Northwest (HHS Region 10)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

# Designing and Implementing Ideal Behavioral Health Crisis Systems

## Behavioral Health Crisis Response Systems Live Webinar Series

SAMHSA
Substance Abuse and Mental Health Services Administration

MHTTC Mental Health Technology Transfer Center Network
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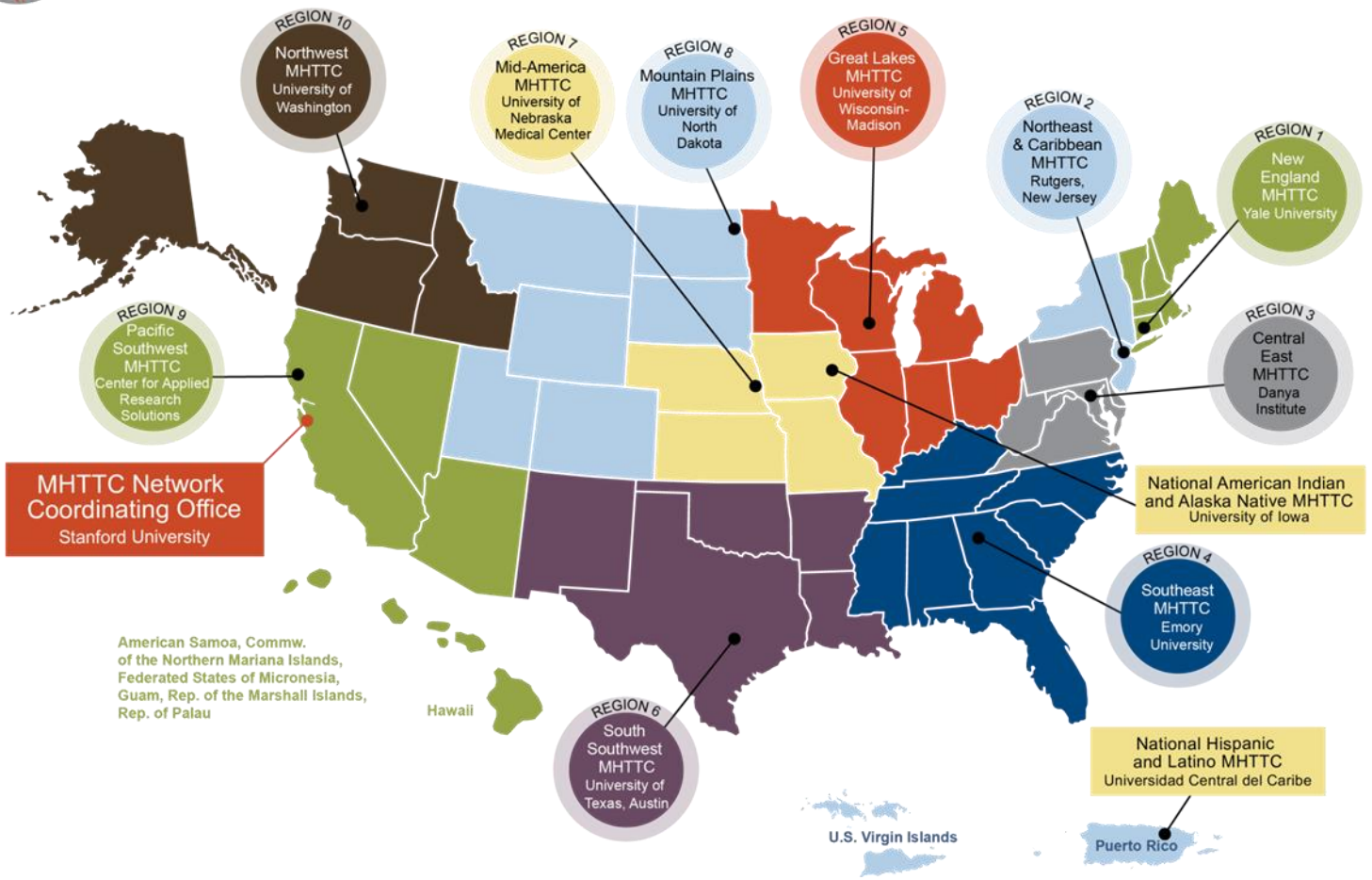
# MHTTC Network




SAMHSA
Substance Abuse and Mental Health Services Administration

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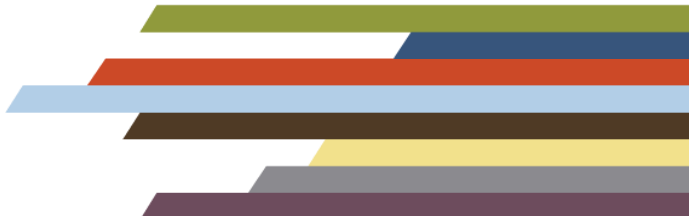
# Northwest Mental Health Technology Transfer Center

## Our Role

Provide training and technical assistance (TA) in evidence-based practices (EBP) to behavioral health and primary care providers, and school and social service staff whose work has the potential to improve behavioral health outcomes for individuals with or at risk of developing serious mental illness in SAMHSA's Region 10 (Alaska, Idaho, Oregon, and Washington).

## Our Goals

- Heighten awareness, knowledge, and skills of the workforce addressing the needs of individuals with mental illness
- Accelerate adoption and implementation of mental health-related EBPs across Region 10
- Foster alliances among culturally diverse mental health providers, policy makers, family members, and clients



The use of affirming language inspires hope and advances recovery.

# LANGUAGE MATTERS.

# Words have power.

## PEOPLE FIRST.

**The MHTTC uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.**

# Today's Trainer

**Ken Minkoff, MD**

- Senior System Consultant, ZiaPartners, Inc., Catalina, AZ
- Part-time Assistant Professor of Psychiatry, Harvard Medical School, Cambridge, MA
- Director of Systems Integration, Meadows MH Policy Institute, Dallas, TX
- Board-Certified Addiction Psychiatrist


# Defining and Implementing A National Standard for BH Crisis Response

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# Vision

Every individual/family
in every community in the U.S.
will have access to a continuum
of best practice BH crisis services that are
welcoming, person-centered, recovery-oriented,
and continuous.

# Vision

An excellent Behavioral Health Crisis System is an essential community service, just like police, fire and emergency medical services (EMS).

As such, every community should expect a highly effective BH crisis response system to meet the needs of its population, just as is expected for the other essential community services.

# Vision

A BH crisis system is more than a single crisis program.

It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent BH crisis needs in a defined population or community, effectively and efficiently.

# Vision

While no system will ever likely reach the ideal, the aspirational goal that drives a person-centered continuous quality improvement process for a Behavioral Health Crisis System is that  (just as for EMS in each community)

“Every person receives the right service in the right place, every time.”

# Interdepartmental SMI Coordinating Committee (ISMICC)

- Initial report: December, 2017
- 45 recommendations in 5 focus areas:
  - Interdepartmental coordination and data
  - Access and engagement
  - Treatment and recovery
  - Criminal justice diversion
  - Financing

# Crisis System Recommendation

Focus 2: Access and Engagement:
Make It Easier to Get Good Care

2.1 Define and implement a national standard for crisis care

# Crisis System Recommendation (cont.)

- Standards consistent with SAMHSA publication, *Crisis Services: Cost Effectiveness and Funding Strategies*
- Include recommendations from *Beyond Beds* and *Crisis Now*
- Standards consistent with National Suicide Prevention Lifelines
- Person-centered, youth-guided, family-driven, and responsive to the needs of children, youth, and adults
- Ensure that federal programs support the standards and enable and incentivize states and communities to support and sustain adequate crisis care systems.

# Question:
# What should be the National Standard for Crisis Care?

How should it compare to our expectations for other essential services? (Police, Fire, EMS, and medical crises)

# Recent Materials

1. Technical Assistance Collaborative Report for NSAMHPD:
   ***Beyond Beds***
   - Describes a continuum of crisis services – beyond "ER" and "bed placement"
2. Action Alliance for Suicide Prevention
   **CRISIS NOW: Transformation is within our Reach**
3. Meadows MH Policy Institute
   **BH Crisis Services: A Component of the Continuum of Care**

# Current Work

**Group for the Advancement of Psychiatry (GAP), Committee on Psychiatry and the Community (2020)**

**Getting to the IDEAL BH CRISIS SYSTEM:**

**ESSENTIAL ELEMENTS,**

**MEASURABLE STANDARDS,**

**AND BEST PRACTICES**

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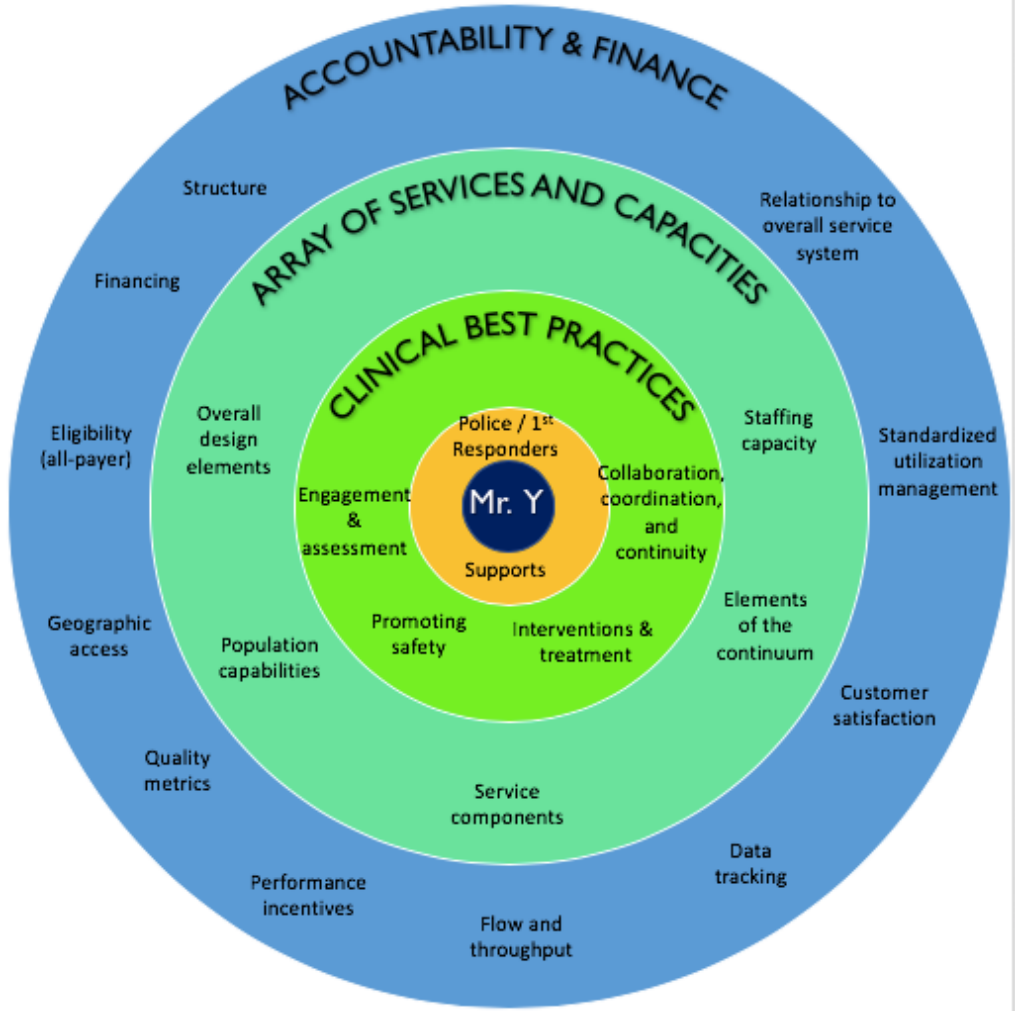
# Framework for an Ideal BH Crisis System

- **Structures and Processes for**
  **Accountability and Finance**

- **Crisis Continuum with**
  **A Comprehensive Array of Capacities and Services**

- **Clinical Best Practices for Crisis Intervention**


ACCOUNTABILITY & FINANCE
Structure
Financing
Relationship to overall service system
Eligibility (all-payer)
Geographic access
Quality metrics
Performance incentives
Flow and throughput
Data tracking
Customer satisfaction
Standardized utilization management
ARRAY OF SERVICES AND CAPACITIES
Overall design elements
Staffing capacity
Population capabilities
Elements of the continuum
Service components
CLINICAL BEST PRACTICES
Police / 1st Responders
Engagement & assessment
Collaboration, coordination, and continuity
Promoting safety
Interventions & treatment
Supports
Mr. Y

# Guiding Principles and Values of an Ideal Crisis System:

***Ideal BH crisis systems are:***

- ***Based on a shared set of values.***

  Welcoming and engaging, customer-centered, hopeful, safe, compassionate, empowering, recovery-oriented, trauma informed, and culturally appropriate.
- ***Accountable for all people and populations***
- ***Designed for the expectation of complexity***
  MH and SUD, plus I/DD, health, housing, criminal justice, child/adult protection, etc.
- ***Designed to be clinically effective and cost effective***
- ***Able to use value-based involuntary intervention - only when necessary***
- ***Organized to share and use data for continuous improvement***

# Elements of an Ideal Crisis System

## Section 1: Accountability/Finance

### Accountable Entity

An ideal BH crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services, AND a mechanism to ensure oversight, accountability and quality of the performance of that continuum.

# Elements of an Ideal Crisis System

## Section 1: Accountability/Finance (continued)

**Key Takeaways**:

- **Accountable entity, Crisis System Coordinator, Community Crisis Collaborative**
- **All payers contribute; all community members are eligible**
- **Service capacity commensurate with population need**
- **Geographic access commensurate with medical urgent care**
- **High quality goal: Every customer gets the right response every time.**
- **Continuous monitoring of individual results and collective performance**
- **Quality standards are defined, and data shared for continuous improvement**

# Elements of an Ideal Crisis System

## Section 2: Comprehensive Array of Capacities and Services

An ideal BH crisis system has comprehensive array of service capacities, a continuum of service components, and adequate multi-disciplinary staffing to meet the needs of all segments of the population.

# Elements of an Ideal Crisis System

## Section 2: Comprehensive Array of Capacities and Services (continued)

- **The system has welcoming and safe access for all populations, for all levels of acuity, and for those who are both voluntary and involuntary.**
- **First responders are priority customers and partners**
- **Crisis response begins early, well before 911 (or 988) and continues until stability is regained.**
- **There is capacity for sharing information, managing flow, and keeping track of people**
- **There is a service continuum for all ages and people of all cultural backgrounds.**
- **All services are designed to respond to the expectation of comorbidity and complexity**
- **Individuals with active substance use are welcomed in all settings in the continuum**
- **Medical screening is widely available and is not burdensome.**

# Elements of an Ideal Crisis System

## Section 2: Comprehensive Array of Capacities and Services (continued)

### ELEMENTS OF THE CONTINUUM – For all ages

- Dispatch call-takers and crisis call center (911, non-911)
- Mobile crisis
- Crisis "hub" including a secure crisis/access center
- Crisis continuum components (23-hour obs, CSU, CRU, peer respite, sobering centers, etc.)
- Psychiatric capacity in Emergency Rooms
- Psychiatric hospitalization
- Continuity of crisis intervention/CTI & transition planning to routine care
- EMS and non-EMS Transportation

# Elements of an Ideal Crisis System

## Section 2: Comprehensive Array of Capacities and Services (continued)

### POPULATION CAPACITIES

- **Age: continuum for youth, older adults**
- **Capacity in the continuum for MH/SUD, BH/IDD/BI, BH/medical**
- **Cultural/linguistic capacity: immigrants, homeless, justice-involved, vets**

### STAFFING CAPACITIES

- **Program components are adequately staffed by multidisciplinary teams, including peer support**
- **Clinical and medical supervision, consultation and leadership available commensurate with that for emergency medical servcies**

# Elements of an Ideal Crisis System

## Section 3: Best Practices for Clinical Crisis Intervention

An ideal BH crisis system has guidelines for utilization of the best clinical practices for crisis intervention, with associated processes for practice improvement and workforce competency development.

# Core Elements of an Ideal Crisis System

## Section 3: Clinical Practice, Practice Guidelines and Core Competencies (cont.)

- **The system has expectations of universal competencies based on values. Welcoming, hope, and safety come first.**
- **Engagement and information sharing with collaterals is an essential competency.**
- **Staff must know how to develop and utilize advance directives and crisis plans**
- **Essential competencies include formal suicide and violence risk screening/intervention.**
- **No force first is a required standard of practice.**
- **Risk screening guidelines for medical and SUD related issues facilitate rather than inhibit access to BH crisis care.**
- **Utilizing peer support in all crisis settings is a priority.**
- **BH crisis settings can initiate medication assisted treatment for SUD.**
- **Formal practice guidelines for all ages/populations, including integrated Rx for MH, SUD, cognitive, and medical**
- **Best practices for crisis intervention (e.g. CTI) promote successful continuity and transition planning.**

# Section 1 Example: Financing

**Rationale:** A comprehensive behavioral health crisis system, with a complete continuum of services, is an essential element of safety net health and human services for any community, in the same way that police, fire, EMS, and emergent/urgent medical care are essential community services. For this reason, that continuum of services must be adequately financed to achieve appropriate community response, just as is the case for other safety net services. Further, alignment of multiple funding streams to support a single crisis system, rather than each funder developing its own system, is likely to be more efficient, effective, and accessible to customers.

# Section 1 Example: Financing (continued)

**Measurable Criteria for an Ideal System:** There is a comprehensive crisis system (as defined herein), with an accountable entity responsible for oversight, contracting, and quality monitoring, and an accountable provider responsible for provision of direct services and/or coordination of all service elements, that has the following approach to financing:

- **The accountable entity is responsible for producing a global budget for the ideal crisis continuum.** This budget is initially based on historical utilization data for all components at risk.
- **Financing supports CAPACITY**, not just utilization. (For example, no community would establish a fire department that is paid only when it responds to a fire).
- **Because crisis utilization naturally waxes and wanes, the budget is designed to provide full capacity at a 95% "maximum" threshold.**
- **Resource contribution:** For best return on investment, all or most potential beneficiaries of the BH crisis continuum are accountable to contribute resources to core capacity. This includes state resources (including Medicaid), local (e.g., county, city) public funding (in lieu of inappropriate use of law enforcement or jails), insurers of all kinds, as well as health systems.

# Section 1 Example: Financing (continued)

- **Incentive payments:** Each component of the crisis system, including contracted MCOs, has some percentage of funding attached to quality
- **Adequate reimbursement rates:** By all payers, reimbursement for crisis services must be commensurate with the complexity and comprehensiveness of services
- **Payment for full continuum:** By all payers, reimbursement for crisis services must be designed to support the full continuum of crisis response:
- **Payment for all populations, including those with comorbidities:** Funding instructions for each significant type of comorbidity and complexity must be delineated in all funding and provider contracts.
- **Financing for safety net:** Financing mechanisms are designed so that the BH crisis system can operate as a safety net for the entire delivery system.

## Section 2 Example:

# Outreach & Consultation to Community Providers

**Rationale:** A comprehensive behavioral health crisis system, with a complete continuum of services, is an essential element of safety net health and human services for any community. As such, an essential component of the continuum of care is for the crisis system to not only “react” to crisis, but to engage in outreach and consultation with all elements of the community service system to address risky situations and to prevent crises or escalation of crises.

## Section 2 Example (continued):

# Outreach & Consultation to Community Providers

**Measurable Criteria for an Ideal System: There is a comprehensive crisis system (as defined herein), with an accountable entity that incorporates the following expectations into contracting, with associated quality indicators and metrics of success.**

- **Mechanisms for Outreach and Consultation:** The crisis coordinator and the crisis system providers will ensure that there are formal mechanisms for both routine and as-needed outreach and consultation to all community service providers.
- **Training on Access to Crisis Services, De-escalation, CIT, and MHFA:** The crisis coordinator will identify crisis system providers to provide training in how to best access crisis services in the most proactive manner, and to provide training in crisis de-escalation and behavior management, including CIT and MHFA training as indicated.

## Section 2 Example (continued):

# Outreach & Consultation to Community Providers

- **Routine Consultation to High-risk Settings:** The crisis coordinator will identify crisis system staff who will develop routine consultation relationships with community providers who work with individuals and families who are at high risk for crisis response: residential programs, schools, ACT teams, emergency rooms.
- **Proactive Consultation and Case Review:** The crisis system has an identified process by which there is proactive consultation provided for programs and/or individuals/families who are having a difficult time.
- **Quality Indicators:** The presence of the above structures, processes, activities, and results are incorporated into quality indicators and metrics of success for the crisis system and for individual crisis providers as relevant.

## Section 3 Example:
# Practice Guidelines for Responding to People with SUD

- Individuals and families with active substance use of any kind are welcomed for crisis services and viewed as a priority population for engagement and care.
- In programs responding to MH crisis at any level of care, individuals with co-occurring SUD are similarly welcomed and prioritized.
- Under no circumstances shall any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with substance use based on requiring that the person must demonstrate that their alcohol level is below a certain number, or that their urine screen must be completed and cleared, prior to initiation of services.

## Section 3 Example:
# Practice Guidelines for Responding to People with SUD

- If a person is too intoxicated to communicate coherently, the assessment begins with WELCOMING ENGAGEMENT, contact of collaterals and obtaining history, with a plan to initiate conversation as soon as the person can begin to communicate clearly. Disposition is made as soon as possible, and it is not necessary in every instance for the person to be "sober" before the next-step response is determined.
- All crisis providers shall have policies and protocols to manage individuals who may be intoxicated in a welcoming and safe manner, and to provide support for withdrawal management commensurate with the level of medical care they do or do not offer.
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# Discussion

**What do you think the standards should include?**

**Which principles or values resonate with you and why? Are there others you would add?**

# Get in Touch!

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# Thank you!