with our payers regarding new state requirements for Pay for Performance contracting. Our work in this area has allowed us to proactively propose sensible metrics for which we already have established baseline performance.

Future Directions

We anticipate that the individual CRISES measures will continuously evolve. Our work has highlighted the need for further research and consensus on certain definitions and assessment tools. As the crisis field advances and new customer needs are identified, new and improved measures will be developed and measures that are no longer useful will be retired. However, the CRISES domains will continue to be a guidepost to inform the development of additional measures. For example, after the creation of the CRISES framework, we recognized that the Partnership domain would be enhanced by the inclusion of a measure reflecting partnership with primary care providers, and now a new provisional measure is in development. Although we started with measures based on existing standards, we continue to develop improved standards. For example, in order to drive more proactive care coordination, we are exploring a measure requiring notification to the outpatient mental health provider within 1 h of arrival. Such a measure may eventually accompany or supplant the current HBIPS-7 measure. Similarly, we are exploring measures to drive more proactive efforts to identify those who need connection to a primary care provider.

The measures included here focus on the internal operations supporting the care of an individual receiving service at a facility-based psychiatric emergency program. While some of the CRISES measures may be generalizable across all crisis settings, different measures may be required for other levels of care and types of programs. Regardless of setting, future measure development should include emphasis on how crisis programs support the community and fit within the larger system of care. Future measures may assess how well crisis programs accept continuing responsibility once the individual leaves its walls (e.g. measures assessing collaboration with outpatient providers for high utilizers, outreach during the gap between discharge and follow-up care, scheduled return visits for individuals unable to obtain timely follow-up appointments, etc.). Organizational assessments could provide more detailed measures of accessibility and capability such as exclusion criteria, pre-admission medical clearance requirements, detoxification protocols, staff competencies, etc.

Healthcare providers will be increasingly required to demonstrate their value as we continue to strive towards achieving the Triple Aim of improving patient experience, population health, and cost (Berwick et al. 2008; Glied et al. 2015). The CRISES framework provides a way for behavioral health crisis programs to select measures that demonstrate value to multiple customers using language and methods familiar to industry and quality leaders. Quality measures and pay for performance targets are not yet well defined for behavioral health, and even less so for crisis services. We in the crisis field have an exciting but time-limited opportunity to define our own standards for the unique services we provide.

Compliance with Ethical Standards

Conflicts of interest Dr. Balfour and Dr. Rhoads are employed by Connections SouthernAZ and have non-compensated affiliations with the University of Arizona. Ms. Tanner and Dr. Jurica are employed by Connections SouthernAZ. Dr. Carson is owner and Chairman of the Board of ConnectionsAZ, Inc. and is also employed by Beacon Health Options.

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APPENDIX B

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PERFORMANCE IMPROVEMENT

Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety

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Background: Lean has been increasingly applied in health care to reduce waste and improve quality, particularly in fast-paced and high-acuity clinical settings such as emergency departments. In addition, Lean's focus on engagement of frontline staff in problem solving can be a catalyst for organizational change. In this study, ConnectionsAZ demonstrates how they applied Lean principles to rapidly and sustainably transform clinical operations in a behavioral health crisis facility.

Methods: A multidisciplinary team of management and frontline staff defined values-based outcome measures, mapped the current and ideal processes, and developed new processes to achieve the ideal. Phase I was implemented within three months of assuming management of the facility and involved a redesign of flow, space utilization, and clinical protocols. Phase II was implemented three months later and improved the provider staffing model. Organizational changes such as the development of shift leads and daily huddles were implemented to sustain change and create an environment supportive of future improvements.

Results: Post-Phase I, there were significant decreases (pre vs. post and one-year post) in median door-to-door dwell time (343 min vs. 118 and 99), calls to security for behavioral emergencies (13.5 per month vs. 4.3 and 4.8), and staff injuries (3.3 per month vs. 1.2 and 1.2). Post-Phase II, there were decreases in median door-to-doctor time (8.2 hours vs. 1.6 and 1.4) and hours on diversion (90% vs. 17% and 34%).

Conclusions: Lean methods can positively affect safety and throughput and are complementary to patient-centered clinical goals in a behavioral health setting.

Lean is an organizational philosophy developed to translate the successes of the Toyota Production System to auto manufacturing in the United States and has since been adapted to a wide variety of industries.[1] Lean has been increasingly applied to health care settings to achieve quality goals.[2,3] An important focus of Lean is the reduction of waste, which is defined as anything that is "non-value added" to the customer, such as time spent waiting.[4] This is naturally appealing to fast-paced health care settings, and thus many implementations of Lean methods have been in emergency departments (EDs) and operating rooms.[5]

In addition to the impact on quality outcomes, Lean can be a catalyst for broader organizational culture change in health care organizations.[6] Fundamental principles of Lean include the challenge of continuous improvement and respect for the teams of people performing the work.[7] This leads to an approach different from that found in traditional top-down management structures; rather, frontline staff are empowered to engage in improvement of the processes in which they work, with support from and collaboration with leadership.[8] In Lean organizations, management functions to support the staff in problem solving, and shifts from asking "Why *didn't* staff do their job?" to "Why *couldn't* staff do their job?"[9] Although Lean employs many tools for data analysis and outcome measurement, it differs from traditional research methods in that the focus is on continuous improvement rather than proving a hypothesis.[10] Improvement efforts are rapid and iterative, and methods change quickly and often as outcomes are continually monitored and new problems are identified and addressed.

The purpose of the study reported in this article is to (1) demonstrate how Lean principles can be applied to achieve rapid transformation of clinical operations, (2) describe strategies for sustaining change and promoting ongoing improvements, and (3) identify special considerations for behavioral health settings.

METHODS

Study Setting and Population

This work was performed at the Crisis Response Center (CRC), a freestanding behavioral health facility providing crisis services and emergency psychiatric care to adults and children in Pima County, Arizona. The CRC was created

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in 2011 to reduce the numbers of people with behavioral health needs booked into jail or boarding in hospital EDs. Management of the CRC was transferred to our organization (ConnectionsAZ) in April 2014 to address concerns related to long waits, poor patient experience, and repeated safety incidents. The CRC serves 11,000 adults and 2,200 children annually. This study includes the adult population served in the urgent care clinic and 23-hour observation unit. Approximately 45% are brought directly from the field by law enforcement, 10% are transferred from outside medical EDs, and the remainder arrive via walk-in. The CRC is staffed 24/7 by behavioral health medical professionals (BHMPs: psychiatrists, nurse practitioners, physician assistants), nurses, behavioral health technicians, crisis workers (social services staff with various credentials), and peer supports. (Peer supports are staff with their own lived experience with mental illness and/or substance use who have received training in how to use that experience to engage with patients in a manner different than that of traditional clinical staff.[11]) The CRC is located on the Banner—University Medical Center campus in Tucson and is a training site for residents and medical students at the University of Arizona. The Regional Behavioral Health Authority is the major source of funding supporting the operations of the CRC.

Study Design

This retrospective, observational, pre-post interventional study compared outcome measures related to throughput and safety before and after the implementation of process improvements. Our organization assumed management of the facility and its staff on April 1, 2014. Phase I interventions were implemented on July 1, 2014, and Phase II interventions were implemented on October 1, 2014. We included all adults presenting for services during the study period of January 1, 2014, to December 31, 2015. The 2014 data were divided into pre- and postintervention intervals and compared. We then compared the preintervention interval to the following year (January 1, 2015, to December 31, 2015) to assess whether the improvements had been sustained.[12] We analyzed administrative data from our electronic health record (EHR) but not individual patient records. As a quality improvement effort, this project was exempt from Institutional Review Board review and did not require informed consent.

Preintervention Activities (April–June 2014)

Engagement, Information Gathering, and Values Development. Executive leadership began by engaging managers, frontline staff, and patients via town-hall meetings, rounding, and working clinical shifts to gain firsthand knowledge of operations and stakeholder concerns. All agreed that the adult triage process was the highest priority, but there was disagreement on the desired outcomes of that process, stemming from a lack of consensus regarding the mission and values of the CRC. Leadership convened the management staff to define values and develop a new mission statement: "To meet the immediate needs of people in behavioral health crisis in a safe and supportive environment in collaboration with community partners." When there was unanimity among management, frontline staff could be engaged in improvement efforts with consistent support and guidance from their managers.

Defining Values-Based Outcomes. As described elsewhere,[13] we used a quality improvement tool called a Critical-to-Quality (CTQ) Tree[14] to translate our core values into outcome measures: Crisis Reliability Indicators Supporting Emergency Services (CRISES). We defined our values as Timely, Safe, Accessible, Least Restrictive, Effective, Consumer/Family Centered, and Partnership. These are consistent with the Institute of Medicine's six aims for quality health care: Safety, Effectiveness, Equity, Timeliness, Patient-Centeredness, and Efficiency,[15] while also focusing attention on goals unique to the behavioral health crisis setting. This work informed the selection of the primary outcome measures for the process improvement initiatives described in the current study, specifically the following:

- Timely: door-to-door dwell times, door to assessment by a BHMP (door-to-doctor time)
- Safe: staff injuries
- Least Restrictive: calls to security to assist with behavioral emergencies
- Partnership: time on diversion

Interventions

Phase I Intervention: Reengineering the Triage Process (July–December 2014). A multidisciplinary group composed of executive leadership, management, and frontline staff (including peer supports who had previously been patients at the CRC) mapped the baseline triage process, which was as follows: Each walk-in patient arrived via an unlocked waiting room (WR) where he or she was checked in and received a brief medical screen by a behavioral health technician. The patient was then called into 1 of 12 clinic assessment rooms where a behavioral health technician performed a safety search and inventoried the patient's property, which was locked up for the duration of the visit. Then the patient met with a crisis worker for a screening assessment and waited in that room for further evaluation. Another crisis worker performed a more extensive assessment, then discussed the case with the BHMP, who may either perform his or her own assessment, direct the crisis worker to discharge the individual, order medication or a period of observation then have the individual wait for reassessment in a clinic assessment room, or write admission orders to the 23-hour observation unit. The observation unit is adjacent to the clinic and is comprised of an open area where patients are visualized at all times and, unlike the clinic, meets inpatient safety standards for anti-ligature design. Police and ambulance arrivals entered through a gated sally port (SP). The process for these patients was the same except they were

assessed for medical issues by a nurse in the SP then taken directly to an assessment room in the clinic.

The team identified opportunities for improvement in dwell times and staff injuries as well as processes that put patients and the organization at risk. For example, it was not clear which patients required assessment by the BHMP vs. social services staff only. Individuals with acute symptomatology were often held for hours or even overnight in clinic rooms that were not ligature-safe or amenable to constant visualization due to inconsistent criteria for admission to the observation unit or delays in finding a BHMP to write admission orders. Staff were spread out over a large area and often unable to proactively attend to the needs of acutely psychotic or intoxicated patients and prevent episodes of agitation or violence. Consequently, security was often called to assist. Other processes led to suboptimal patient experience, such as seclusion/restraint of high-acuity patients in close proximity to low-acuity patients and their families who were seeking outpatient urgent care services.

The team developed the following goals for the ideal process:

1. Treat patients in the least restrictive setting that can safely meet their needs.
2. Move the highest-risk patients to the safest location (observation unit).
3. Begin treatment as quickly as possible.
4. Reduce unnecessary or redundant tasks.
5. Use space more efficiently.
6. Create the experience we would want for our families or ourselves.

The team performed a gap analysis comparing the current process to the ideal, then developed new policies and procedures for clinical assessments, patient flow, and space utilization.

The new process was implemented July 1, 2014, and is as follows: WR arrivals are checked in and receive a brief medical screen as before. In addition, vital signs are performed in a designated area in the WR to facilitate early identification of acute medical issues. The WR is monitored by a behavioral health technician stationed there at all times, and peer supports have an increased presence. Patients are brought to one of two triage assessment rooms (TR) where the crisis worker performs a single streamlined assessment using a newly developed tool to triage patients into low/moderate/high risk categories based on dangerousness to self/others and symptom acuity (Appendix 1, available in online article). High-risk patients are automatically admitted to the observation unit via a standing order protocol, eliminating the need to wait for BHMP orders. A nurse and behavioral health technician are called to the assessment room to begin the admission process and move patients to the observation unit. Low- and moderate-risk patients are redirected to the WR and called back into the TR assessment room to meet with the BHMP or crisis worker as needed. They are not searched or separated from their belongings unless there is a compelling reason to do so for a given individual. Patient flow is tracked using a visual management tool (Appendix 2, available in online article) comprised of a whiteboard with magnets and colors to indicate patient status. The process is the same for SP arrivals except that the nurse meets individuals in the SP, directs them to one of three designated assessment rooms, and determines the risk level based on the same triage tool described above. A value stream map[16] illustrating the old and new processes is shown in Appendix 3 (Appendix 3, available in online article).

Phase II Intervention: Addition of a Behavioral Health Medical Provider in Triage (October–December 2014). After the Phase I interventions, there continued to be long waits to BHMP assessment, and the facility was frequently on diversion. To address this, we added an additional 12-hour BHMP shift assigned to the clinic beginning October 1, 2014. The clinic BHMP focuses on newly arrived patients, whether discharged from the clinic or admitted to the observation unit. He or she typically starts the day assisting the observation unit with re-assessments and discharges, then focuses on the clinic when walk-in and SP patients begin arriving later in the day.

Sustainability Interventions: Building a Lean Culture

Some staff were initially skeptical of improvement efforts because of a belief that things would not change. Others were fearful of being punished for breaking the rules or criticizing their superiors. Leadership made considerable efforts to change the culture to one of staff feeling supported in values-based decision making and problem solving in the moment. This was primarily achieved via frequent contact and modeling (for example, regular rounding, open-door accessibility, working clinical shifts on the floor, and inclusion of frontline staff in improvement efforts). In addition, we hardwired Lean concepts into our organizational structure in order to sustain improvements and continue developing the culture.

Daily Huddles. We implemented daily huddles[17] with key operational leaders, in which we ask "What do we need to do to support the frontline staff today?" The huddles were implemented shortly after assuming management of the facility in April 2014 and refined throughout the study period. The huddle centers around the shift report (Appendix 4, available in online article), which is prepared by frontline staff twice daily and contains key pieces of actionable data. For example, multiple patients waiting for their initial psychiatric evaluation may indicate a need to call in additional BHMPs, whereas high numbers of patients waiting for transfer to external inpatient facilities may indicate a need for the medical director to review the cases to ensure that they all do in fact meet medical necessity criteria for inpatient admission and a need for leadership to work with external stakeholders to address the backup. The huddle also highlights individual patients who may need specialized

intervention. For example, data indicated that patients with developmental disabilities were more likely to be restrained; now these individuals are flagged on the shift report, which triggers a review of the behavioral plan by the director of nursing. Some activities that once required a separate meeting (for example, review of safety events) have been incorporated into the daily huddle, which both ensures that these events are addressed as they occur and reduces time wasted on unnecessary meetings.

Shift Leads. We made the transition to a structure of discipline-specific leads for each 12-hour shift, analogous to Lean line managers,[18] which includes a charge nurse, lead crisis worker, lead behavioral health technician, and lead unit clerk. This transition occurred in the fourth quarter (Q4) of 2014 through Q1 2015 and replaced the previous structure in which a single house supervisor was responsible for the day-to-day operations on each shift, and management staff, often via retrospective chart review or monthly groups, performed clinical supervision. The shift leads are now empowered to solve problems in the moment affecting their specific discipline's responsibilities. More complex problems are addressed in the next daily huddle (or directed to the administrator on call if urgent). Clinical supervision is performed by the shift leads, as they can identify opportunities for improvement and provide correction and feedback in real time. This frees managers to use their time more efficiently, focusing only on individual staff needing more intensive intervention, so that they are free to engage in more strategic planning and complex improvement activities. A modified Lean curriculum was designed for the shift leads to give them the tools to lead future improvement projects.

Outcome Analysis

Data Extraction. Existing data reports had been destroyed immediately prior to our assuming management of the facility. Thus, baseline data were reconstructed concurrently with the process improvement activities described in this study. The EHR was used to extract patient demographics, arrival and discharge times, and assessment times for all adults presenting for services. Calls to security were compiled from daily security logs. Nonemergent calls such as routine escorts were excluded. Staff injuries were compiled from incident reports. We did not have access to reliable data on staff injuries or door-to-doctor times that occurred prior to ConnectionsAZ assuming management of the CRC; thus pre-April 2014 data are not included. The percentage of hours on diversion (not accepting transfers from EDs because of overcapacity) was calculated from daily logs. Standardized criteria for diversion were developed in July 2014; thus pre-July data are not included.

Statistical Analysis and Data Presentation. Outcome data were analyzed using Minitab 17 (Minitab Inc., State College, Pennsylvania) and XLSTAT (Addinsoft, New York City). Wilcoxon rank-sum tests were used to compare non-normally distributed data (door-to-door dwell times and door-to-doctor times); *t*-tests were used to compare all other measures. In addition, statistical process control charts were used to illustrate changes in throughput measures over time.

RESULTS

Population and Encounters

We analyzed 10,546 encounters from January 1, 2014, through December 31, 2014, and 10,353 encounters in the postimplementation year of January 1, 2015, through December 31, 2015. Demographic descriptors and monthly volumes did not significantly differ across the study periods. Some 61% of the population was male, and 20% were 18–24 years of age; 35%, 26–40; 42%, 41–64; 3%, 65–84; and 0.1%, 85 years of age or older. Some 53.2% were white-non-Hispanic, 26.8% Hispanic, 4.8% African American, 4.5% Native American, 1.4% biracial, 0.6% Asian, and the remainder classified as "other" or declined to answer.

Interventions

Phase I Interventions (July–December 2014). Phase I outcomes are summarized in Table 1. There was a decrease of 225 minutes in the median door-to-door dwell time in the clinic (95% confidence interval [CI]: −224– −208; $p < 0.0001$). The change over time is depicted as a control chart in Figure 1a. There was a decrease of 2 hours in the median door-to-door dwell time in the observation unit (CI: −3.7– −2.0; $p < 0.0001$) despite the fact that 232 more patients per month were identified as high-risk and triaged to that unit (CI: 163–299; $p < 0.0001$). The percentage of patients evaluated by a BHMP (as opposed by being seen by social services staff only) increased by 21 percentage points (CI: 19–23; $p < 0.0001$). The mean number of emergent security calls per month decreased by 9.2 (CI: −16.3– −2.0; $p = 0.017$), and staff injuries decreased by 2.1 (CI: −4.1– −0.02; $p = 0.034$). Injuries sustained in the clinic were eliminated (Figure 2). These improvements were sustained during the following postimplementation year, as shown in Table 1.

Phase II Interventions (October–December 2014). Phase II outcomes are summarized in Table 2. (For the statistical analyses, the preimplementation comparison period for Phase II is July–September because the conditions that existed prior to Phase I do not provide a meaningful comparison condition because of the low percentage of patients receiving psychiatric evaluations by a BHMP and the lack of standardized criteria for diversion.) Observation unit median door-to-doctor time decreased by 6.6 hours (CI: −6.1– −5.1; $p < 0.0001$). The change over time is depicted, as a control chart in Figure 1b. There was an increase following Phase I, as more patients were required to be evaluated by the BHMP, then a reduction after the implementation of Phase II interventions targeted at BHMP staffing. Hours on diversion decreased by 73 percentage points (CI: −125–

Table 1. Comparison of Phase I Outcome Variables: Pre- vs. Postimplementation and Pre- vs. One Year Postimplementation

	Pre (Jan–Jun 2014)	Post Phase I Implementation (Jul–Dec 2014)			One Year Postimplementation (Jan–Dec 2015)			
		Difference (vs. pre)	95% CI	p		Difference (vs. pre)	95% CI	p
Clinic Door-to-Door Dwell Time (median in minutes)	343	118	−225	(−224, −208)	< 0.0001	99	−244	(−241, −229)	< 0.0001
Observation Unit Door-to-Door Dwell Time (median in hours)	24.2	22.2	−2.0	(−3.7, −2.0)	< 0.0001	23.5	−0.7	(−1.7 – 0.3)	0.0086
Number of Patients Triaged to Observation Unit per Month (mean)	405	637	232	(163, 299)	< 0.0001	648	243	(107, 380)	0.004
Patients Seen by BHMP (%)	57%	78%	21	(19, 23)	< 0.0001	84%	27	(25, 28)	< 0.0001
Emergent Calls to Security per Month (mean)	13.5	4.3	−9.2	(−16.3, −2.0)	0.017	4.8	−8.7	(−14.3, −3.1)	0.005
Staff Injuries per Month (mean)*	3.3	1.2	−2.1	(−4.1, −0.2)	0.034	1.2	−2.1	(−3.9, −0.4)	0.019

Wilcoxon rank-sum tests were used to compare door-to-door dwell times; *t*-tests were used to compare all other measures.
*Reliable data on staff injuries from before April 2014 data were not available.
CI, confidence interval; BHMP, behavioral health medical professional.

−20; $p < 0.0001$). These improvements were sustained over the following postimplementation year, as shown in Table 2.

Redistribution of Space. More efficient use of space (Figure 3) resulted in 1,046 square feet of unused space in the clinic (47% of the total clinic space). The clinic was remodeled to create an overflow observation unit in February 2015, increasing the observation unit capacity from 25 to 34 patients. The seclusion/restraint room in the clinic is no longer in use.

DISCUSSION

This study describes the application of Lean methods to achieve a rapid and sustainable transformation of clinical operations in a behavioral health crisis program. This initiative began with an engagement and information-gathering phase, during which we developed value-based outcome measures. Then a multidisciplinary team composed of leaders and frontline staff designed and implemented two consecutive sets of interventions. Phase I was implemented within three months of our assuming management of the facility and involved a redesign of flow, space utilization, and clinical assessment and care protocols, resulting in improvements to clinic throughput and safety measures without additional staffing. Phase II involved improvements to the BHMP staffing model, resulting in a dramatic decrease in observation unit door-to-doctor time.

Most published studies of Lean applications in the emergency setting focus on process outcomes and do not include outcomes reflecting patient safety, quality, or effects on employees.[19] Our study demonstrates improvements in such measures, including staff injuries and calls to security to manage violent patients. Other measures, such as incidents of self-directed violence or restraint-related injuries to patients, were low at baseline and remained unchanged during the study period.

The improvements described in this study were sustained through the following year by incorporating Lean concepts into our organizational structure and culture. Rapid communication of information to people with the ability to problem-solve—a key component of sustainable Lean implementations[20]—is accomplished via the new system of shift leads, shift reports, and daily huddles. Shift leads solve problems in the moment, while the shift report and huddles ensure that more complex problems are communicated quickly to higher-level managers. In addition, shift leads received training in Lean methods to engage more of the workforce in future improvement activities.[21]

Unique Considerations for Behavioral Health Services

Early assessment is associated with positive outcomes in the ED setting,[22–25] but to our knowledge this is the first study demonstrating this approach in a behavioral health crisis setting. Several key considerations unique to behavioral health

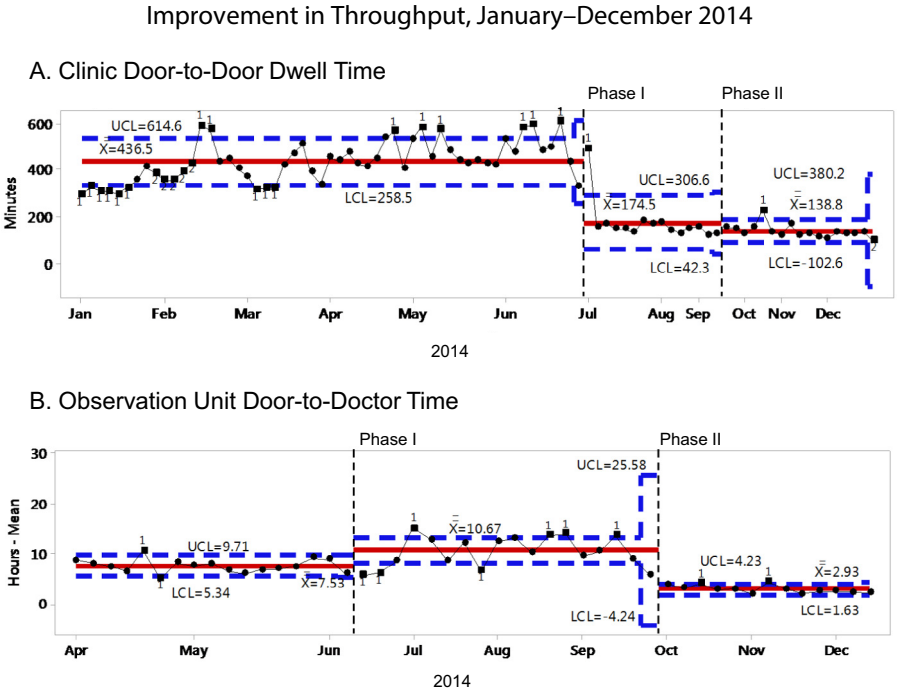

Figure 1: These X-bar charts depict improvement in throughput measures. Each data point represents the mean of a random sample of up to 100. The center line (X-bar) represents the process mean. Upper control limits (UCL) and lower control limits (LCL) are set at three standard deviations above and below the mean, respectively. S-charts plotting the standard deviation verified that the processes were in control and are not displayed. Clinic door-to-door dwell time decreased following Phase I interventions, and this improvement was sustained during Phase II (Figure 1a). There was an increase in observation unit door-to-doctor time following Phase I, as more patients were required to be evaluated by the behavioral health medical professional (BHMP), then a reduction after the implementation of Phase II interventions targeted at BHMP staffing (Figure 1b). Figure 1a is reprinted with permission of Springer SBM US, from Balfour ME, et al. Crisis Reliability Indicators Supporting Emergency Services (CRISES): a framework for developing performance measures for behavioral health crisis and psychiatric emergency programs. Community Ment Health J. 2016;52:1–9.

were aligned with Lean concepts to improve both safety and experience for this specialized population (Figure 4). Continuous observation and proactive intervention are critical to address symptoms and diffuse behaviors that may escalate quickly. It is equally important to engage with patients in crisis and treat them with respect in the least-restrictive environment possible.[26] The more efficient use of space resulted in the consolidation of staff onto the locked observation unit, where the highest staff-to-patient ratio is needed, and our new assessment process reduced the delay in moving high-risk patients to this unit. To ensure constant observation, peer supports stay with these patients during the time it takes to move them to the observation unit; thus, what was once non-value-added waiting time gained value via peer engagement. Similarly, the assignment of a peer and technician to the waiting room creates a more therapeutic milieu for patients and families waiting for the clinic process. Early segmentation of low- and moderate-risk patients allowed us to dispense with the one-size-fits-all approach of treating everyone as dangerous and subjecting them to searches and instead concentrate our highest level of precautions and safety procedures on the high-risk subpopulation. The reallocation of unused clinic space into a smaller overflow observation unit allowed us to further individualize care for high-risk patients. For example, patients with severe anxiety or psychological trauma often feel more comfortable on this smaller, quieter unit.

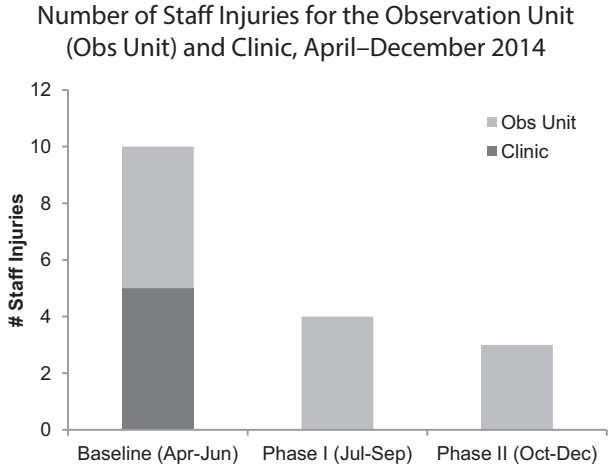

Figure 2: The number of staff injuries steadily decreased and were eliminated from the clinic setting altogether (see Table 1 for statistical analysis).

Table 2. Comparison of Phase II Outcome Variables: Pre- vs. Postimplementation and Pre- vs. One Year Postimplementation

		Post Phase II Implementation (Oct–Dec 2014)				One Year Postimplementation (Jan–Dec 2015)			
	Pre* (Jul–Sep 2014)		Difference (vs. pre)	95% CI	*p*		Difference (vs. pre)	95% CI	*p*
Observation Unit Door-to-Doctor Time (median in hours)	8.2	1.6	–6.6	(–6.1, –5.1)	< 0.0001	1.4	–6.8	(–6.3, –5.5)	< 0.0001
Hours on Diversion (%)	90%	17%	–73	(–125, –20)	< 0.0001	34%	–56	(–100, –4)	< 0.0001

Wilcoxon rank-sum tests were used to compare door-to-doctor time; *t*-tests were used to compare hours on diversion.
*The preimplementation comparison period for Phase II is July–September because the conditions that existed prior to Phase I do not provide a meaningful comparison condition due to the low percentage of patients receiving psychiatric evaluations by a behavioral health medical professional and the lack of standardized criteria for diversion.
CI, confidence interval.

Challenges and Limitations

As stated, baseline data had been destroyed immediately prior to our assuming management of the facility. The severity of the safety concerns necessitated quick action; therefore, we were building reports, reconstructing baseline data, and creating a quality program concurrently with the work described in this study. As a result, some measures such as patient satisfaction could not be compared, as they were either lost or not consistently measured prior to our interventions. The need to intervene quickly also affected the ability to conduct more extensive preintervention measurements. For example, although we currently administer the Hospital Survey on Patient Safety Culture[27] and analyze for trends in staff responses, we did not have the time or bandwidth to collect baseline data prior to

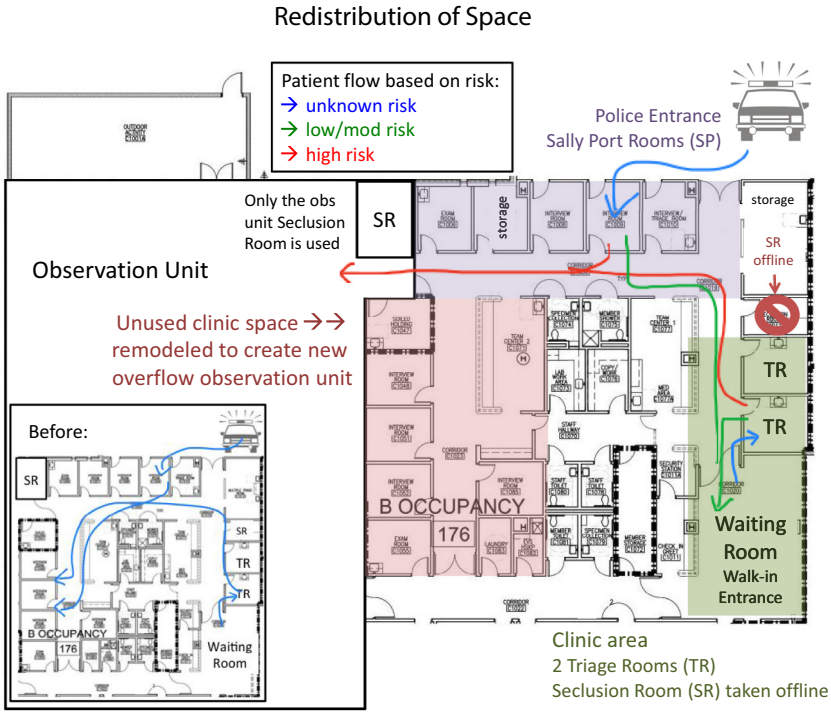

Figure 3: Before the Phase I interventions, staff were spread out over a large area, with mixing of patients with unclear risk profiles (blue arrows), who often slept overnight in unmonitored, non-ligature safe assessment rooms. After the new process, risk level is determined early. Green arrows show the flow of low- and moderate-risk patients, and red arrows show the flow of high-risk patients, who may arrive via the waiting room (walk-ins) or the gated sally port (law enforcement drops). Staff are consolidated with the high-risk patients on the observation unit. More efficient flow resulted in unused space that was converted to an overflow observation unit. The process improvement team developed the new flow using an enlarged laminated floor plan and dry erase markers; their final product looked much like this electronic version.

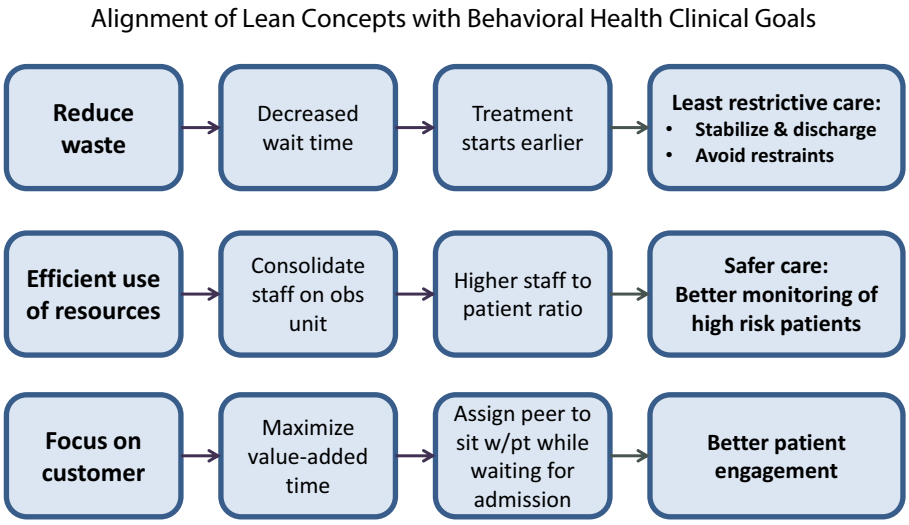

Figure 4: Alignment of Lean concepts with behavioral health clinical goals improves both safety and experience for this specialized population. Obs unit, observation unit; pt, patient.

our interventions. Such a formal assessment of organizational culture change would have been a worthwhile endeavor.

CONCLUSION

This work demonstrates how Lean methods can be applied to achieve rapid and sustained improvements in safety and throughput in a behavioral health crisis setting. Lean is complementary to behavioral health clinical goals, as the focus on customer experience and eliminating waste can result in processes that deliver care quickly and safely while also promoting engagement, individualized care, and respect.

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Conflicts of Interest. All authors report no conflicts of interest.

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ONLINE-ONLY CONTENT

See the online version of this article for Appendix 1. Crisis Triage Guide. Appendix 2. Visual Management System for Patient Tracking. Appendix 3. Value Stream Map of the Triage Process. Appendix 4. Sample Shift Report.

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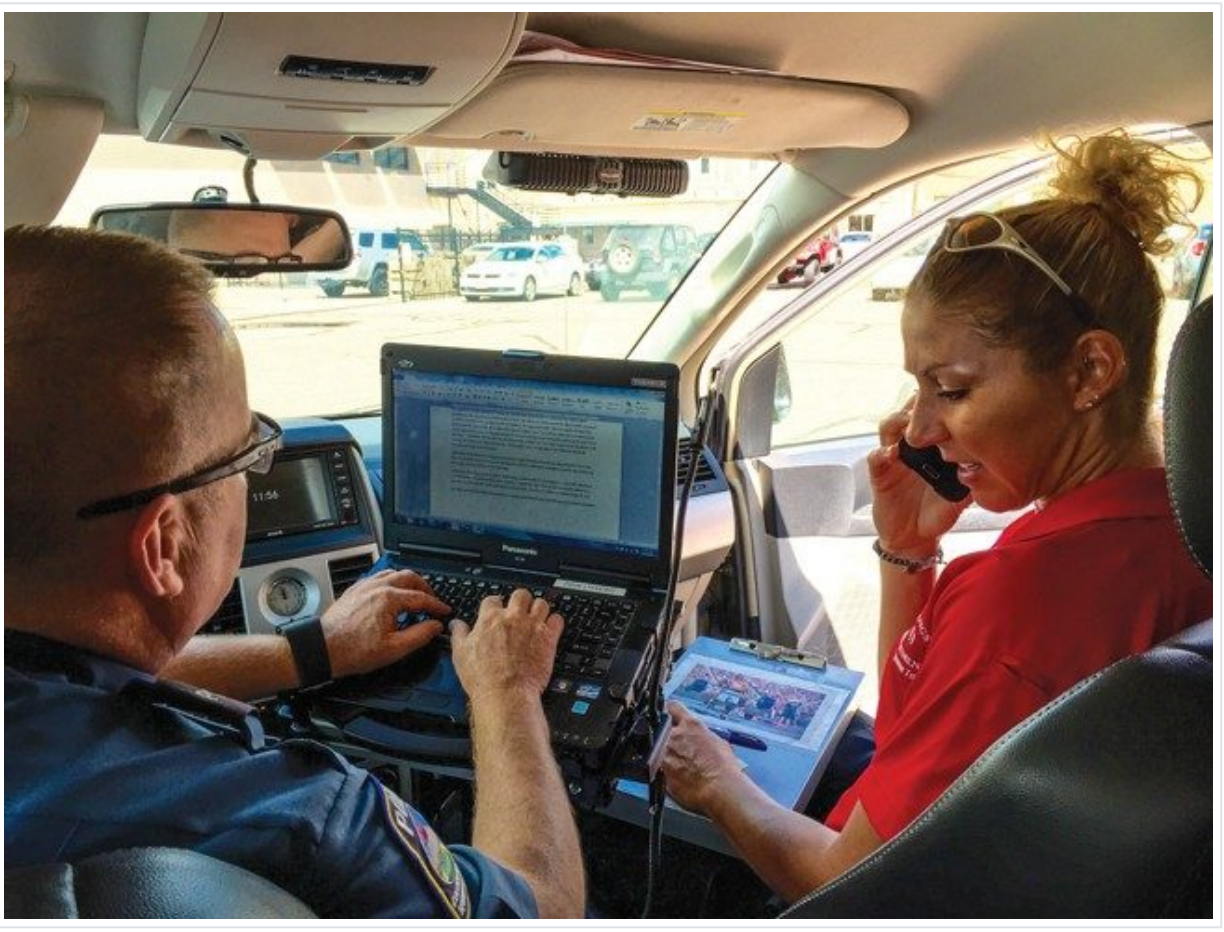
APPENDIX C

The Conscience of EMS JEMS JOURNAL OF EMERGENCY MEDICAL SERVICES ®

Mobile Integrated Healthcare Program Changing How EMS Responds to Behavioral Health Crises

Sat, Oct 1, 2016 | By Stein Bronsky, MD , Kristin Giordano , Robin Johnson, MD, FACEP



Photos courtesy Stein Bronsky/Colorado Spring Fire Department

The patch comes over the radio: A paramedic informs the local hospital's ED that her team is en route with a suicidal male who requires psychiatric evaluation. The paramedic and her crew were on scene for an hour trying to convince him to consent to receive help.

At the hospital, the paramedic shares the information she collected with the ED staff, who assume responsibility for the patient. A lengthy ED stay—his fourth this year—is in this patient's future.

This all-too-common scenario occurs across the country, spurring the same thoughts among emergency providers who attend to patients in crisis: Wouldn't it be better if there was an efficient way to deliver definitive services to patients with psychiatric emergencies besides the status-quo inefficient field navigation and prolonged ED visits? Can the high recidivism of patients in behavioral health crisis be combatted with the proper tools and infrastructure to facilitate proper and timely navigation for these patients? Isn't there a more appropriate primary option for helping patients with behavioral health crises than the already-stretched-too-thin EMS, law enforcement and ED resources?

Reforming Old Ways

Community stakeholders in Colorado Springs, Colo., decided to channel those lines of thought into action. In 2012, the Colorado Springs Fire Department (CSFD) started a mobile integrated healthcare/community paramedicine program to address the issue of frequent users of EMS and local EDs. The Community Assistance Referral and Education Services (CARES) program gave special attention to the 76% of frequent 9-1-1 users with behavioral health issues, with EMTs and paramedics making home visits and providing assistance with education and navigating patients to community resources.

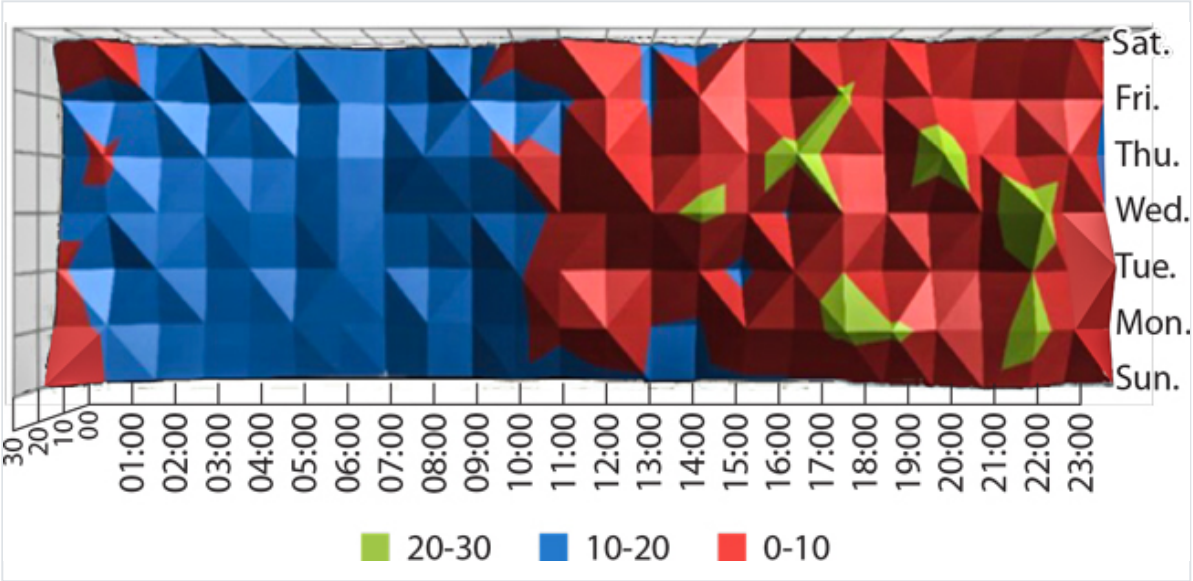
The program achieved considerable success by dropping 9-1-1 one-year use by 50% among two-thirds of the program's patients.

CARES program stakeholders recognized that if they didn't find working solutions to underlying psychiatric concerns in the community's population, the CARES programs

would see limited sustainable success without additional community assistance/support.

However, CARES was set up as a nonemergent program, working with patients only after multiple 9-1-1 calls or ED visits. CARES doesn't change the system's response to initial, emergent psychiatric crises. Calls to 9-1-1 by patients experiencing an emergent behavioral health crisis would still be met with the same timely response that a patient who had suffered severe trauma, myocardial infarction, or stroke would see: three CSFD EMTs, one CSFD paramedic, one American Medical Response (AMR) paramedic, one AMR EMT, and one to three law enforcement officers. A psychiatric patient might need further evaluation and medication and perhaps placement in a psychiatric hospital. A patient with a mental health crisis might wait days to receive the help that they needed, even after arriving at the ED. Clearly, this one-size-fits-all approach was neither necessary nor effective.

Figure 1: Colorado Springs citywide time of day and day of week for behavioral health calls for service



Creating a new program and protocols that would effectively address the issue of psychiatric crises wouldn't be easy. Years of history indicated that emergency personnel and other episodic care providers regularly experience complications in treatment and disposition of patients with underlying behavioral health conditions. The treatment modalities for psychiatric patients, in fact, reflect system-wide, multidisciplinary, resource utilization inefficiency.

Another challenge was that the training curriculum for firefighters, EMTs, paramedics and law enforcement doesn't include comprehensive training on managing behavioral

health crises, and even expanded protocols and training wouldn't give them the necessary tools to efficiently and safely manage and disposition psychiatric patients.

Moreover, community collaborators were aware that for patients who truly need psychiatric treatment, interaction with local emergency responders often doesn't result in optimum patient outcomes. When police respond and eventually contact EMS, there's already been a delay in care, sometimes with adverse outcomes. And the arrival of EMS doesn't necessarily translate into efficient care; EMS personnel aren't equipped to perform a true medical clearance, psychiatric evaluation, or determine and facilitate a definitive disposition.

Thus, EMS essentially becomes a taxi service to the ED. And once the patient arrives at the ED, he or she can spend several hours or even days there before appropriate intervention and disposition or treatment occurs. So what really exists is a handoff from one agency to the next, each of which isn't designed for effective management of behavioral crises.These suspicions would later be statistically confirmed by a retrospective evaluation of emergency calls in Colorado Springs that revealed 81.1% of all CSFD responses were medical in nature and 18.1% of the 49,297 medical 9-1-1 calls to CSFD in 2014 involved behavioral health emergencies, over 98% of which were transported the local EDs by AMR.

The Colorado Springs Community Response Team sees an average of 81

patients per month.

Vital Elements Identified

Cross-agency collaboration was key in working toward a solution. In 2012, a local summit to address the lack of mental health services brought 36 different agencies together to map the existing behavioral health patient navigation process and better understand the issues.

At the outset, the stakeholders identified three critical elements as being vital to a positive outcome: scene safety, medical clearance and definitive disposition—and for optimal results, all of these components must take place simultaneously on scene.

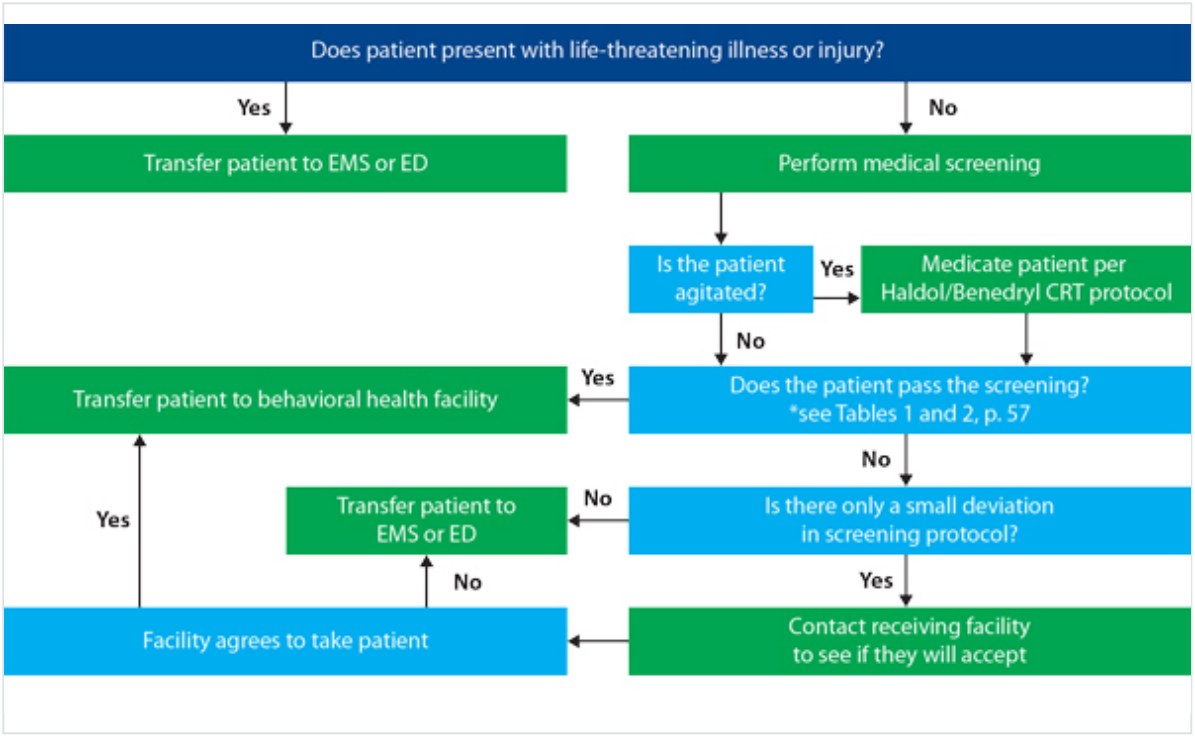
The first step toward program development involved conducting a comprehensive analysis of the treatment path for psychiatric patients in the EMS system as it already existed—from initial contact to definitive disposition. That exploration revealed that the system was surprisingly complex, involving more than 50 points of contact, including dispatch communication centers, crisis lines, law enforcement, the fire department, EMS, hospital EDs, physicians, nurses, lab technicians, social workers and behavioral health organizations.

Another surprise that emerged from the analysis was the significant number of contacts by law enforcement with individuals experiencing behavioral health issues that never resulted in EMS or ED contact. The analysis indicated that law enforcement officers were requesting EMS assistance on only 20% of calls in which they dealt with such patients. This data clearly demonstrated the enormity of law enforcement resource utilization in behavioral health issues.

With this information in hand, the Colorado Springs Police Department (CSPD) and CSFD collaborated with AspenPointe, a local behavioral health organization, to form a specially staffed mobile integrated mental emergency response team to efficiently and expertly evaluate and disposition behavioral health patients directly from the field.

First deployed in December 2014, the Community Response Team (CRT) consists of a CSFD medical provider, a CSPD officer and a licensed behavioral health clinician. Deployment was originally set at 40 hours per week from 10 a.m. to 7 p.m., Monday through Thursday, based on the days of the week and times of day with the highest behavioral health 9-1-1 call volume. (See Figure 1, above.)

Figure 2. Colorado Springs Fire Department Community Response Team protocol



From December 2014 through May 2015, the unit responded to 764 incidents and saw 488 patients, averaging 81 patients per month, with 86% of patients being managed in place or dispositioned directly to a mental health facility, and only 14% of patients requiring transport to local EDs for further medical evaluation. These initial successes within the first six months led to the deployment of a second CRT unit on July 1, 2015.

CRT2 is scheduled an additional 40 hours each week to cover the weekend—Friday through Monday. The two units overlap deployment to address the higher volume of 9-1-1 psychiatric incidents that occur on Mondays and, together, the units ensure daily coverage to respond to 9-1-1 and crisis hotline calls where a patient is or may be experiencing a behavioral health crisis.

Prior to the CRT program, 98% of patients seen by the CSFD and AMR for a behavioral health crisis were transported to the ED. In a matter of months, this new approach has significantly reduced strain on local emergency services, law enforcement and local EDs by intersecting, diverting and redirecting behavioral health patients to appropriate community resources directly from the field.

The local 9-1-1 call center helps by diverting qualified calls directly to the CRT, therefore decreasing the burden of these calls from the regular EMS, FD and PD dispatch.

Table 1: Field medical clearance protocol

Patient demeanor	
Pt can follow basic commands	
Pt is not aggressive	
Pt can demostrate some self control	
Vital signs	
Systolic BP: >90 <180	
Heart Rate: >50 <120	
$PaSO_2$: > 88% RR > 8–< 24	
Chem 8 values	
Na > 126 < 150	K > 3–< 6
TCO_2 > 16	Glu < 300
BUN < 25	Crea < 2
Hb > 8.5	Anion gap < 15
UA values	
Pregnancy test results (negative)	
Urine tox negative other than THC	
Breathalizer	
EtOH ≤ 200	

Table 2: Psychiatric facility admission exclusion criteria

1	Unable to ambulate or transfer self if in a wheel chair.
2	Wound care must be able to be cared for by patient and no active MRSA or Staph resistant infections are acceptable.
3	IV's, tracheostomies, chest tubes, or PIC lines.
4	IQ < 70.
5	Patient on methadone.
6	Shakes are OK but no serious active withdrawal from substance (for example change in vital signs, vomiting, hallucinations).
7	Active TB or other communicable diseases.
8	Dialysis, chemotherapy, or HIV regimens or tube feedings.
9	Patient requires specialized medical equipment such as ventilator, positive pressure machine. This does not include oxygen or CPAP, Bi-PAP if they have their own equipment.
10	On Coumadin if history of unstable INR that requires active testing.
11	Active vomiting, diarrhea, acute head injuries, respiratory distress or uncontrolled asthma, uncontrolled seizures, severe alcohol withdrawal, prolonged post-ictal phase, other acute medical condition.

Unit Composition

The success of the CRT can primarily be attributed to the team's unique, multidisciplinary composition. When the CRT arrives on scene, it carries an assortment of personnel and skills: an EMS provider, law enforcement officer, and a licensed clinical behavioral health social worker.

A fire department medical provider performs a medical clearance in the field. (See Table 1, above.) The medical clearance algorithm includes a physical exam, serum labs, a urine toxicology screen and a urine pregnancy test. This medical clearance system allows the team to decrease and eliminate unnecessary evaluations in the ED. Additionally, the FD medical provider screens every patient by facility admission eligibility, using criteria pre-designed by the partnered psychiatric facility. (See Figure 2, above.)The medical provider also has the ability to employ chemical sedation when needed.

A police officer provides scene safety and addresses law enforcement needs. Scene safety is often a challenging obstacle for EMS providers in traditional behavioral health crises, and the presence of the officer on scene helps to mitigate potential negative outcomes for both the patient as well as for the EMS personnel. Having an officer on scene also helps prevent the need for EMS calls for PD assistance in the traditional response model.

A medical clearance algorithm for behavioral health patients in an emergent crisis helps decrease prolonged field assessment times and eliminate unnecessary evaluations in the ED.

A licensed clinical social worker provides guidance on how to manage the patient, including on-scene crisis de-escalation, navigation to outpatient resources or disposition to a behavioral health facility.

The CRT unit has the authority to transport patients to designated receiving facilities, reducing the overuse of limited resources. Implementation of the CRT unit has resulted in an unprecedented streamlining between the initial 9-1-1 call for an acute behavioral crisis and patient receipt of definitive behavioral health services. Of the 2,519 patients treated by both CRT units from Jan. 1, 2015 through June 30, 2016, 49% were treated in place and 27% were transported to the local Crisis Stabilization Unit (CSU).An additional 9% were transported by CRT to a non-CSU psychiatric facility, including the County Detoxification Facility and local in-patient psychiatric hospitals. About 15% didn't meet CRT criteria for scene clearance or disposition to an alternate destination and were therefore transported to the ED for further evaluation.

CRT refers patients requiring long-term stability to the CARES program for navigation to non-emergent medical, social and behavioral health resources.

Early indications reveal behavioral health patients are benefiting from ongoing navigation: ED recidivism for CARES patients has been reduced by nearly 50%, and 88% of patients seen by the CRT in 2015 were only seen once by the CRT.

The CRT has also proven to be a marked workforce multiplier for police, EMS and ED resources. From Jan. 1, 2015 through June 30, 2016, the CRT unit has responded to 3,984 calls and treated 2,519 patients, which resulted in a release of 906 fire/EMS crews and 2,448 police units back into service. When you take into account that each call consumed an average of 45 minutes, this adds up to a tremendous amount of personnel hours saved for other vital FD, EMS and PD services.

Looking Ahead

Initial support came from a combination of statewide grant funding and partner contributions. Continued partnerships with behavioral health organizations, FD and PD are generating opportunities for sustainability.

In evaluating the effect of the CRT program, one thing is clear: This innovative approach to responding to behavioral health crisis has shifted the EMS paradigm for Colorado Springs, and may serve as a model for other communities to achieve that same goal.

By

Stein Bronsky, MD

Kristin Giordano

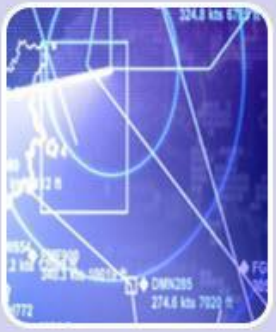
Robin Johnson, MD, FACEP

APPENDIX D

How Does Your Crisis System Rate?

A Framework for State/Regional Self-Assessment

For more info see http://crisisnow.com





What makes Level 5 different?	① Call Center Hub Real Time Access Valve Mgmt	② Mobile Outreach Meets Person at Home/Apt/Street	③ Sub-acute Stabilization Direct LE Drop Off <10 Min	Crisis Now System Equal Partners 1st Responders	Level 5 System Also Conforms to 4 Modern Principles
Level 5: FULLY INTEGRATED	Air Traffic Control Connectivity	Adequate Access Statewide	Adequate Access Statewide	Adequate Access Statewide Plus →	① Priority Focus on Safety/Security
Level 4: CLOSE	Data Sharing (Not 24/7 or Real Time)	Statewide Access but Reliant on ED	Statewide Access but Reliant on ED	Integrated System w/ Diversion Power	② **Suicide Care Best Practices**, e.g. Systematic Screening, Safety Planning and Follow-up
Level 3: PROGRESSING	Formal Partnerships	Adequate Access **<1 Hr Response**	Adequate Access **>50% Bed Available**	Adequate Access Major Payers Included	
Level 2: BASIC	Shared MOU/ Protocols	Some Availability Limited to Urban	Some Availability Limited to Urban	Limited State/ County Support	③ Trauma-Informed, Recovery Model
Level 1: MINIMAL	Agency Relationships	None or Very Limited Availability	None or Very Limited Availability	Fragmented Status Quo	④ Significant Role for Peers

APPENDIX E

Crisis Services Task Force

National Action Alliance for Suicide Prevention

Crisis Now

Transforming Services is Within Our Reach

Suggested Citation Format: National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc.

The National Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership advancing the *National Strategy for Suicide Prevention* by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the National Strategy for Suicide Prevention (NSSP), and cultivating the resources needed to sustain progress. Launched in 2010 by Health and Human Services Secretary Kathleen Sebelius and former Defense Secretary Robert Gates, the Action Alliance envisions a nation free from the tragic event of suicide. Education Development Center, Inc. (EDC), operates the Secretariat for the Action Alliance through the Suicide Prevention Resource Center.

Learn more at http://actionallianceforsuicideprevention.org

Contents

Foreword: Message from Co-leads

Vastly outnumbered. Ill equipped. Foraging for resources. The nation's emergency departments are the Alamo of mental health access and care.

The recent headline was not surprising: "8 in 10 ER Docs Say Mental Health System Is Not Working for Patients." The survey by the American College of Emergency Physicians (ACEP) of 32,000 physicians, residents, and medical students working in hospital emergency departments concluded that "boarding" wait times for psychiatric inpatient needed to be reduced and more training and education of staff about psychiatric emergencies was required (http://prn.to/1VIKuU4).

Sheree Kruckenberg is Vice President of Behavioral Health for the California Hospital Association, which represents 400 hospitals and health systems. Her April 2015 open letter drew similar conclusions:

> *The increasing dependence on…hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff (http://bit.ly/1PxFqSq).*

Everyone seems to agree with the problem.

While efforts to improve suicide care in emergency departments (e.g., as suggested by the recent Joint Commission Sentinel Event Alert #56) are necessary, we must also work toward more fundamental improvements in crisis care.

Several pioneering states have already shown us a path.

The vision of the National Action Alliance for Suicide Prevention is a nation free from the tragic experience of suicide. The members of the Crisis Services Task Force hope that this report, *Crisis Now: Transforming Services is Within Our Reach*, will lead to expedited and substantive changes in behavioral health crisis care.

The time is now. Together, we can, and must, do this.

David W. Covington, LPC, MBA
CEO & President
RI International

Michael F. Hogan, PhD
Principal
Hogan Health Solutions

Introduction and Overview

Summary of the Problem

Crisis mental health care in the United States is inconsistent and inadequate. This is tragic in that good crisis care is a known effective strategy for suicide prevention, a preferred strategy for the person in distress, a key element to reduce psychiatric hospital bed overuse, and crucial to reducing the fragmentation of mental health care.

Short-term, inadequate crisis care is shortsighted. Imagine establishing emergency services in a town by purchasing a 40-year-old fire engine and turning the town's old service shop into the fire station. It will work until there is a crisis.

With non-existent or inadequate crisis care, costs go up because of hospital readmissions, overuse of law enforcement, and human tragedies. In too many communities, the "crisis system" has been unofficially handed over to law enforcement, sometimes with devastating outcomes. Our current approach to crisis care is patchwork, delivering minimal care for some people while others (often those who have not been engaged in care) fall through the cracks—resulting in multiple readmissions, life in the criminal justice system, or death by suicide.

Our country's approach to crisis mental health care must be transformed. Crisis care is the most basic element of mental health care, yet in many states and communities, it is taken for granted. Limited. An afterthought. A work-around. Even non-existent. In many communities, the current crisis services model depends primarily upon after-hours work by on-call therapists or space set aside in a crowded emergency department (ED). These limited and fragmented approaches are akin to plugging a hole in a dike with a finger.

Include Crisis in Mental Health Reforms

Foundational elements of an improved mental health system are in place with mental health parity, coverage expansion, the launch of the Certified Community Behavioral Health Clinics and the Excellence in Mental Health Act, and the national implementation of first episode psychosis programs. Our nation's political leaders recognize the work is not done, and for the first time in many years, there are several robust legislative proposals that focus on "fixing the broken mental health system." Now is the time to get it right. Therefore, comprehensive crisis care must be included in mental health reform. Yet systematic improvements in crisis care, which could save lives and reduce fragmentation, are not included in current leading reform proposals.

> *Now is the time to establish comprehensive crisis care as a foundational, transformative, life-saving core element of behavioral health care and of suicide prevention.*

A Time for Change

After reviewing approaches to crisis care across the United States, the Crisis Services Task Force (hereafter "Task Force") of the National Action Alliance for Suicide Prevention (Action Alliance) believes now is the time for crisis care to change. The Task Force, established to advance objective 8.2 of the *National Strategy for Suicide Prevention* (NSSP), comprises many experts (see Task Force and Support Team Participants in the Appendix), including leaders who have built and who operate many of the most acclaimed crisis programs in the nation.

After reviewing the literature and model programs, we offer this report to suggest what can be done, galvanize interest, and provide a road map for change. Our comprehensive review finds that now is the time for crisis services to expand because of a confluence of factors and forces, including:

- Crisis care often being the preferred and most efficient care for people in crisis
- The absence of core elements of successful crisis care in many communities
- Mental health reform proposals that are on the table but fail to seize the opportunity to improve crisis care
- Mental health parity legislation and coverage expansion

The challenge EDs face addressing behavioral emergencies

The Task Force has studied elements of successful programs and reviewed their effectiveness. While some communities are crisis-ready, there are very few communities where all key elements of crisis care are in place, and many where even the "parts" of crisis care that exist are inadequate.

In short, core elements of crisis care include:

1. Regional or statewide crisis call centers coordinating in real time
2. Centrally deployed, 24/7 mobile crisis
3. Short-term, "sub-acute" residential crisis stabilization programs
4. Essential crisis care principles and practices

These elements are discussed in more detail later in this report. Effective crisis care that saves lives and dollars requires a systemic approach, and these key elements must be in place. In this report we will review the proven key components of good crisis care and demonstrate that piecemeal solutions are unacceptable.

Crisis Care as a Part of Mental Health Infrastructure

The tragedies and problems associated with inadequate crisis care have produced wounds in our national identity and revealed unacceptable chasms in care. These chasms are longstanding, having been made worse by deinstitutionalization and never filled in the 50+ years since President Kennedy's Community Mental Health initiative. Growth of some mental health services has undeniably occurred as

a result of parity legislation and coverage expansion. However, expanded coverage has not led to adequate crisis care, because crisis care must be built and paid for as part of mental health infrastructure.

Preventable Tragedies

An adequate crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. Tragedies like:

- Thousands of Americans dying alone and in desperation from suicide: In 2014, 42,773 people ended their life by suicide. Over the last 15 years, the rate of increase in suicide deaths exceeds the increase in every other leading form of death except Alzheimer's disease. In July 2015, the Action Alliance launched the Task Force, with the goal to provide stronger 24/7 supports to the 9 million Americans at risk each year. Over 115 people per day in the United States die alone and in despair.
- Unspeakable family pain: In November 2013, Virginia State Senator Creigh Deeds told CNN that he was alive for just one reason: to work for change in mental health. A week earlier, he was stabbed 10 times by his son, Austin "Gus" Deeds, who then ended his life by suicide. The incident happened hours after a mental health evaluation determined that Gus needed more intensive services. Unfortunately, he was released before the appropriate services could be found (http://bit.ly/cbs-deeds).
- Psychiatric "boarding": In October 2013, the *Seattle Times* concluded its investigation of the experience for individuals with mental health needs in EDs. "The patients wait on average three days—and in some cases months—in chaotic hospital EDs and ill-equipped medical rooms. They are frequently parked in hallways or bound to beds, usually given medication, but otherwise no psychiatric care (http://bit.ly/ST-boarding)." In 2014, the Washington State Supreme Court ruled the practice of "psychiatric boarding" unconstitutional (http://bit.ly/Forbes-SupremeCourt).
- The wrong care in the wrong place, delivered in a way that compromises other medical urgent care: In April 2014, California approved $75 million for residential and crisis stabilization and mobile support teams. This investment was based on the belief that 3 out of 4 visits to hospital EDs for mental health and addiction issues could be avoided with adequate community-based care (http://bit.ly/CA-crisiscare).
- Law enforcement working as "mobile crisis": Law enforcement resources in many communities are tied up delivering "substitute crisis care" because mental health crisis care is inadequate. The results have sometimes been tragic, have added to the stigma associated with mental illness, and have drawn police resources away from other priorities. A January 13, 2015, *New York Times* Op-Ed piece described the recent death of 19-year-old Quintonio LeGrier, who was shot and killed by a Chicago police officer a month earlier. The author links the death with recent substantial cutbacks in Illinois's troubled mental health system (including the closure of half of Chicago's mental health centers) and recommends that "we need to invest more broadly in a mental health crisis system to work in conjunction with the police" (http://bit.ly/OpEd-LeGrier).

Five compelling reasons for change. In this document, the Task Force will present solutions that work to address one of our most stubborn human problems.

Some States Are Making Progress

In a few states and communities across the United States, solutions are in place. *But until now we did not have the vision or will to approach crisis care with national resolve and energy.*

Systematic reform of crisis care has been or is being implemented in a number of states like California, Colorado, Georgia, and Washington State. These states were driven to new approaches for different reasons; however, their approaches share the four core, common elements presented earlier and are explained in further detail below:

1. **Regional or Statewide Crisis Call Centers**. These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards.
2. **Centrally Deployed Mobile Crisis on a 24/7 Basis**. Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.
3. **Residential Crisis Stabilization Programs**. These programs offer short-term "sub-acute" care for individuals who need support and observation, but not ED holds or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.
4. **Essential Crisis Care Principles and Practices**. These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

These core elements of comprehensive crisis care are drawn from well-established principles for emergency services, as well as new developments in technology and mental health care. Historically, the essential nature of crisis/emergency services was established when emergency services were designated one of five categories of "essential services" required to be offered by community mental health centers (CMHCs). These centers resulted from President Kennedy's 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164).

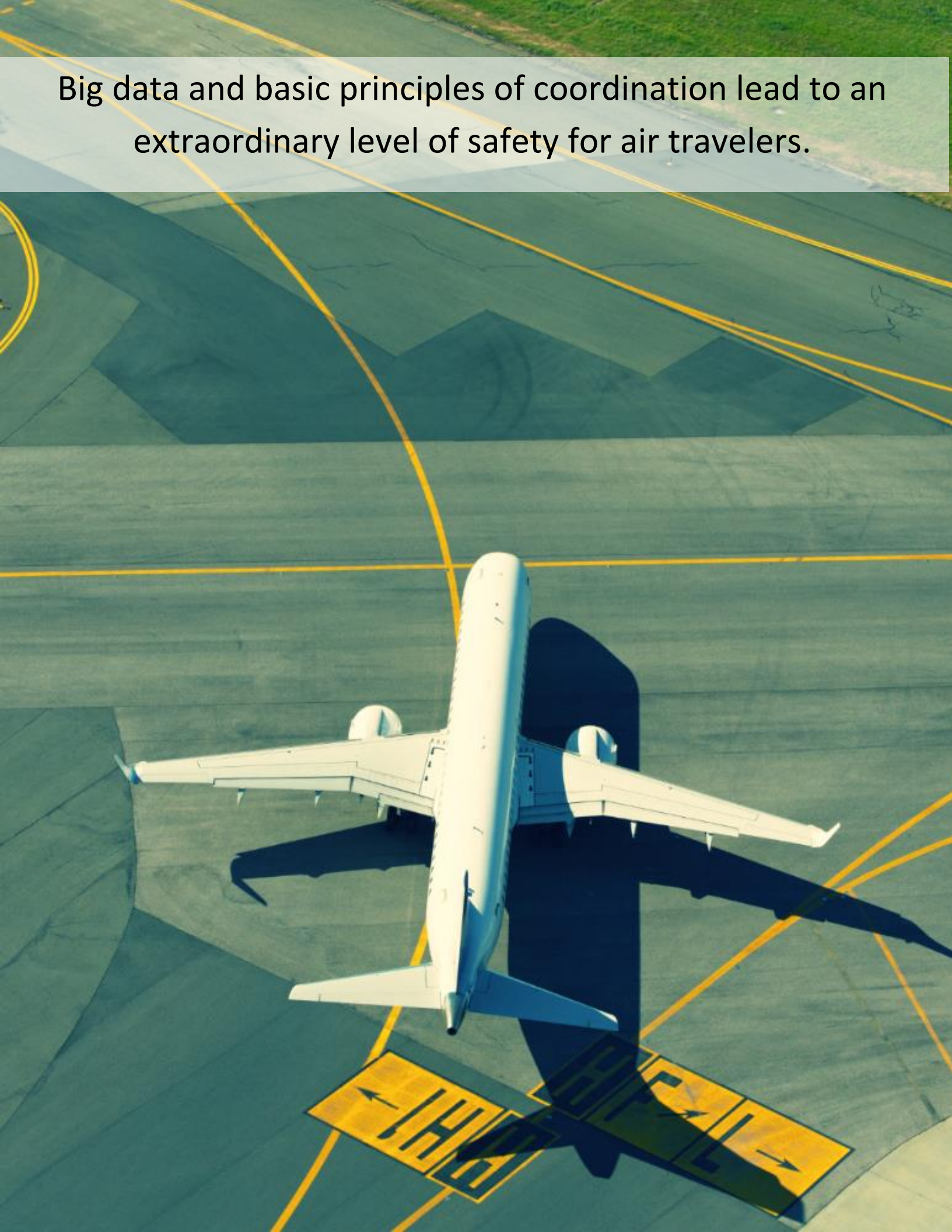
The central mission of crisis services and the core elements described above are not new. In 1979, Massachusetts's Brewster v. Dukakis Consent Decree (76-4423, D. Mass., 1979) defined the *crisis intervention unit* required for each area as "a program designed to provide crisis intervention on a 24 hour a day, 7 days a week basis for up to five days, 24 hours a day to clients both new to the [mental health] system and those already receiving services" (p. 151). The program was intended to serve "clients who are acutely and severely disturbed, including those who may be dangerous to themselves

or others, extremely psychotic, intoxicated, or experiencing some severe life crises" and was to act as a gatekeeper for hospital care "for highly assaultive persons or those needing medical attention" (p. 151–152).

In addition to these long-established principles, the evolution of information and communications technology and of best practices in mental health care has led to newer elements of comprehensive crisis care that we can now define as essential:

- Harnessing Data and Technology. The Georgia Crisis and Access Line utilizes technology and secure Web interfaces to provide a kind of "air traffic control" (ATC) that brings big data to crisis care and provides the ability of real-time coordination. This essential capability could not have been envisioned a generation ago.
- Power of Peer Staff. PEOPLe, Inc.'s Living Room model, peer staffing, and the retreat model provide safety, relief, and recovery in an environment more like a home than an institution. The paradigm of recovery and the value of peers, highlighted in the Surgeon General's report on mental health (DHHS, 1999) and the report of the President's New Freedom Commission on Mental Health (DHHS, 2003), are now cornerstones of modern mental health care.
- Power of Going to the Person. Colorado mobile crisis teams do not wait for law enforcement to transport a person in need to the hospital. They go to the person. Colorado is the first state to prove this can be done everywhere, and in *any* area: urban, rural, and even frontier. Combining modern technology with the long-established value of care close to home, this approach is essential in modern crisis care (also, see the Action Alliance's *The Way Forward* report).
- Evidence-based Suicide Prevention. The effectiveness of high-quality crisis lines in suicide prevention has been well established (e.g., Gould et al., 2007). The nation has a national crisis line in the NSPL, but crisis care in many communities is lacking. Since the NSPL's network of qualified local crisis lines depends on state and local resources to fund participating centers, many parts of the United States do not have a local crisis line. Thus, many calls to the NSPL's 1-800-273-TALK (8255) number are answered in their regions or in a national call center, not in a local center where both crisis calls and in-person crisis support can be most effectively delivered.

These approaches to modern crisis care must be developed in every state. The systems blend both long established principles (regional or statewide 24/7 functioning, focus on urgent care for an entire population, use of structured alternatives to hospitalization) with new approaches that were not available or proven during President Kennedy's time (sophisticated communications, real-time data, and the proven power of peers to facilitate engagement and recovery). Table 1 demonstrates this.



Big data and basic principles of coordination lead to an extraordinary level of safety for air travelers.

Table 1: Modern Crisis Care Changes the Paradigm

FROM	TO
Absence of data and coordination on ED wait times, access, crisis bed availability, and outcomes	Publically available data in real-time dashboards
"Cold" referrals to mental health care are rarely followed up, and people slip through the cracks	Direct connections and 24/7 real-time scheduling
EDs are the default mental health crisis center	Mobile crisis provides a response that often avoids ED visits and institutionalization
Crisis service settings have more in common with jails; police transport to distant hospitals takes law enforcement off the beat and is unpleasant and stigmatizing for people in crisis	Crisis service settings—the urgent care units for mental health—look more like home settings and also provide a reliable partner for law enforcement
Despair and isolation worsened by trying to navigate the mental health system maze	Crisis care with support and trust: what the person wants and needs, where the person wants and needs it

Our society takes for granted a national emergency medical response system. 911 centers use advanced technology to ensure individuals with *other medical problems* do not fall through the cracks. For example, using mobile scanners for immediate assessment that supports timely administration of clot-busting medications has transformed stroke and heart attack care. With emergency medical services in nearly every area of the country, ambulance services go to the person directly to ensure life-saving care for acute heart disease. If this can be done for heart disease and stroke—a brain condition—we can, and must, also do it for mental health crises.

This brings us to our first recommendation:

> *Recommendation 1: We recommend national-and state-level recognition that effective crisis care must be comprehensive and include the core elements listed above.*

Overview of the Report

In the sections that follow we summarize findings about the essential elements of effective, modern, and comprehensive crisis care, and the actions needed to bring it to communities across the United States. The following is an overview of the report.

- **Section 1:** Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text, chat), meeting the standards of the NSPL and also providing ATC-quality coordination of crisis care, with real-time data management of:
    - Clients in crisis
    - Availability of outpatient and inpatient services in the area
    - Mobile crisis teams
    - Crisis stabilization programs
- **Section 2:** Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or other convenient and appropriate setting
- **Section 3:** Crisis stabilization facilities providing short-term observation and support in a home-like, non-hospital environment
- **Section 4:** The essential qualities that must be "baked into" comprehensive crisis systems, including:
    - Embracing recovery, significant use of peers, and trauma-informed care
    - Suicide safer care, providing comprehensive crisis services that include all core elements described in this report
    - Safety and security for staff and consumers
    - Law enforcement and crisis response training and coordination
- **Section 5:** Financing crisis care, including a discussion of current payment/financing models, as well as opportunities and threats in the current environment
- **Section 6:** Strategic directions for crisis care

About the Task Force

This report, prepared by the Task Force of the Action Alliance, summarizes the status, needs, and opportunities for mental health crisis care. The Task Force was launched in July 2015 by the Action Alliance and was composed of 31 leaders in the field of crisis services (list of members is included at the end of this document). In preparing this report, which was reviewed by all members, the Task Force also considered a recent national review of key issues in crisis care, *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies* (Substance Abuse and Mental Health Service Administration, SAMHSA, 2014) for evidence of effectiveness and as a basis for recommendations on funding.

Our review has taught us that all the elements of excellent crisis care are proven and have been demonstrated as feasible in some communities. However, many essential elements are not available in most communities. Sadly, this gap is both fatal and expensive. It will only be filled by the efforts of both a united mental health community and leadership by elected and appointed officials.

In all the states that have achieved or are advancing comprehensive crisis care, the involvement of elected/appointed officials was crucial. Change was achieved with activating legislation in California and Colorado, engagement of governors in Colorado and Georgia, and prodding by the judicial branch (Department of Justice, Supreme Court) in Georgia and Washington State.

Section 1: Air Traffic Control (ATC) Capabilities with Crisis Line Expertise

As mentioned in the introduction, State Senator Creigh Deeds was stabbed by his son, Gus, who then took his own life by suicide. Shortly before, Gus had been assessed at a local hospital and a magistrate had ordered an involuntary commitment, but no beds were available at any nearby inpatient psychiatric hospitals, so Gus was sent home (Gabriel, 2013). Sadly, it is common for individuals in mental health crisis to initially be assessed, but then later be released, only to "fall through the cracks" (http://bit.ly/CNN-Deeds).

The cracks occur because of interminable delays for services deemed essential based on professional assessments and are often attributable to two critical gaps, including the absence of:

1. Real-time coordination of crisis and outgoing services
2. Linked, flexible services specific to crisis response, namely mobile teams and crisis stabilization facilities

Because of these gaps, individuals walk out of an ED often "against medical advice" and disappear until the next crisis occurs.

Making the Case for a Close and Fully Integrated Crisis Services Collaboration

Prior to 2000, there were several hundred local crisis call centers across the country, underfunded, fragmented, and lacking in credibility with policymakers and funders. Staffed with dedicated volunteers, these poorly funded programs lacked the technology, data-tracking tools, and consistent protocols needed to effectively perform their work. In some larger communities with strong community mental health programs, crisis call centers were part of or strongly linked to mental health crisis care programs. But many communities lacked comprehensive crisis services, and advocates questioned the value and effectiveness of crisis call centers.

The nation's approach to crisis call centers received a significant upgrade starting in 2004 with creation of the NSPL. Over time, the NSPL has demonstrated its effectiveness and raised the performance bar for crisis call centers.

Comprehensive crisis systems are necessary to prevent avoidable tragedies and to orchestrate effective care. It is time to establish crisis systems as essential in a system of care, and to raise the bar on their functioning, to achieve a different set of results.

> *Recommendation 2: Crisis call services should participate in and meet the standards of the NSPL, and crisis intervention systems should adopt and implement Zero Suicide/Suicide Safer Care across all program elements.*

However, two critical problems remain. First, in many parts of the United States, there is no qualified crisis call center, thus calls roll over to a regional or national center, which may be in a different state. Second, in most communities there is not a comprehensive crisis care system that includes or is linked with ATC-like capabilities to the local call center.

ATC systems provide a meaningful point of reference for the necessity of national availability of service, with consistent standards and functioning. The ATC analogy teaches us important lessons in the value of real-time, technology-driven coordination and collaboration. Adopting an ATC model for crisis services could significantly reduce the incidence of suicide by individuals in crisis.

Learning from ATC Safety

ATC works to ensure the safety of nearly 30,000 U.S. commercial flights per day. In the United States this occurs with a very high success rate. ATC makes it remarkably safe to fly today.

But it can be very unsafe for an individual experiencing a mental health crisis.

The advancements in ATC that have helped transform aviation safety are two vitally important objectives, and without them it is nearly impossible to avoid tragedy:

- Objective #1: Always know where the aircraft is (in time and space) and never lose contact.
- Objective #2: Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

These objectives easily translate to behavioral health and to a crisis system of care in particular. Always knowing where an individual in crisis is and verifying that the hand-off has occurred to the next service provider seem like relatively easy objectives to fulfill, yet they are missing from most of the U.S. behavioral health and crisis systems. Individuals and families attempting to navigate the behavioral health system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that ATC provides.

The ATC Model for Crisis Services

This model used within integrated crisis call centers creates a professional framework for all levels of crisis services. It provides a hub for effective deployment of mobile crisis and for ensuring timely, appropriate access to facility services like crisis stabilization and crisis respite, and ultimately psychiatric hospitalization. Furthermore, this model is considered a part of the whole, integrated crisis system of care. It identifies the next generation of integrated crisis systems and the essential components that are required, including:

- Qualified crisis call centers that meet the standards of and participate in the NSPL
- 24/7 clinical coverage with an identifiable single contact point covering a defined region

- The ability to deploy mobile crisis services, with control over access to a sufficient range and diversity of sub-acute alternatives (respite, etc.), and the ability to secure same-day/next-day outpatient clinical services
- Clinically sufficient personnel to make triage decisions, preferably including control of acute inpatient access
- Clear expectations for outpatient clinical providers that interface with crisis care of routine emergent care

> *Note: The ATC approach does not imply a belief that human beings can be routed like objects, nor is it an effort to force a one-size-fits-all approach on unique geographies, demographics, funding streams, and behavioral health care systems. Rather, it ensures no individual gets "lost" in the system.*

Required Core Elements of an ATC Model Crisis System of Care

The "front door" of a modern crisis system is a crisis call center that meets NSPL standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 160 call centers meet the standards of and participate in the NSPL.

However, in many regions of the country—just as other crisis intervention programs like mobile teams are absent—there is no qualified call center, and calls from distressed people are routed to centers in other states. The Veterans Administration (VA) system, with its own national call center and national network of facilities, is a partial exception to this rule, although travel times to VA facilities in many parts of the country are excessive.

It is no longer acceptable for there to be no local access to a competent call center. Ideally, each call center is embedded in a comprehensive crisis system with ATC capabilities.

The system should provide electronic interconnectedness in the form of secure HIPAA-compliant, easy-to-navigate, Web-based interfaces and community partner portals to support communication between support agencies (including EDs, social service agencies, and community mental health providers) with intensive service providers (such as acute care psychiatric inpatient, community-based crisis stabilization, inpatient detoxification, and mobile crisis response services).

Ubiquitous and inexpensive technology is changing nearly every other industry. It’s time for the same in crisis services.

Interfaces should also include Web-based submission forms for use by collaborating agencies to support mobile crisis dispatch, electronically scheduled referrals by hospitals as a part of discharge planning, and managed care and/or authorization requirements.

An ideal system would provide functionality described in the following sub-sections.

Status Disposition for Intensive Referrals
There must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for medical clearance algorithms, and data on speed of accessibility (average minutes until disposition). The program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Some systems display names on a pending linkage status board, highlighted in green, white, yellow, or red, depending on how long they have been waiting.

24/7 Outpatient Scheduling
Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the state while providing data on speed of accessibility (average business days until appointment).

Shared Bed Inventory Tracking
An intensive services bed census is required, showing the availability of beds in crisis stabilization programs and 23-hour observation beds, as well as in private psychiatric hospitals, with interactive two-way exchange (individual referral editor, inventory/through-put status board).

High-tech, GPS-enabled Mobile Crisis Dispatch
Mobile crisis teams should use GPS-enabled tablets or smart phones to quickly and efficiently determine the closest available teams, track response times, and ensure clinician safety (time at site, real-time communication, safe driving, etc.).

Real-time Performance Outcomes Dashboards
These are outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency provides an extra layer of urgency and accountability.

> *Recommendation 3. State and national authorities should review the core elements of Air Traffic Control qualified crisis systems, apply them to crisis care in their jurisdictions, and commit to achieving these capabilities within 5 years, so that each region of the United States has a qualified hub for crisis care.*

A Continuum of Care

In 2010, the Milbank Memorial Fund published the landmark *Evolving Models of Behavioral Health Integration in Primary Care*, which included a continuum from "minimal" to "close and fully integrated" that would establish the gold standard for effective planned care models and change the views of acceptable community partnership and collaboration (http://bit.ly/MilbankContinuum). Prior to this, coordination among behavioral health and primary care providers had frequently been minimal or non-existent, and it would have been easy to accept any improvement as praiseworthy.

The Milbank report portrayed close agency-to-agency collaboration (evidenced by personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols, etc.) at the lowest levels of the continuum and insufficient. It described these community partnerships and their coordination as minimal or basic, citing only sporadic or periodic communication and inconsistent strategies for care management and coordination. Even organizations with numerous close relationships can be extremely inefficient and ineffective when clinical care relies on telephonic coordination of care (voicemails, phone tag, etc.). It called for frame-breaking change to the existing systems of care, and its report continues to reverberate throughout the implementation of integrated care.

A modification of the Milbank collaboration continuum provides a standard for evaluating crisis system community coordination and collaboration, as shown in Table 2 (http://bit.ly/crisiscontinuum).

Table 2: Continuum to Evaluate Crisis Systems and Collaboration

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM→				
Level 1 **MINIMAL** *Agency Relationships*	*Level 2* **BASIC** *Shared MOU Protocols*	*Level 3* **BASIC** *Formal Partnerships*	*Level 4* **CLOSE** *Data Sharing (Not 24/7 or Real-Time)*	*Level 5* **CLOSE** *"ATC Connectivity"*

In this model, the highest level requires shared protocols for coordination and care management that are supported in real time by electronic processes. For a crisis service system to provide Level 5 close and fully integrated care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update, and monitor available resources in a network of provider agencies.

Given the now-established value of high-quality crisis call centers to support many individuals who may be suicidal or distressed, but who do not need or may not prefer face-to-face care, integration of crisis call centers as the telephonic hub of crisis care is a powerful and effective approach.

Section 1 Conclusion

Statewide community collaboration for Level 5 crisis systems of care is needed. The approaches described above are not theoretical or hypothetical; they have been employed on a statewide basis for nearly eight years in Georgia. New Mexico and Idaho added statewide crisis and access lines in 2013; Colorado launched its statewide system in 2014.

In most U.S. locations, the crisis system is not able to properly track individuals receiving services, from their entry into the system—whether via an ED, a mobile crisis team, a crisis hotline, or a walk-in clinic—to their discharge. It is typical for hand-offs to occur throughout an individual's experience in the crisis system. In a system without close, full integration supported by electronic communication, updates, and monitoring, individuals are too likely to fall through the cracks. The consequences of losing track of people who are in a crisis situation can be disastrous, including potential harm to self and to others.

Section 2: Community-Based Mobile Crisis Teams

Since the 1970s, community-based mobile crisis services have been a core component of crisis care systems. These services emerged in response to the mental health center movement of the 1960s and comprised significant changes in the treatment of people with mental illness (Ruiz et al., 1973).

What is Mobile Crisis?

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Since the mid-2000s many metropolitan area mobile crisis programs have used GPS programming for dispatch in a fashion similar to Uber, identifying the location of teams by GPS signal and then determining which team can arrive at the location of an individual in crisis the quickest.

Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff, for example, a Master's- or Bachelor's-level clinician with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues past the crisis period.

Goals of Community-based Mobile Crisis Programs

According to SAMHSA's recent report on crisis care (2014, p. 10):

> *The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.*

Community-based mobile crisis programs exist in the majority of states, but few have statewide coverage. While terms describing mobile crisis care differ, these programs share common goals to:

1. Help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible
2. Meet individuals in an environment where they are comfortable
3. Provide appropriate care/support while avoiding unnecessary law enforcement involvement, ED use, and hospitalization

Evidence of Mobile Crisis Team Effectiveness and Cost-Effectiveness

SAMHSA's same report confirmed previous evidence on the effectiveness of mobile crisis service:

> *Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.*

SAMHSA (p. 15) summarized the cost-effectiveness of mobile crisis, as well:

> *Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.*

Task Force Findings on Mobile Crisis Services

After reviewing previous reports and research on mobile crisis programs and considering model programs, the Task Force finds mobile crisis services accomplish a wide range of tasks and are a necessary, core component of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an ATC-capable regional call center.

Further, the Task Force recommends that essential functions of mobile crisis services should include triage/screening, including explicit screening for suicidality; assessment; de-escalation/resolution; peer support; coordination with medical and behavioral health services; and crisis planning and follow-up.

Triage/Screening

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and the most appropriate mobile crisis team. In discussing the situation with the caller, the mobile crisis staff must decide if emergency responders should be involved.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve

It’s time for a national ***mental health*** Emergency Medical Services (EMS) system.

the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event, including psychiatric, substance abuse, social, familial, and legal factors
- Safety and risk for the individual and others involved, including an explicit assessment of suicide risk
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports
- Recent inpatient hospitalizations and/or current relationship with a mental health provider
- Medications and adherence
- Medical history

Task Force Spotlight

Becky Stoll, LCSW, VP for Crisis & Disaster Management

Centerstone offers a comprehensive crisis system in 20 counties of Middle Tennessee. The entryway is via a 24/7 virtual Crisis Call Center. Staff work from home with telephonic crisis intervention and follow-up, silent monitoring, call recording, and supervision. Centerstone operates three Mobile Crisis Outreach Teams (MCOT) that respond to any location where an individual is experiencing a behavioral health crisis, regardless of payer status. Many assessments occur in local EDs. In partnership with the Healthcare Corporation of America and the Tennessee Department of Mental Health and Substance Abuse Services, Centerstone provides crisis assessments in many locations via telehealth.

De-escalation and Resolution

Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

Peer Support

According to SAMHSA (2009, p. 8), mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis" (see Significant Role for Peers in Section 4).

For community-based mobile crisis programs, including peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport, share experiences, and strengthen engagement with individuals experiencing crisis. They may also

engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services

Community-based mobile crisis programs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization, treatment in the community (e.g., CMHCs, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA's essential values for responding to mental health crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*" (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support professional should engage the individual in a crisis planning process, which can result in the creation or update of a range of planning tools including a safety plan.

When indicated, they should then follow up with individuals to determine if the service or services to which they were referred was provided in a timely manner and is meeting their needs. For example, Behavioral Health Response (BHR) in St. Louis has a follow-up program in which eligible crisis callers receive a follow-up call within 48 hours by a follow-up coordinator who continues to ensure support, safety, assistance with referrals and/or follow-up until the crisis is resolved or the individual is linked to other services.

Section 2 Conclusion

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations.

Recommendation 4: State and national authorities should work to ensure that mobile crisis teams capable of providing the functions we cite are available to each part of every state.

Section 3: Crisis Stabilization Facilities/Settings

Many individuals in crisis brought to hospital EDs for stabilization report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who had little experience with psychiatric disorders. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals, an experience they did not have at the hospital. In such an alternative setting, psychiatric crises could be de-escalated.

What are Crisis Stabilization Facilities?

In its recent review of crisis services, SAMHSA (2014) defined crisis stabilization as:

> *A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery" (page 9).*

Crisis residential facilities are usually small (e.g., 6–16 beds), and often more home-like than institutional. They are staffed with a mix of professionals and paraprofessionals. They may operate as part of a community mental health center or in affiliation with a hospital. The Task Force recommends crisis stabilization facility function is maximized when the facilities:

- Function as an integral part of a regional crisis system serving a whole population rather than as an offering of a single provider
- Operate in a home-like environment
- Utilize peers as integral staff members
- Have 24/7 access to psychiatrists or Master's-level mental health clinicians

Evidence on Effectiveness and Cost-Effectiveness of Crisis Stabilization Facilities

In general, the evidence suggests a high proportion of people in crisis who are evaluated for hospitalization can safely be cared for in a crisis facility, the outcomes for these individuals are at least

as good as hospital care, and the cost of crisis care is substantially less than the costs of inpatient care. In its recent review, SAMHSA (2014) summarizes evidence on crisis stabilization facilities as follows:

> *The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care. For the studies examined in this review, the populations range from late adolescence (aged 16–18 years) through adulthood. Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. The authors concluded that there is preliminary evidence to suggest that residential alternatives may be as effective and potentially less costly than standard inpatient units (pages 9–10).*

Task Force Findings on Crisis Residential Facilities

After reviewing prior reports and research and considering presentations on model programs, the Task Force recommends that small, home-like crisis residential facilities are a necessary, core element of a crisis system of care.

To maximize their usefulness, crisis residential facilities should function as part of an integrated regional approach within a state serving a defined population (as with mobile crisis teams). Access to the program should be facilitated through the ATC-capable hub of the regional system.

The Task Force also notes two of the most exciting new approaches to crisis residential services: the "living room" and peer-operated respite.

The "Living Room" Model

Ashcraft (2006) and Heyland et al. (2013) describe an alternative crisis setting called "the living room," which uses a different recovery model to support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose.

Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy. A team of "crisis competent" professionals, including peers with lived experience (individuals with first-person knowledge of receiving services and/or experiencing mental health, suicidal and/or addiction experiences), engages with the guest. Risk assessment and management, treatment planning, and discharge goals are set. A peer counselor is assigned to each guest to discuss any crisis and coping skills that can be used to reduce distress and empower the guest on his or her recovery journey.

In some communities, "living rooms"/crisis respite facilities are available for direct drop-off by trained law enforcement teams (see discussion below). This advanced practice can avoid both criminalization of crisis-induced behavior and the costs and potential trauma associated with hospitalization. If it is determined a guest continues to pose a safety threat to self or others, he or she may be transferred to a more intensive level of care.

Peer-Operated Respite

The second new and very promising model of crisis facilities is peer-operated respite. Peer-operated/governed respite programs function at the intersection of the consumer/independent living movement and the professional behavioral health system. They provide restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. A 2013 survey by Ostrow found 13 such facilities around the country, with others planned in 12 states. In some cases, these facilities are part of a local array of peer-operated support activities. At Rose House (2 facilities in New York State), analysis showed costs of peer respite stays were 30% the cost of inpatient care. The Task Force finds that peer-operated respite facilities are a valuable alternative. Ideally, there should be one respite alternative in every crisis care system.

> *Recommendation 5: After reviewing the findings about effectiveness and the cost-sensitive nature of crisis respite care, the Task Force recommends that these alternatives to hospitalization be made available as a core component of comprehensive crisis systems in every state.*

Section 3 Conclusion

Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum. But for those individuals whose crisis represents the middle of the ladder, outpatient services are not intensive enough to meet their needs, and acute care inpatient services are unnecessary. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, and more easily designed to feel like home.

Carolinas HealthCare's Charlotte crisis facility was designed with safety, privacy, and trauma-informed care principles.

Section 4: Core Principles and Practices of Modern Crisis Care

The Task Force recommends several additional elements that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that we find essential for modern crisis systems (ATC capabilities, mobile crisis teams, and crisis residential facilities). These essential principles and practices are:

- Embracing recovery
- Significant role for peers
- Trauma-informed care
- Suicide safer care
- Safety/security for staff and consumers
- Crisis response partnerships with law enforcement

Embracing Recovery

The fact that recovery is possible—and the realization that recovery means not just absence of symptoms, but also development of meaning and purpose in life—has begun to transform mental health care (Anthony, 1993). The President's New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The Task Force found that the significance of a recovery-oriented approach is elevated for individuals in crisis, and thus for crisis settings. In an outmoded, traditional model, crises reflect "something wrong" with the individual. Risk is seen as something to be contained, often through involuntary commitment to an inpatient setting. In worst-case situations, this obsolete approach interacts with inadequate care alternatives, resulting in people restrained on emergency room gurneys or transferred to jails because of their behavior.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises. The Task Force finds that a recovery-oriented approach to crisis care is integral to transforming a broken system. Not only must we expand crisis care, but we must forge a better approach to crisis care.

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities, and compassion of people who have experienced mental health crises. Including peers as

core members of the crisis team and in all elements of the crisis system recognizes that individuals with lived experience could "take all of [their] experiences, regardless of the pain, and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007).

Analyses investigating peer services and supports have found support for a range of peer support models. Benefits include strengthened hope, relationship, recovery, and self-advocacy skills and improved community living skills (Landers & Zhou, 2011).

Using peers—especially people who have experienced suicidality and suicide attempts and learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11%–50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following ED referral (Kessler et al., 2005). Peers can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement while reducing distress.

The role of peers—specifically survivors of suicide attempts as well as survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience*, in July 2014 (http://bit.ly/AA-wayforward). The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished. This Task Force endorses recommendations of *The Way Forward* and finds that including individuals with lived experience in many roles in crisis care settings is effective. Further, taking this step will result in improved risk management and support for people with suicidal thoughts and feelings.

Task Force Spotlight

Shannon Jaccard, MBA, CEO

The San Diego affiliate of NAMI began in the early 1970s as a group called "Parents of Adult Schizophrenics." Over the decades, it has found that a Family Support Specialist is an invaluable resource to those whose family member is in crisis, and adjunct to peer support. It is designing a program with coaches to help family members navigate next steps immediately following an involuntary commitment in which the loved one is forcibly removed from the home by law enforcement. These services are especially important if it is the first experience with psychosis.

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance abuse, and poor medical health in these individuals (Finkelhor et al., 2005). Persons with history of trauma or trauma exposure were more likely to engage in self-harm and suicide attempts as well, and their trauma experiences make them very sensitive to how care is provided.

A first implication is that mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments, and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, the Task Force finds that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited five guiding principles for trauma-informed care:

1. Safety
2. Trustworthiness and transparency
3. Peer Support and mutual self-help
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues

These principles should inform treatment and recovery services. If such principles and their practice are evident in the experiences of staff as well as consumers, the program's culture is trauma-informed and will screen for trauma exposure in all clients served, as well as examine the impact of trauma on mental and physical well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57).

The Task Force finds that trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis, and the vulnerability of people in crisis (especially those with trauma histories).

Zero Suicide/Suicide Safer Care

Crisis intervention programs have *always* focused on suicide prevention. This stands in contrast to other health care and even mental health service, where suicide prevention was not always positioned as a core responsibility. This has begun to change, largely through the efforts of the Action Alliance.

One of the first task forces of the Action Alliance was the Clinical Care and Intervention (CCI) Task Force. Its report, *Suicide Care in Systems Framework* (2012), suggested transformational change in health care on two dimensions: adopting suicide prevention as a core responsibility, and committing to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the

revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The recommendations of the CCI Task Force have now been translated into a set of evidence-based actions (together known as Zero Suicide or Suicide Safer Care) that health care organizations can implement to work more systematically on this goal. An implementation toolkit for health care organizations has been developed (see http://zerosuicide.sprc.org/toolkit) by the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC), and several hundred health and behavioral health organizations are implementing the approach.

The seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

- Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles
- Develop a competent, confident, and caring work force
- Systematically identify and assess suicide risk among people receiving care
- Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means
- Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors
- Provide continuous contact and support, especially after acute care
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the NSPL, which has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, and has promoted collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Given that crisis intervention programs have always focused on suicide prevention, how do these developments affect crisis intervention services? The Task Force has made two findings related to this question.

First, since comprehensive crisis intervention systems are the most urgently important clinical service for suicide prevention, and since this report confirms most parts of the country do not have adequate crisis care, we find a national- and state-level commitment to implementing comprehensive crisis services as defined in this report is foundational to suicide prevention. Comprehensive crisis

intervention systems must include all of the core elements and core principles and practices that we discuss.

Second, although suicide prevention is central to crisis services, the Task Force finds best practices in suicide care (for clinical settings, "Zero Suicide") have not been implemented uniformly in all crisis settings. Additionally, these best practices in suicide care are not yet required by health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare).

Safety/Security for Consumers and Staff

Safety for both consumers and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. And while ensuring safety for people *using* crisis services is paramount, the safety for staff cannot be compromised.

People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement, and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. DHHS's Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation, and stabilization.

The keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff.
- Role-specific staff training and appropriate staffing ratios to number of clients being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent.
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures.
- Pre-established criteria for crisis system entry.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical

interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers, peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat of punishment, alternative to appropriate staffing of crisis programs, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

The National Association of State Mental Health Program Directors (NASMHPD) (2006) discussed core strategies for mitigating the use of seclusion and restraint. These included leadership that sets seclusion and restraint reduction as a goal, oversight of all seclusion/restraint for performance improvement, and staff development and training in crisis intervention.

Person-centered treatment and use of assessment instruments to identify risk for violence were also critical in developing de-escalation and safety plans. Other recommendations include partnering with the consumer and his or her family in service planning, as well as debriefing staff and consumers after a seclusion/restraint event, to inform policies, procedures, and practices to reduce the probability of repeat use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the Mental Health Division of the Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals.

According to SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

The Task Force finds that ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the *perception of safety* is

also essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly "Job One" in all crisis settings.

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. As first responders, they are often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis.

Police officers are critical to mobile crisis services as well, often providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995). Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns
- Address many incidents informally by talking to the individuals with mental illness
- Encounter a small subset of "repeat players"
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission

Task Force Spotlight

Barbara Dawson, MEd, Deputy Director, Comprehensive Psychiatric Emergency Program Division

The Harris Center for Mental Health and IDD, formerly known as "MHMRA of Harris County," has partnered with Houston Police Department (PD) and the Emergency Communications 9-1-1 Center to co-locate and integrate its mental health crisis line team members, with the purpose of diverting appropriate calls from law enforcement interaction. Houston PD received more than 30,000 mental health calls in 2014.

However, in many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health crisis system. This is unacceptable and unsafe. The Task Force finds that the role of local law enforcement in mental health crisis response is essential and important. However, the absence of adequate mental health crisis care, which has led to this function being dumped on law enforcement, is deplorable. Adequate mental health crisis systems must be built. With good mental health crisis care in place, good collaboration with law enforcement can proceed in a fashion that will improve both public safety and mental health outcomes.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between mental health and law enforcement, found the alliance between first responders and mental health professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to mental health crisis included police-based specialized police

response, police-based specialized mental health response, and mental health-based specialized mental health response. These forms of collaboration share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and mental health programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006).

With a second type of law enforcement-based response program, police-based specialized mental health response, mental health professionals are partnered with law enforcement officers at the scene to provide strategic consultation/intervention and to support persons in accessing treatment. Outcome studies comparing models of police response to individuals in mental health crisis found that officers in a police-based response were more likely than other officers to transport individuals to mental health services. As discussed above, availability of a central crisis drop-off center for individuals with mental illness that had a no-refusal policy for police cases increased the number of police calls that implemented a specialized response (Steadman et al., 2000).

Specialized law enforcement responses to mental health crises have shown improved safety outcomes for persons served. Studies examining CIT have found significantly less use of force in situations rated as high violence risk (Skeem & Bibeau, 2008), and Morabito et al. (2012) found CIT-trained officers used less force as person's resistance increased compared to resistance experienced by officers who lacked CIT training. In a qualitative study, Hanafi et al. (2008) noted that officers reported the application of their CIT skills served to decrease the risk of injury to officers and individuals with mental illness.

In many cases, officers receive a call that is not presented as a suicidal crisis, but rather as a public disturbance, domestic violence, or other dangerous situation. The CIT officers identify people at risk for suicide, address safety issues for all present, and offer support and hope to the person who is suicidal. In conjunction with other mental health service providers and/or Emergency Medical Services (EMS) personnel, they may directly transport or arrange transport for the person who is potentially suicidal to be brought to an ED or mental health center for an evaluation (Suicide Prevention Resource Center, 2013).

In addition, as first responders for persons with mental illness in crisis, the officers can assess individuals and provide transport to alternative levels of care to divert hospitalization. Further support for the model is provided by police officers' reports of improved confidence in identifying and responding to persons with mental illness and enhanced confidence in their department's response to mental health-related calls (Wells & Schafer, 2006).

The Task Force finds that strong partnerships between crisis care systems and law enforcement are essential for public safety, including suicide prevention. We also find that the absence of comprehensive crisis systems has been the major "front line" cause of the criminalization of mental illness, and a root cause of shootings and other incidents that have left people with mental illness and officers dead.

> *Recommendation 6. The Task Force recommends that national and state authorities (and where relevant, accrediting organizations and payers such as health plans) commit to ensuring that the core principles and practices covered here are addressed in existing and to-be-developed comprehensive crisis systems.*

Section 4 Conclusion

It is easy to fall into the trap of attempting to guarantee safety in community-based crisis programs with the use of Plexiglas-walled rooms and security keypads that separate staff and guests. Other programs work to ensure that law enforcement has sent a consumer through a lengthy ED visit prior to admission to the program. However, the most effective community-based crisis care occurs in welcoming and trauma-informed care environments that serve individuals whose mental health and/or addiction crisis has resulted in interactions with law enforcement. The critical component to making these approaches work is the integration of trained and certified peer support staff and law enforcement.


stabilization
organizations
provide
individuals
used
curriculum
practices
based
local
funding
Crisis Services
child
mental
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programs
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work
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reimbursement
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Crisis
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helpful

Section 5: Financing Crisis Care

The method of financing crisis mental health services varies from state to state. In many cases, it is cobbled together. Inconsistently supported. Inadequate.

The federal government provides a very small SAMHSA investment (just over $6 million annually) in the NSPL; however, that investment only provides for a national call infrastructure and does not cover the state/local costs of either crisis lines or crisis intervention systems. Aside from this minimal investment, there is no dedicated national funding source, nor is there a national infrastructure for a service that is perhaps the most important single element of community mental health care, and which provides the most important elements of acute suicide care.

Crisis Care Funding vs. Emergency Care Funding

It is revealing to compare mental health crisis care to other first responder systems like firefighting or EMS. There are striking similarities:

- The service is essential.
- The need for it is predictable over time, but the timing of crises is not predictable.
- Effective crisis response is lifesaving, yet it is also much less expensive than the consequences of inadequate approaches.

For EMS, we might measure its effectiveness in lives saved because of timely intervention for individuals with acute heart disease. For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief crisis respite stays at about $300/day vs. inpatient rates of $1000/day.

It is also useful to think about financing of core crisis services. It would be unthinkable for any community except frontier or very small ones to go without a fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are always provided. Sometimes users may pay a fee for service calls, but the station and the equipment are provided. A frequent scenario for mental health crisis services is the opposite approach. Health coverage (e.g., Medicaid) will pay for the visit, but often no one will pay for the infrastructure: phone and computer systems, 24/7 coverage, or crisis facilities.

This will not work.

A Financial Crisis for Crisis Care

SAMHSA's (2014) report on crisis service effectiveness and funding discusses "funding strategies" for this care. The report includes important information about funding *approaches,* but provides no analysis of funding *levels.* Given the absence of any national expectations for establishing or maintaining crisis

infrastructure (excepting the NSPL network) and the absence of national funding for crisis care, the general absence of comprehensive crisis services is not surprising.

Partial data on the financing of crisis care have been complied by NASMHPD. In his presentation to the Task Force, Brian Hepburn, MD, NASMHPD Executive Director, shared data at both the provider and state levels that illustrate the problem. NASMHPD's analysis of funding patterns for one typical crisis care provider demonstrates how financing is cobbled together from multiple sources:

- State grant funding: 41% (includes hotline/mobile crisis team/detoxification)
- Federal funding: 10% (includes portion of hotline costs paid through mobile crisis team payments)
- Fee for service: 45% (33% of this is Medicaid; 67% State general funds)
- Private organizations & miscellaneous: 4%
- TOTAL: 100%

The Problem with Typical Funding Patterns

What is wrong with this typical pattern of crisis care funding? First, there is no overall, reliable source of funding. Resources are cobbled together from multiple sources, including private fund raising. It is as if we had a fire department with no fire station and the fire fighters must use their own vehicles. The Task Force finds that the absence of national expectations for crisis care infrastructure, as well as lack of funding for such infrastructure, is the primary cause of inadequate crisis services.

Second, less than half of all funding in this typical example comes from a dedicated/reliable source (in this case, the State Mental Health Authority). This is problematic, since dedicated state mental health funding is threatened by the transition of services paid by Medicaid, which is typically delivered per unit-of-care (i.e., the visit), not for the 24/7 infrastructure essential for crisis care.

According to NASMHPD surveys, over $4 billion, or about 10%, in state mental health funding was cut/eliminated in the 2007–2009 recession; however, funding has been restored through Medicaid Expansion. Therefore, there needs to be a method for covering crisis services through changes to the State Medicaid Plan.

To put this cut into perspective, NASMHPD reports that *total* funding through state mental health agencies is only $39 billion. Additionally, as Medicaid has become a more reliable way to pay for many mental health services, state budget offices have been reducing general state mental health funding, which is currently the major source for crisis funding. While this works well in terms of overall investments in mental health, which have improved, it is a problem for crisis care.

Third, and reinforcing this point, the biggest single source of funding in this example is Medicaid billings. This is both an expensive/cumbersome way to bill for crisis care (a claim must be submitted for every contact), and it also reveals the overall lack of program funding for the core elements of crisis care.

Finally, in this example one sees no payment from Medicare and commercial/private health insurers. This means that the nation's crisis care infrastructure has essentially no support from mainstream health payers. In more sophisticated crisis systems, there is some billing to health insurers.

In his presentation to the Task Force, NASMHPD Executive Director Brian Hepburn reported that a survey of states reveals great variability in patterns of crisis funding.

Table 3: Examples of State Funding for Crisis Care

STATES	MOST STATES	MAINE	RHODE ISLAND	PENNSYLVANIA	OHIO
Sources of Crisis Funding					
State Mental Health	Primary	70%	50%	--	16.5%
State/Federal/ Other	--	--	—	--	5%
Medicaid	Limited	30%	50%	54%	29.5%
Block Grant	--	--	--	46%	4%
Local/County	--	--	--	--	45%

The NASMHPD survey data reinforce the conclusions about crisis care funding, namely the lack of consistent, reliable, and robust national support for the 24/7 infrastructure of crisis care, and the virtual absence of payment by health insurance programs except for Medicaid.

Patchwork Medicaid Funding

The NASMHPD data complement SAMHSA's 2014 report, which also illustrates the patchwork nature of crisis service funding. To complete the SAMHSA report, Truven Health Analytics examined patterns of Medicaid funding of crisis care in all 50 states. Examining Medicaid is particularly important because it is the largest payer for community mental health care. The SAMHSA report notes that its survey methodology—that is, review of Medicaid State Plans and other official documents—was thorough, but limited. The review also included in-depth case study interviews with officials from eight states. SAMHSA

did note that in some states, authorities have worked through their managed care partners to support comprehensive crisis care. The Task Force examined the Truven/SAMHSA findings with reference to the three core structural elements of comprehensive crisis care that we identified.

The SAMHSA report finds:

- *No* states are using Medicaid to pay for the central, ATC-capable infrastructure that is needed as the hub of comprehensive crisis care, including the crisis call center.
- A dozen states are using Medicaid to pay for mobile crisis services.
- Ten states are using Medicaid to pay for crisis residential services and/or observation beds.

The Task Force finds that the absence of consistent expectations for crisis care functioning and funding is problematic given Medicaid's key role as a payer. It is perhaps likely to become more problematic as Medicaid managed care responsibilities are increasingly integrated with/scattered to competing mainstream health plans that are less likely to support an integrated, statewide crisis care solution.

An Emerging Opportunity: New Legislation

The Comprehensive Community Behavioral Health Centers (CCBHC) legislation (Section 223 of the Protecting Access to Medicare Act, also referred to as "Section 223") represents perhaps the most significant national effort to build community mental health capacity in the past several decades. The legislation authorizes demonstration grants to eight states that agree to raise standards for and implement a statewide network of CCBHCs. Currently in 2016, 24 states have received planning grants totaling $22.9 million to develop an infrastructure that will allow them to compete to become one of the eight demonstration states. Legislative advocacy to expand the number of pilot states is also occurring.

The Section 223 initiative is relevant and helpful to crisis care and suicide prevention in several ways. As we referenced early in this report, crisis care was one of five "essential services" in CMHCs funded under President Kennedy's legislation. However, CMHC grants were time-limited, most areas of the country never received one, and CMHC requirements were all but eliminated when the CMHC program was converted to a block grant in President Reagan's first budget.

The Section 223 requirements for CCBHC crisis care are robust and include requirements for 24/7 availability, a continuum of crisis care options, and individuals in crisis to be seen within 3 hours. Section 223 also elevates requirements for suicide care, including additional training, protocols for risk assessment, the expectation that all consumers are informed about crisis lines, and finally a mandate to measure suicide deaths for people in care.

To date, the Section 223 requirements are perhaps the most concrete and useful federal steps to improve access to crisis care. The Task Force finds that this is a very promising development and urges that Section 223 be made permanent and extended to all states. These would be very substantial and

helpful steps. They would not, however, accomplish all the actions we recommend here to make comprehensive crisis care available across the United States.

Recommendation 7: This recommendation follows directly from the Task Force's conclusion that crisis calls should always be answered by an NSPL-qualified and participating center in the caller's area. Federal support for crisis call centers is necessary to allow for, at a minimum, the development of crisis call centers in areas where one does not exist. Ideally, funding would come from an expansion of the Mental Health Block Grant, coupled with a requirement that states ensure the presence of qualified call centers covering their population. Call centers should be part of comprehensive crisis systems that have all the core requirements we have discussed: 24/7 clinical coverage with ATC capabilities, adequate mobile crisis teams, and sufficient crisis respite alternatives.

Recommendation 8: All major health payers should recognize and reimburse crisis services provided to their members by comprehensive crisis systems. An analogy for this is payment for EMT by health providers. This step is necessary in order to have adequate capacity for crisis care and for efficiency. In order to achieve this step, leadership will be needed from CMS (Medicare/Medicaid), the Department of Labor, and state Insurance Commissioners.

Section 5 Conclusion

In order to achieve the kind of EMS response in mental health crises described above, payers must prioritize these services and programs. The piecemeal approach currently utilized by states has been inconsistent with the original tenets of the community mental health movement. Funding of a primary community capacity for mental health crisis response is also consistent with current mental health parity, coverage expansion, and the launch of the Comprehensive Community Behavioral Health Center initiative.

Report Conclusion

The Task Force has outlined five compelling reasons for change. These include:

- Thousands of Americans dying alone and in desperation from suicide
- Unspeakable family pain for those whose children have serious mental illness
- Inhuman treatment of individuals who sometimes wait for days in EDs
- The wrong care in the wrong place, compromising other medical urgent care
- Tying up valuable law enforcement resources to substitute as “mobile crisis”

We have presented the solutions, and they are accessible now, summarized below.

The problem with delaying is…crises are happening now.

Summary of Task Force Recommendations

Recommendation 1: We recommend national-and state-level recognition that effective crisis care must be comprehensive and include these core elements and practices: a) ATC-capable central coordination, using technology for real-time care coordination while providing high-touch support meeting NSPL standards; b) availability of centrally deployed Mobile Crisis Services on a 24/7 basis; c) residential crisis stabilization programs; and d) conformance with essential crisis care principles and practices.

Recommendation 2: Crisis call services should participate in and meet the standards of the NSPL, and crisis intervention systems should adopt and implement Zero Suicide/Suicide Safer Care across all program elements.

Recommendation 3: State and national authorities should review elements of ATC-qualified crisis systems, apply them to crisis care in their jurisdictions, and commit to achieving these capabilities within 5 years, so that each region of the United States has a qualified hub for crisis care.

Recommendation 4: State and national authorities should work to ensure that mobile crisis teams are available to each part of every state.

Recommendation 5: Residential crisis stabilization alternatives to hospitalization should be made available as a core component of comprehensive crisis systems in every state.

Recommendation 6: The Task Force recommends that national and state authorities (and where relevant, accrediting organizations and payers such as health plans) commit to ensuring that the core principles and practices discussed in this report are addressed in existing and to-be-developed comprehensive crisis systems.

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Making the crisis center welcoming and comfortable is an important first step (RI Crisis in Peoria, Arizona).

Appendix

Task Force and Support Team Participants

A group of consensus national experts were invited to participate in the Task Force and associated Support Team. They include government and health plan administrators, provider executive leaders, people with lived experience, and family members of those with serious mental illness:

David Covington, LPC, MBA, Task Force Co-lead; EXCOM member; RI International; Behavioral Health Link

Michael Hogan, PhD, Task Force Co-lead; EXCOM member; Hogan Health Solutions

Jason H. Padgett, MPA, MSM, Deputy Secretary, National Action Alliance for Suicide Prevention; Suicide Prevention Resource Center; Education Development Center, Inc. (EDC)

Bart Andrews, PhD, Behavioral Health Response

Leon Boyko, MBA, MSW, LCSW, RI Crisis (RI International)

Lisa Capoccia, MPH, Suicide Prevention Resource Center, EDC

Lynn Copeland, Georgia Department of Behavioral Health and Developmental Disabilities

Barbara Dawson, MEd, The Harris Center for Mental Health and IDD

Susan Dess, RN, MS, Crestline Advisors

Steven Dettwyler, PhD, Community Mental Health and Addiction Services Delaware DHSS/DSAMH

Bea Dixon, BSN, PhD, Optum WA Pierce RSN

John Draper, PhD, Link2Health Solutions; National Suicide Prevention Lifeline

Phil Evans, ProtoCall Services

Gerald Fishman, PhD, RI Crisis (RI International, Inc.)

Vijay Ganju, PhD, Behavioral Health Knowledge Management

Larry Goldman, DMD, Beacon Health Options

Gabriella Guerra, MSW, Mercy Maricopa Integrated Care

Brian Hepburn, MD, National Association of State Mental Health Program Directors (NASMHPD)

Shannon Jaccard, MBA, NAMI San Diego

Helen Lann, MD, Beacon Health Options

Nick Margiotta, Phoenix Police Department

Richard McKeon, PhD, Substance Abuse and Mental Health Services Administration (SAMHSA)

Tim Mechlinski, PhD, Crestline Advisors

Steve Miccio, PEOPLe, Inc.

Heather Rae, MA, LLP, Common Ground

John Santopietro, MD, DFAPA, Carolinas HealthCare System

Wendy Schneider, LPC, Behavioral Health Link

Cheryl Sharp, MSW, ALWF, National Council for Behavioral Health

Becky Stoll, LCSW, Centerstone

Eduardo Vega, MA – EXCOM member; MHA of San Francisco

James Wright, LCPC, SAMHSA

Task Force Schedule

The Crisis Services Task Force worked a sprint schedule meeting twice monthly by WebEx Video Conferencing from September to December 2015:

- Introductions & Task Force Sponsors (September 4, 2015) – Co-chairs David Covington and Mike Hogan launch the Action Alliance Crisis Services Task Force
- The Framework & Agenda (September 18) – Introductory comments from the Action Alliance (Jason Padgett) and SAMHSA (Richard McKeon), and description of the Task Force roadmap
- Topic 1: Peers & Recovery (October 2) – Living Rooms, peers, and new models for crisis alternatives (Steve Miccio) and trauma-informed care (Cheryl Sharp)
- Topic 2: Air Traffic Control (October 16) – Adaptation of the Milbank integration continuum (David Covington) and Georgia Crisis & Access Line (Wendy Schneider)
- Topic 3: Integration with First Responders (November 6) – Harris County 9-1-1 co-location (Barbara Dawson) and Crisis Intervention Team Training (CIT) - International Board Member and Phoenix Police Department (Nick Margiotta)
- Topic 4: Community-based Mobile Crisis (November 20) – St. Louis-area Behavioral Health Response model (Bart Andrews) and Centerstone (Becky Stoll)
- Topic 5: Safety/Security for Consumers and Staff (December 4) – State of Washington Safety Summit Clinical Training (Bea Dixon) and RI Crisis utilization of peer staffing and healing spaces (Leon Boyko)
- Topic 6: Pay for Value, Financing, and ROI (December 18) – Shift to value-based care/financing (Larry Goldman) and NASMHPD/public-sector (Brian Hepburn)

Timeline of Crisis Innovations

1958

First Free, 24-Hour Crisis Hotline – In 1958, Edwin Shneidman founded the Los Angeles Suicide Prevention Center, which was the nation's first crisis hotline and later consolidated into Didi Hirsch Mental Health Services. Ten years later, Shneidman would form the American Association of Suicidology (http://www.didihirsch.org/History).

1995

Hi-tech, Professionally Staffed – Behavioral Health Response was formed by the Missouri legislation after the shooting deaths of prominent family members by a person with serious mental illness. It was first with advanced software, clinical staffing, mobile crisis, and a Board of Directors comprised of local CMHCs (http://bhrstl.org/).

2003

Full Continuum of Crisis Services – Harris County MHMRA developed a groundbreaking array of integrated crisis services for the greater Houston metropolitan area, one of the largest in the United States, with a psychiatric emergency room, crisis residential services, mobile crisis outreach team, homeless services, and crisis help line (http://www.mhmraharris.org/Crisis-And-Emergency-Services.asp).

2006

Statewide Crisis & Access Line – After Hurricane Katrina, the Georgia Department of Behavioral Health and Developmental Disabilities expanded its Single Point of Entry into a statewide program for all 159 counties with 24/7 scheduling, online dashboards, and advanced analytics (recognized as innovation by *Business Week*) (http://behavioralhealthlink.com/).

2010

Big Box Full Continuum – The Regional Behavioral Health Authority for Tucson and University Physicians Hospital partnered on a $54 million community bond to launch a mega-crisis center with co-located call center, crisis stabilization (adults and teens), law enforcement sally port, and more (http://bit.ly/TucsonCRC).

Americans with Disabilities Act & Olmstead – The Department of Justice entered into a Settlement Agreement with Georgia over complaints of unnecessarily institutionalization. The agreement included

new crisis stabilization programs, mobile crisis teams, crisis apartments, expanded crisis hotline, etc. (http://www.ada.gov/olmstead/olmstead_cases_list2.htm).

2012

24/7 Outpatient & Short-term Residential – The Regional Behavioral Health Authority for Phoenix, Arizona, expanded its robust crisis continuum with two new Access Point/Transition Point facilities for individuals with after-hours presentations but whose needs did not require sub-acute stabilization (http://bit.ly/CBAccessPoint).

A Plan to Safeguard All Coloradans – In response to the Aurora theater tragedy, Governor Hickenlooper and the Colorado legislature introduced over $100 million in state funds for a five-year contract to expand crisis stabilization, crisis respite, mobile crisis, crisis call center, warm line, and marketing. (http://bit.ly/CO-Crisis).

2013

Investment in Mental Health Wellness Act – California legislation SB 82 provided nearly $150 million to improve access to and capacity for crisis services, believing that 70% of ED presentations for psychiatric evaluation could be avoided with improved crisis stabilization, mobile crisis, and crisis triage (http://bit.ly/CAimhwa).

2014

Air Traffic Control Level 5 System –Milbank collaboration continuum modified (original citation: Doherty, 1995) for evaluating crisis system community coordination and collaboration. The model suggests five required elements, including electronic crisis bed inventories (http://bit.ly/crisiscontinuum).

National Council Leadership – Linda Rosenberg and the National Council for Behavioral Health launched the first-ever specialized track for crisis service at the spring Washington, DC, conference, including a pre-conference, town hall, and multiple sessions on crisis services, and one of its most actively subscribed list serves ever (http://bit.ly/1KVp54i).

"Psychiatric Boarding" Ruled Illegal – In 2013, ten persons filed a suit in Pierce County contesting their petitions due to long waits. A year later, the Washington State Supreme Court said holding an individual in an ED until an appropriate bed is available is unconstitutional and therefore unlawful (http://onforb.es/1P4pXaX).

2015

Effective Inpatient Interventions & Alternatives – NIMH, NIDA, SAMHSA, and AFSP release Request for Information (RFI): Building an Evidence Base for Effective Psychiatric Inpatient Care and Alternative Services for Suicide Prevention. “While a number of interventions… have been effective and even replicated, the effectiveness of inpatient care… remains a question” (http://1.usa.gov/1JWouEH).

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