Colorado Department of Human Services

people who help people

EXECUTIVE DIRECTOR
Reggie Bicha

1575 Sherman Street
Denver, Colorado 80203-1714
Phone 303-866-5700
www.cdhs.state.co.us

John W. Hickenlooper
Governor

Reggie Bicha
Executive Director

February 22, 2013

The Honorable Irene Aguilar
Chair, Senate Health and Human Services Committee
Colorado State Capitol
200 East Colfax Avenue
Denver, Colorado 80203

The Honorable Beth McCann
Chair, House Health, Insurance & Environment Committee
Colorado State Capitol
200 East Colfax Avenue
Denver, Colorado 80203

The Honorable Dianne Primavera
Chair, House Public Health Care & Human Services Committee
Colorado State Capitol
200 East Colfax Avenue
Denver, Colorado 80203

Dear Senator Aguilar, Representative McCann, and Representative Primavera:

The Colorado Department of Human Services, Office of Behavioral Health submits the enclosed report concerning the Behavioral Health Crisis Response Services Study Report established by House Bill 2010 - 1032.

In 2010 the Legislature passed and the Governor signed into law House Bill 2010 – 1032 Behavioral Health Crisis Response Services Study. We apologize for the delay of this report as we encountered some internal tracking issues that delayed the process for finalizing of this report. The tracking issues have been resolved thereby preventing this from occurring in the future.
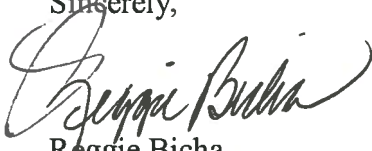
House Bill 2010 – 1032 was created by the General Assembly requesting the Department of Human Services to review the current behavioral health crisis response in Colorado and to formulate a plan to address the lack of coordinated crisis response in the state.

House Bill 2010 – 1032 requires the Department of Human Services to present to a joint meeting of the Health and Human Services Committees of the House of Representatives and the Senate, or any successor committees, a report concerning coordinated behavioral health crisis response in Colorado.

If you have specific questions regarding the Department's activities related to this report please feel free to contact Dr. Lisa Clements, the Director of the Office of Behavioral Health at (303) 866-7655 or by email at Lisa.Clements@state.co.us.

Sincerely,

Reggie Bicha
Executive Director

Enclosure

cc: **Senate Health & Human Services Committee**
Senator Irene Aguilar, Chair
Senator Linda Newell, Vice-Chair
Senator Larry Crowder
Senator Kevin Lundberg
Senator Ellen Roberts
Senator John Kefalas
Senator Jeanne Nicholson

House Health, Insurance & Environment Committee
Representative Beth McCann, Chair,
Representative Sue Schafer, Vice-Chair,
Representative Kathleen Conti
Representative Steve Humphrey
Representative Dianne Primavera
Representative Rhonda Fields
Representative Janak Joshi
Representative Amy Stephens

Representative Joann Ginal
Representative Lois Landgraf
Representative Dave Young

House Public Health Care & Human Services Committee
Representative Dianne Primavera, Chair
Representative Dave Young, Vice-Chair
Representative Kathleen Conti
Representative Beth McCann
Representative Spencer Swalm
Representative Justin Everett
Representative Sue Schafer
Representative Max Tyler
Representative Janak Joshi
Representative Jonathan Singer
Representative Jim Wilson
Representative Jenise May
Representative Amy Stephens

Colorado Department of Human Services
Office of Behavioral Health

House Bill 2010 - 1032
Behavioral Health Crisis Response
Services Study Report

January 2013

This report was prepared by:

Chris Habgood, Director of Policy & Planning, Office of Behavioral Health
&
Jere Thomas, LCSW, Sage Resources Inc.

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House Bill 2010 - 1032 Behavioral Health Crisis Response Services Study

As evidenced by the passage of House Bill 2010-1032, attention and energy is being focused on improving public behavioral health systems of care, especially through the implementation of evidenced based practices. Comprehensive crisis response and stabilization services, rapidly developing into an evidenced based practice, have long been considered a crucial element of public behavioral health systems. Comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. In many communities, crisis response services also perform important public health, public safety, and community well-being functions.

Access and availability to behavioral health crisis services continues to be a gap in Colorado's behavioral health system. The goals of crisis services are to improve access to the most appropriate treatment resources and to decrease the utilization of hospital emergency departments, jails, prisons and homeless programs for behavioral health emergencies. A strong, comprehensive crisis system is integral to creating a seamless integrated behavioral health care system, where consumers will receive appropriate, timely, and quality care. Coloradans need and deserve a more comprehensive approach to behavioral health crisis services. This study examines existing crisis response systems and provides a plan for the creation of a comprehensive crisis response system.

Overview of Legislative Directive

In 2010 the Legislature passed and the Governor signed into law House Bill 2010 – 1032 Behavioral Health Crisis Response Services Study. The bill is provided below.

27-60-101. Mental health crisis response system - legislative declaration - report by department

(1) (a) The general assembly hereby finds and declares that:

(I) There are people in Colorado communities who are experiencing mental health or substance abuse crises and need professional crisis care or urgent psychiatric care from skilled mental health clinicians and medical professionals who excel at providing compassionate crisis intervention and stabilization;

(II) Mental health or substance abuse crisis can happen any hour of the day and any day of the week;

(III) Persons in crisis frequently come in contact with community first responders who are often unable to provide necessary mental health interventions or who must transport these persons in crisis to emergency rooms for services, or, in cases where a crime is alleged, to jail;

(IV) Colorado ranks fiftieth in the nation in the number of inpatient psychiatric beds;

(V) Fewer than one-half of the persons who are in crisis and are taken to an emergency room are admitted for inpatient hospitalization, meaning that thousands of people each year return to

community streets with little, if any, mental health or substance abuse crisis intervention or treatment; and

(VI) Significant time and resources are required of community first responders in addressing persons in mental health or substance abuse crisis and, in many cases, this community response is neither timely nor safe for the person in crisis nor cost-efficient for the state.

(b) The general assembly therefore finds that:

(I) A coordinated crisis response system provides for early intervention and effective treatment of persons in mental health or substance abuse crisis;

(II) A coordinated crisis response system should involve first responders and include information technology systems to integrate available crisis responses;

(III) A coordinated crisis response system should be available in all communities statewide; and

(IV) A coordinated crisis response system may include community-based crisis centers where persons in mental health or substance abuse crisis may be stabilized and receive short-term treatment.

(2) (a) The department of human services shall review the current behavioral health crisis response in Colorado and shall formulate a plan to address the lack of coordinated crisis response in the state. The plan shall include an analysis of the best use of existing resources, including but not limited to managed service organizations, behavioral health organizations, mental health centers, crisis intervention trained officers, metro crisis services, hospitals, and other entities impacting behavioral health crisis response. The department of human services shall complete the review, formulate the plan, and prepare the report required in paragraph (b) of this subsection (2) within existing appropriations and shall design the plan to be implemented within existing appropriations.

(b) On or before January 30, 2013, the department of human services shall present to a joint meeting of the health and human services committees of the house of representatives and the senate, or any successor committees, a report concerning coordinated behavioral health crisis response in Colorado. The report, at a minimum, shall include the plan prepared pursuant to paragraph (a) of this subsection (2).

Background on Need for Crisis Services

The appropriate response to those in crisis is the ultimate test of any behavioral health system. Crisis services are an essential component in a comprehensive behavioral health system, and are often the entry point to services. Crisis and urgent care problems that are not considered immediate danger or risk can often be minimized and given inadequate follow up. The consequence of a missed intervention can give people a diminished sense of importance and can result in a reluctance to seek help at a later time.

When people are unable to access care at the community level, they are forced to access mental health and substance abuse services in hospital emergency departments, jails, prisons and homeless programs. Law enforcement officers are increasingly becoming the "first responders" to mental health crisis calls. Crisis services need to be developed to address the issue of improper utilization of hospital emergency departments and jails by individuals experiencing a mental health or substance abuse crisis.

- In 2007, 12.0 million emergency department (ED) visits involved a diagnosis related to a mental and/or substance abuse condition, accounting for 12.5 % of all ED visits in the U.S., or one out of every eight ED visits. [i]

- Mental health and/or substance abuse condition related ED visits in the U.S. were two and a half times more likely to result in hospital admission than ED visits related to non-mental health and/or substance abuse condition. Nearly 41 % of mental health and/or substance abuse condition related ED visits resulted in hospitalization. [ii]

- In the U.S. ED visits related to mental health conditions accounted for 63.7 % of all mental health and/or substance abuse condition related ED visits. Substance abuse conditions accounted for 24.4 % of all mental health and/or substance abuse condition related ED visits, and co-occurring mental health and/or substance abuse conditions accounted for 11.9 %. [iii]

- In the U.S. patients with psychiatric disorders are likely to use the ED on multiple occasions and to have multiple hospitalizations, compared to patients without psychiatric disorders. [iv]

- In the U.S. 60 % of emergency room physicians believe the increase in ED visits by individuals with mental illnesses is having a negative impact upon access to emergency medical care for all patients - causing longer wait times, increasing patient frustration and diminishing the capacity of hospital staff. [v]

- In the U.S. untreated clients with mental health illnesses are 4 to 6 times more likely to be incarcerated which increase expenses in the state's justice system [vi]

- In the U.S. 90% of deaths by suicide can be attributed to a misdiagnosed or untreated mental health condition. [vii]

The goal for crisis services is to improve access to the most appropriate treatment resources and decreasing utilization of emergency departments and jails. By working toward better integration of acute care services and community-based services, individuals will receive appropriate, timely, and quality care through the implementation of comprehensive crisis response services.

Study Plan

The Colorado Department of Human Services, through its Office of Behavioral Health (OBH), led implementation of House Bill 2010-1032.

OBH used the following processes to complete this study:

Stakeholder meetings - In order to conduct a high-quality stakeholder review of the behavioral health crisis response system, OBH hired a consultant to facilitate six meetings with stakeholders across the state in cooperation with the Department. A separate stakeholder survey was also developed and submitted via survey monkey to capture written comments.

Transparency – OBH was dedicated to ensuring a transparent process for the study and created a dedicated web page that allowed stakeholders to provide comments, take a survey, find research information, and view stakeholder meeting notes and other materials important to this study.

Research study – OBH acquired research from other state systems to identify unique and promising practices and information that may guide Colorado in creation or enhancements to crisis response systems.

Plan Development – OBH then incorporated stakeholder recommendations from the facilitator report and the results from the research on unique/promising practices to create this final report. Throughout the process OBH maintained a focus on the needs and interests of consumers and family members who may be involved in a crisis situation.

For the purpose of this document, **crisis services are defined as**:

A collection of integrated services that are available 24 hours a day, seven days a week to respond to and assist individuals in a behavioral health emergency. These services are provided to persons who are in an emergency condition or crisis situation. The individual's need may be such that they require treatment to reduce the likelihood of death, harm to themselves or someone else, serious injury or deterioration of a physical condition or a major setback in their condition or illness. Examples of these services include but are not limited to: crisis hotlines, crisis residential and respite services, crisis/mobile outreach, short-term crisis counseling, crisis walk-in clinics, and crisis stabilization services to name just a few.

Stakeholder Meetings and Findings

House Bill 2010-1032 did not allocate any funding to conduct the behavioral health crisis study. The Department hosted six stakeholder meetings utilizing current resources. Announcements for all meetings were sent to a very broad and diverse group of stakeholders through electronic mail and posted on the Office's web page. The stakeholders invited included: state government agencies, county government, county social services offices, statewide law enforcement agencies, statewide legal organizations, county peace officers, managed service organizations, behavioral health organizations, mental health centers, substance use disorder providers, prevention services organizations, Metro Crisis Services, hospitals and hospital association, statewide primary care organizations, statewide health care professional provider organizations, philanthropy organizations, consumer and family advocacy organizations, and other entities impacting behavioral health crisis response.

Two meetings were held in the Denver Metropolitan area and four regional meetings touching the four regions of Colorado. The regional meetings included two Western slope meetings and two eastern plains meetings.

Behavioral Health Crisis Study – Stakeholder Meetings Final Report

Between April 2011 and July 2012, six community stakeholder meetings were conducted around the state of Colorado related to the HB2010-1032 Behavioral Health Crisis Study:

April 15, 2011 – *Denver*
(45 attendees including: Colorado Behavioral Healthcare Council, behavioral health providers, behavioral health advocacy organizations, Metro Crisis Services, prevention providers, county human services staff, West Pines hospital, family advocates, law enforcement, substance use disorder providers, private practitioners, and consumers)

October 12, 2011 – *Durango* - Co-hosted with Axis Health System
(25 attendees including: behavioral health providers, county human services staff, county health department staff, Head Start programs, Mercy Medical Center hospital, homeless programs, independent living programs, law enforcement, and prevention provider programs)

October 13, 2011 – *Grand Junction* - Co-hosted with Colorado West Regional Mental Health (12 attendees including: prevention providers, behavioral health providers, county human services, family advocates, substance use disorder providers, private practitioner, and consumers)

December 8. 2011 - *Denver* - Co-hosted with Behavioral Health Advocacy community – Mental Health America of Colorado, National Alliance for the Mentally Ill, Federation of Families for Children's Mental Health, Advocates for Recovery, and Colorado Mental Wellness Network. (40 attendees including Colorado Behavioral Healthcare Council, behavioral health providers, behavioral health advocacy organizations, Metro Crisis Services, prevention providers, county human services staff, family advocates, substance use disorder providers, law enforcement, private practitioners, and consumers)

April 20, 2012 – *Pueblo*
(5 attendees including area hospitals, brain injury group, behavioral health providers, and private practitioners)

July 16, 2012 – *Ft. Morgan* - Co-hosted with Centennial Mental Health Center
(18 attendees including probation department staff, behavioral health providers, Metro Crisis Services, school safety resource center, and county social services)

In an effort to maintain consistency, the same agenda and format was used in all six meetings:
Agenda
   A. Welcome (10 min).
      ▪ Overview of HB2010-1032.
      ▪ Purpose and process of statewide stakeholder meetings.
   B. Current service structures (45 min).
      ▪ Observations of current services and gaps.
      ▪ Discussion on current services.
      ▪ Research on best practices and crisis models.
   C. Visioning the future of crisis response (45 min).
      ▪ Developing consensus in small groups on priorities for a future crisis response system.
      ▪ Share top priorities with the larger group.
   D. Wrap up (15 min).
      ▪ Next steps in HB2010-1032 process.
      ▪ Thank you for being here.

The goals of the community stakeholder meetings were to gather input on existing crisis services as well as priority areas for both an ideal and a feasible crisis response system. This report includes common themes and input that emerged across all six meetings.

Current Crisis Response System
Meeting participants were asked to complete a checklist of crisis services, indicating which currently exist in their community. Overall, participants tended to agree that all the services listed do exist in some form or another. However, there was also almost unanimous agreement that the existence of a service in no way means it is accessible or sufficient to meet the needs of those in crisis. Specifically, several themes related to service gaps emerged across all the meetings:

▪ Limited Access - Limited access to existing services was the most commonly listed gap. For example, in La Plata County one or two youth programs have mobile crisis response where a trained mental health worker goes to the site of the crisis. However, that service is only available to the clients of that program. Similarly there are access issues for people facing other health issues beyond mental health. This population includes those with a dual diagnosis, developmental disabilities, medical conditions, and seniors. It appears that these populations often encounter more barriers to access or are excluded from existing resources by virtue of the accompanying issue. For example, a dually diagnosed person in a mental health crisis may be told he/she is not eligible for crisis services because it is actually the

result of the developmental disability or substance use disorder. While that person may ultimately receive care, it may take longer and involve more navigation of the system.

- <u>Inadequate Services</u> - While there is limited access to a 24-hour hotline for Medicaid client in crisis, consumers may not be able to speak with a trained professional. Similarly, while some communities report providing mobile crisis team services, it is most commonly a law enforcement unit, not always the consumer's preferred first point of contact.

- <u>Transportation</u> - In the rural areas, a number of gaps in services were identified with transportation. Consumers often lack transportation to get to a secure assessment site. Communities often have limited resources to transport a consumer to a higher level of care and are forced to use law enforcement for transportation. In addition, consumers re-entering the community post-crisis often lack transportation back to their home.

- <u>Inpatient Bed Space</u> - There are insufficient beds to meet the needs for inpatient placement. Additionally, the outpatient services available are inadequate to compensate for this bed shortage. This gap appears to cross all ages though youth may have the highest need.

- <u>Low Awareness</u> – There appears to be low awareness on the part of consumers and behavioral health professionals of services that are currently available. This may be due to lack of marketing of services as well as to insufficient collaboration between agencies.

Ideal Crisis Response System
At each meeting, participants agreed that an ideal crisis response system would be fully funded, locally driven, and cover the life cycle with a full continuum of care from early intervention through crisis stabilization, respite and re-entry into the community. In addition, the following ideals were presented at each meeting:

- System orientation to crisis would revolve around the patient need rather than diagnosis or payer source.
- There would be alignment across agencies for seamless care.
- There would be adequate beds to meet the needs of inpatient care and jails would have in-house diversion programs and designated areas specializing in psychiatric issues.
- Behavioral health crisis training would be provided for first responders, covering both youth and adult crisis. This includes emergency department staff, transport staff and anyone who has first point of contact.
- Transport would be funded throughout the state.
- Statewide definitions, generally accepted best practices and protocols would be identified across the state.

Feasible Crisis Response System within existing resources
Moving from the ideal to what is feasible given current funding; a number of priorities were identified as viable and requiring minimal new resources. Participants expressed both frustration and optimism with the system and the potential for change. While these meetings included a broad range of perspectives, there was a shared sentiment that crisis response services should serve the needs of the consumer and that this can be done better:

- Address transportation needs (For example, a mental health center has developed a partnership with law enforcement in one community so they have full time access to a secure vehicle where a mental health staff member can transport a consumer without shackles and handcuffs).
- Develop consistent definitions of crisis response systems and services statewide.
- Training for medical staff on child and adolescent presentations.
- More telemedicine to assist with assessment.
- One point of access with a high degree of collaboration across community agencies.
- A seamless approach that follows consumers through to post-crisis. This would include a designated entity to follow the person after crisis contact through connection with longer-term supports. It would also include access to emergency psychiatric services.
- Warm line – peer consumer support provided by persons with lived experiences.
- More training (Mental Health First Aid training that is free).
- Reorganize funds and payment for crisis to be driven by service not diagnosis.
- Increase collaboration and coordination between substance abuse, mental health, developmental disabilities and other specialized organizations.
- Improve transitions and follow up care (For example, from jail/corrections back to communities).
- Review of best practices and outcomes, and begin tracking data that is meaningful and informative to the process.
- Change approach to have no exclusions based on co-occurring disorders or issues.
- Consider developing clear procedural steps into after care and maintenance.

Stakeholder Survey Findings
A behavioral health crisis study survey was developed and posted on the Division of Behavioral Health website from winter 2011 through summer 2012. The survey was open to anyone and was advertised via several avenues, including at the stakeholder meetings. The survey questions parallel the stakeholder meeting agenda in most respects, and were designed to provide an additional avenue for providing input into the HB2010-1032 process.

Two hundred and fourteen respondents completed the survey. Of these, 54.5% categorized themselves as mental health professionals, 19% as government employees, 16% as drug and alcohol treatment providers, and 12.8% as prevention providers. The remaining respondents included consumers, medical professionals or elected officials. Participants in the stakeholder meetings were also encouraged to take the online survey so it should be noted that the respondents in both reports are not mutually exclusive.

According to survey respondents none of the nine listed crisis services exist in 100% of their communities and/or regions. Seven services reportedly exist in less than 50% of respondents'

communities. When asked how well the existing crisis response system is working in their community, fewer than 40% said the system fully or mostly meets the need. Thirty-four percent (34%) said it sometimes meets the need and fewer than 20% reported it rarely meets the need.

Survey respondents were asked to rate their area's services in relation to response time, timely access to follow up, detox services and overall continuum of care. Respondents most frequently chose "inadequate" to rate their community services.

How would you rate the following services for your community?
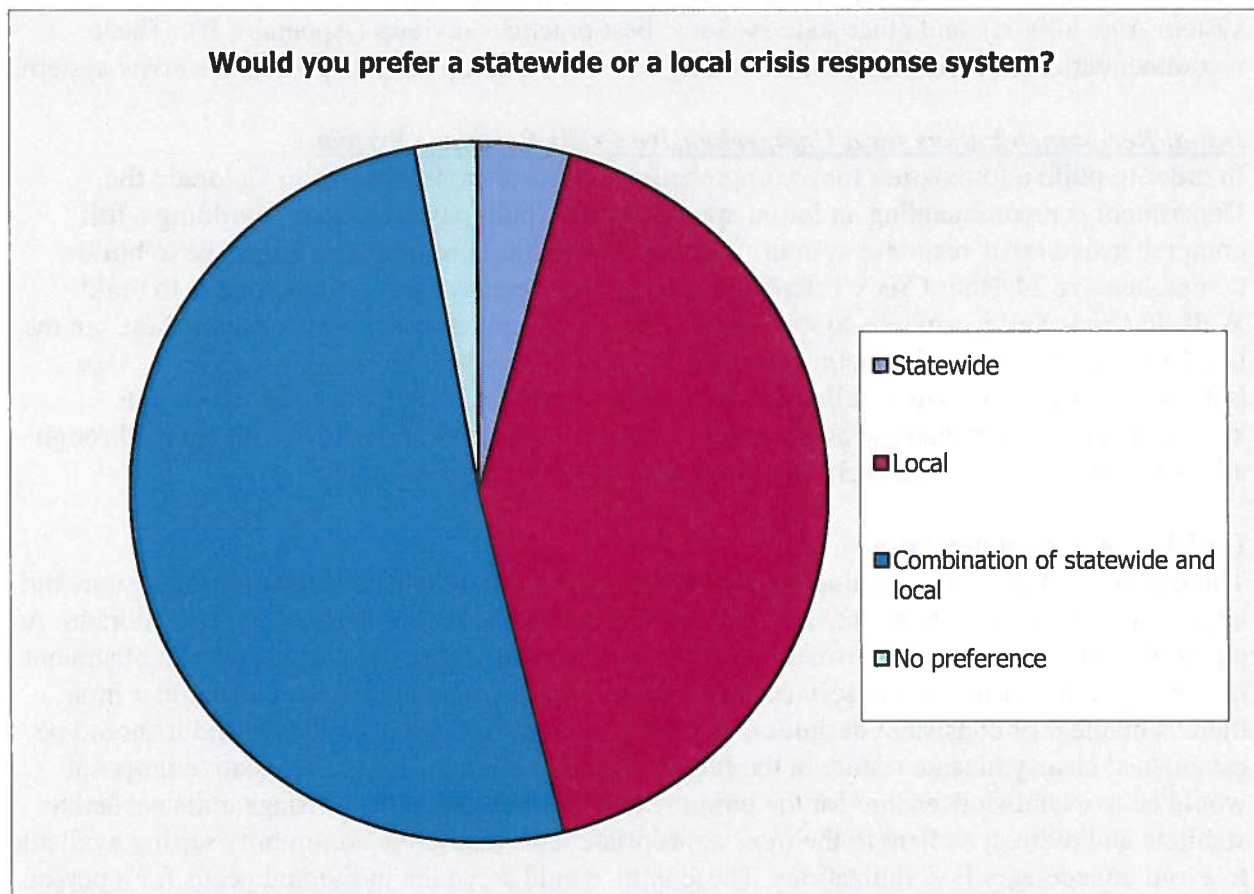

Percent responded
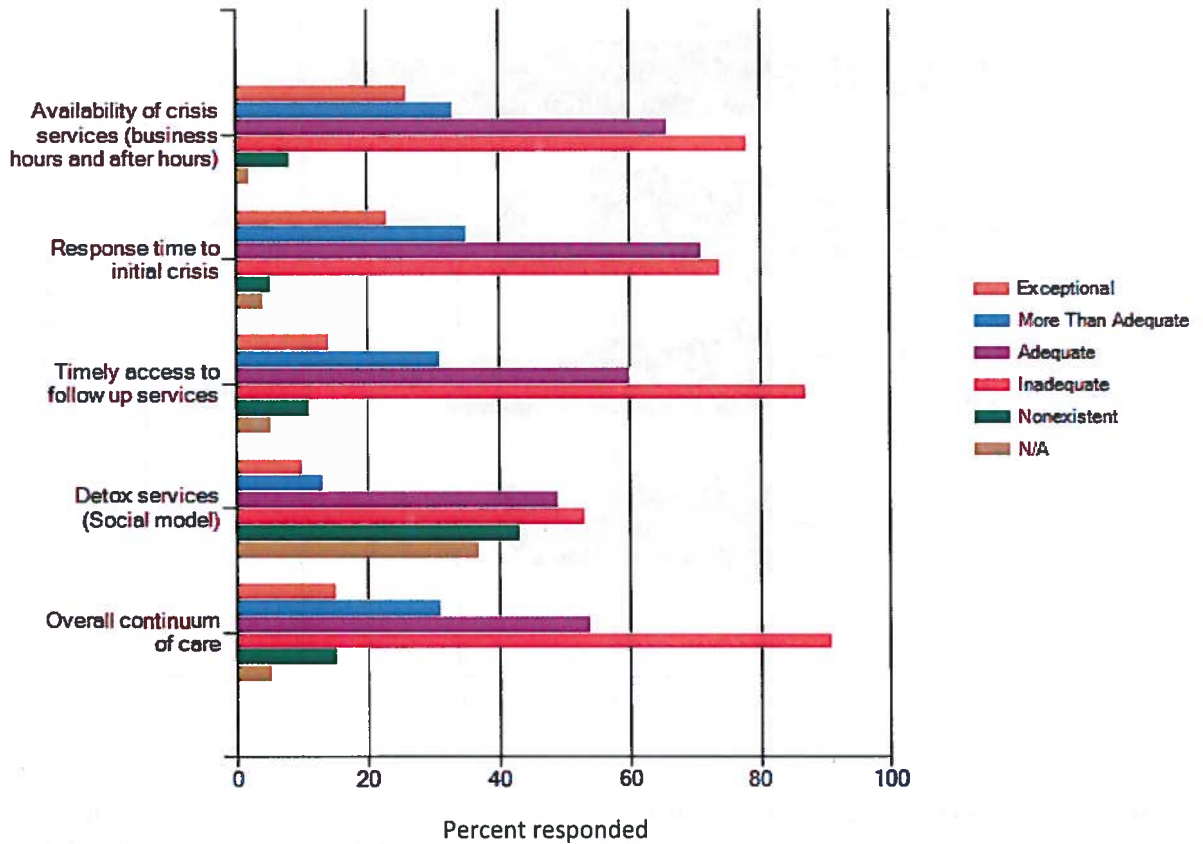
The survey also asked how well the crisis response system is working with citizens and other agencies. As shown in the following chart, the majority of respondents said that the system is average or below average in community awareness of services, collaboration, outreach and communication, and consumer satisfaction.

How is the crisis response system working with citizens and other agencies in your community? Please rate the following:

Percent responded
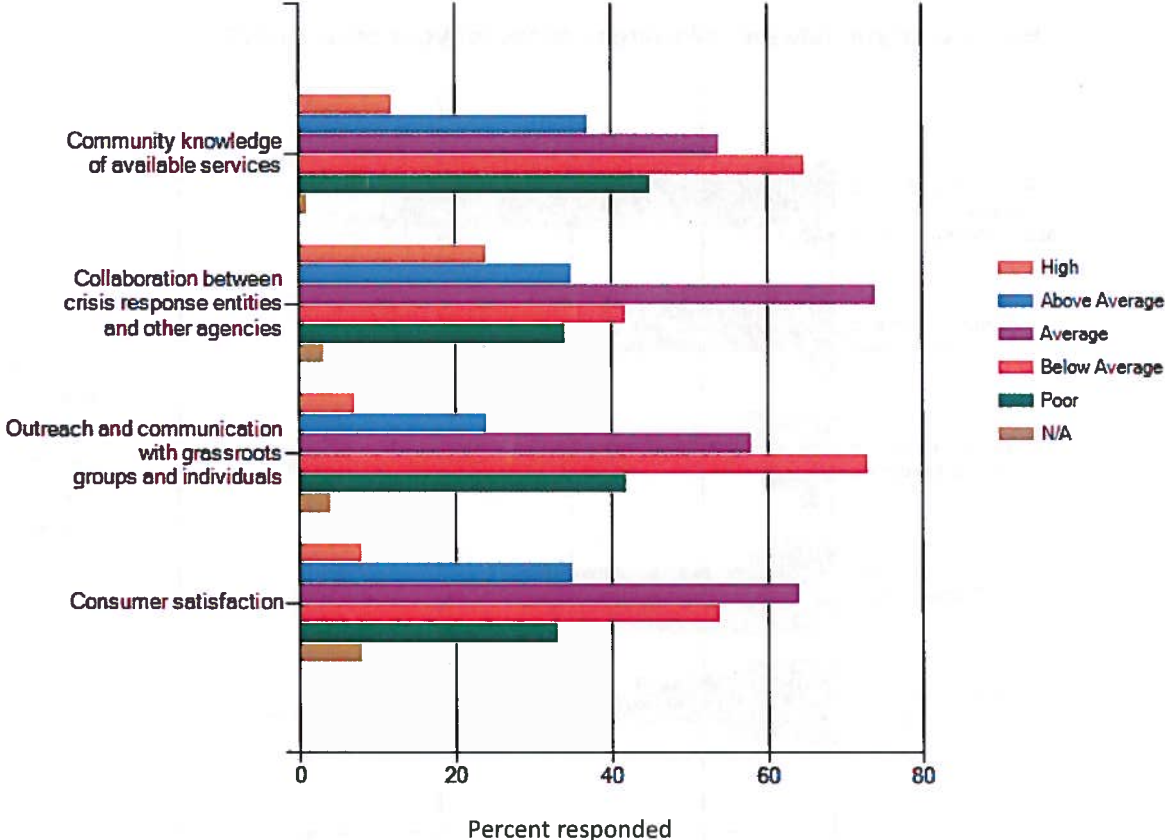
When asked what an ideal and feasible crisis response system within existing resources would look like, survey respondents provided very similar input to what was shared in the stakeholder meetings. Ideal systems would be fully funded, integrated and cover a full continuum of care for all populations in need. A feasible crisis response system would use existing resources more effectively through increased collaboration, increasing knowledge of what services do exist, better follow up and more flexible funding streams. This is consistent with what participants expressed in stakeholder meetings as well as in follow up conversations with Office of Behavioral Health staff.

The final survey question asked if respondents would prefer a statewide, local or combined system and the vast majority prefer a combined effort.

Would you prefer a statewide or a local crisis response system?

- Statewide
- Local
- Combination of statewide and local
- No preference

The information gathered through this process expanded on the identified challenges to providing quality crisis intervention services across the state, including:

- Utilization of 911, answering services, or national hotlines to meet the 24/7 telephonic access requirement.
- Lack of coordination of care/follow-up.
- Limited access to community diversion resources resulting in the use of more restrictive services to resolve the crisis such as avoided involuntary commitments.
- Underutilization of peer services as a resource for crisis intervention.
- Lack of uniform training requirements for crisis intervention staff.
- Inadequate funding to support quality crisis intervention services.

Recommendations for a Comprehensive Behavioral Health Crisis Response System in Colorado

As stakeholder input indicates, creating a comprehensive crisis response system requires an approach that incorporates a combination of statewide, local, and other strategic collaborative partners. The following recommendations are based on the stakeholder input, best practice literature reviews (see model crisis system Appendix A), and other state systems' best practices reviews (Appendix B). These recommendations are the foundation building blocks to a complete comprehensive crisis system.

Initial Recommendations for a Comprehensive Crisis Response System

In order to build a foundation for a comprehensive crisis response system in Colorado the Department is recommending an initial approach that would pave the way to building a full comprehensive crisis response system. The first foundation building step would be to build a comprehensive 24-Hour Crisis Telephone Line or crisis call system. The second is to build Walk-In Crisis Services/Crisis Stabilization Units. As found in other state systems these are the two key building blocks that help to establish a comprehensive crisis response system. One critical aspect to these two building blocks is a statewide marketing and communications approach. This would increase awareness of mental health and substance use disorders through educating those in need and their families where to go in a time of crisis.

Legislative Recommendation

The Department is recommending a legislative proposal that would establish a crisis system and approaches in statute to begin paving the road to a comprehensive crisis system for Colorado. As a part of the proposal the Department would recommend, as other states have, the establishment of crisis system definition and services into statute. As recommended from stakeholder input there is no clear or consistent definition of what crisis services are in Colorado and it should be established clearly in state statute in the future. Another component of a legislative proposal would be to establish licensure for the unique crisis stabilization units or triage units needed to stabilize and redirect a client to the most appropriate least restrictive community setting available to avoid unnecessary hospitalizations. These units would serve the individual needs for a person in crisis to deescalate the situation and coordinate and link the individual to ongoing treatment in the community. Crisis stabilization units would help to prevent unnecessary behavioral health involuntary civil commitments by interviewing before an individual decompensates to the level where a civil commitment is necessary.

☎ **24-Hour Crisis Telephone Lines** (including Warm Lines) - Telephone crisis services staffed by skilled professionals to assess and make appropriate referrals.

Recommendation:

Create a statewide crisis telephone line with one telephone number statewide. The State should initiate a competitive bid process to identify a service provider to develop and manage a statewide toll free crisis and access line that can actively link callers 24/7 to appropriate local service providers. This statewide crisis call system would provide a "no wrong door" approach to access, offer telephonic crisis intervention and scheduling opportunities with consumer choice,

real time data and reporting for strategic planning and outcome tracking. This recommendation is modeled on the award winning Georgia Crisis and Access line.

- **Walk-In Crisis Services/Crisis Stabilization Units** - Urgent care services with the capacity for immediate clinical intervention, triage, and stabilization.

Recommendation: Create five crisis stabilization units statewide until there is other resource capacity at local service levels that would ensure comprehensive crisis services. The State should initiate a competitive bid process to identify service providers to develop and manage crisis stabilization units as part of a larger comprehensive crisis system to specifically target regions throughout the state based on major population areas.

One core component of the crisis stabilization unit that should be considered is an integrated health and behavioral health approach. The Department recommends that in the establishment of crisis stabilization units there should be a direct collaboration with public health entities that fall under the federal Public Health Services Act. This works to integrate health care and behavioral health care to ensure continuity for the individual overall needs and services.

Secondary Recommendations for a Comprehensive Crisis Response System
The following recommendations are the secondary building blocks that would assist Colorado in building a complete and comprehensive crisis response system.

- **Mobile Crisis Services** - Mobile crisis units with the ability to respond within one hour to a behavioral health crisis in the community (e.g., homes, schools, or hospital emergency rooms).

- **Crisis Residential/Crisis Respite Services** - A range of short-term crisis residential services (e.g., supervised apartments/houses, foster homes, and crisis stabilization services).

- ☺ **Peer services** - should be infused in the crisis response process to allow an individual access to a supportive person with lived experience.

These recommendations are based on the stakeholder input, best practice literature reviews (see model crisis system Appendix A), and other state systems' best practices reviews (Appendix B). Creating a comprehensive crisis response system requires an approach that incorporates a combination of statewide, local, and other strategic collaborative partners. The initial recommendation builds a foundation and the secondary recommendations will build the walls and roof for a comprehensive crisis response system in Colorado.

Appendix A

Model of a Comprehensive Behavioral Health Crisis Response System

In 2005 the Technical Assistance Collaborative, Inc. (TAC) published "A Community-Based Comprehensive Psychiatric Crisis Response Service."[viii] This report is the first of its kind that reviewed best practices in crisis service delivery systems nationwide and provides an overview of a comprehensive crisis response system based on best practices. In 2009 the Substance Abuse and Mental Health Services Administration (SAMHSA) "Practice Guidelines: Core Elements for Responding to Mental Health Crisis,"[ix] were published. Both of these reports established the core components of a comprehensive crisis system to include:

Purpose of a Behavioral Health Crisis System

For persons experiencing behavioral health crises, a competent crisis response service system should be able to:
- Provide timely and accessible aid.
- Provide access to a wide range of crisis stabilization options.
- Stabilize them as quickly as possible and assist them to return to their pre-crisis level of functioning.
- Increase and maintain their community tenure.
- Increase their ability to recognize and deal with situations that may otherwise result in crises.
- Increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention.

In order to fulfill the operational capabilities listed above, a crisis response system **must** be able to:
- Resolve crises for persons with serious behavioral health issues, 24 hours a day, and seven days a week.
- Recruit and retain appropriately skilled and trained, linguistically and culturally competent staff that are capable of serving adults, children, adolescents, and families.
- Serve as a community resource for crisis response, stabilization, and referral of individuals, including children and adolescents, who are in crisis.
- Provide appropriate linkages and arrangements that alleviate the use of law enforcement as the primary responder to individuals in crisis, thus, minimizing the criminalization of persons with behavioral health issues.
- Provide services that are adequate for individuals with multiple service needs, specifically individuals with co-occurring disorders and/or accompanying medical conditions.
- Provide a range of crisis services that divert people from inpatient psychiatric hospitalization, emergency rooms to less costly service alternatives.
- Directly transport and/or arrange for the transport of individuals in crisis to treatment.
- Establish links with healthcare resources to provide and/or arrange for medical clearance, toxicology screens, and lab work, as well as medical and non-medical detoxification services.
- Coordinate with the consumer's primary behavioral health provider for follow-up and post-crisis care.

- Incorporate evaluation protocols to measure the effectiveness of the crisis services.

Examples of crisis program components might include:

☎ Telephone crisis services staffed by skilled professionals to assess, make appropriate referrals, and dispatch mobile teams.

🚌 Mobile crisis units with the ability to respond within one hour to a behavioral health crisis in the community (e.g., homes, schools, or hospital emergency rooms).

🏠 A range of short-term crisis residential services (e.g., supervised apartments/houses, foster homes, and crisis stabilization services).

🏥 Urgent care services with the capacity for immediate clinical intervention, triage, and stabilization.

Crisis Services as an Integral Part of the Health Care System

There is growing recognition that behavioral health crisis services cannot and do not operate on the fringe of the health care system, but rather are mainstream activities necessary to complete the health care continuum. Crisis services cut across many different systems, including:

- **Social services**: Housing, medical benefits, child welfare, etc.
- **Legal**: Involuntary confinement or detainment for the purpose of treatment and evaluation.
- **Health**: Medical services.
- **Community and personal safety**: Law enforcement assessment of danger to self or the community.

Due to this multi-system involvement in delivering crisis services, a psychosocial rehabilitation framework is promoted through the application of a "systems" approach to crisis service intervention. Such an approach ensures that no aspect of the life of the individual with mental illness is ignored or denied the necessary assessment or intervention.

Service Components

A comprehensive crisis system (CCS) is designed to address and overcome many of the constraints inherent in a hospital-based setting, including time, space, and a lack of community treatment orientation. Community-based crisis services, when well-coordinated and implemented, are an effective and humane approach to service delivery for persons in psychiatric crisis. Rather than a single service response, a CCS encompasses a range of timely services that are integrated across multiple providers. A well-designed CCS can provide backup to community providers, perform outreach by connecting first-time users to appropriate services, and improve community relations by reassuring that persons with severe behavioral health issues will be supported during crises.

Of equal importance, a CCS must have the ability to address the needs of individuals with **co-occurring mental illness and substance abuse disorders**. Such co-occurring disorders are remarkably common. An estimated 10 to 12 million people live with co-occurring mental and addictive disorders nationwide. Research suggests that the mental health problems often predate the substance abuse problems by 4-6 years; alcohol or other drugs may be used as a form of self-medication to alleviate the symptoms of the mental disorder. The capacity to address co-

occurring disorders should be viewed as a **fundamental feature** of an effective CCS based upon the prevalence of co-occurring disorders in the population served.

The information in this section of the report will provide a general description of the core components of a comprehensive crisis system. The core components of a CCS system include:
- 24-Hour Crisis Telephone Lines (including Warm Lines)
- Walk-In Crisis Services
- Mobile Crisis Services
- Crisis Residential/Crisis Respite Services
- Crisis Stabilization Units

Although the names of the particular services may differ from system to system, their function is the same or very similar.

☎ *24-Hour Crisis Telephone Lines*
The telephone is often the first point of contact with the crisis system for a person in crisis or a member of his/her support system. Telephone crisis services should be available 24 hours per day to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated.

✎ *Warm-Lines*
Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre- and post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers.

Warm lines focus on the following:
- Building peer support networks and establishing relationships.
- Active listening and respect for consumer boundaries.
- Making sure callers are safe for the night.

✝ *Walk-in Crisis Services*
Walk-in crisis services are provided through Urgent Care Centers in some communities. Services typically include:
- Screening and assessment.
- Crisis stabilization (including medication).
- Brief treatment.
- Linking with services.

Single or multiple community agencies may be identified to address walk-in crisis and "urgent" situations on a 24-hour basis or through extended service hours.

🚐 *Mobile Crisis Outreach*
Mobile crisis teams are one of the most innovative components of a CCS. Mobile teams have the capacity to intervene quickly, day or night, wherever the crisis is occurring (e.g., homes,

emergency rooms, police stations, outpatient mental health settings, schools, etc.). These teams can serve persons unknown to the system and often work closely with the police, crisis hotlines, and hospital emergency services personnel. Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in serving adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. Thus, an "extended intervention," which can include short-term counseling, may be necessary. In this instance, a mobile team member may act as the primary care provider until it is appropriate to transition the family into mainstream services.

Some mobile teams may have broad authority and responsibilities for service management that include, but are not limited to:
- Providing pre-screening assessments or acting as gatekeepers for inpatient hospitalization of consumers utilizing public services.
- Managing and controlling access to crisis diversionary services.

In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Some mobile teams operate 24 hours a day, whereas others operate only during nights and weekends, relying on community agencies or walk-in centers to handle crises during regular working hours. In some systems, mobile teams provide preventive support in the form of "wellness checks" for persons felt to be fragile or at risk.

While one of the goals of a mobile crisis team is to link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort.

Crisis Respite/Residential Services
On occasion, resolution of a crisis may require the temporary removal of a consumer from his or her current environment. The purpose of crisis respite/residential services is to provide the individual in crisis with support in calm, protected, and supervised non-hospital setting. During this period, the person can stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings for residential/respite crisis support should be available to meet the varying needs and desires of individuals. Residential supports can be classified as either individual or group.

Individual Residential Supports
Individual approaches serve one or two persons in a particular setting.
Examples include **family-based crisis homes** where the person in crisis lives with a screened and trained "professional family." In addition to practical and emotional support from "family" members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services.

A **crisis apartment** is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked

with other supports. In a **peer support** model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere.

Finally, an **in-home support** approach, similar to a crisis apartment but in the person's own residence, can be considered if separation from the natural environment is not felt to be necessary. A similar range of services as described in the family-based peer model above are available to consumers in their own home.

✏ *Group Residential Supports*

Group respite/residential approaches have the capacity to serve more than two consumers at a time. These services are generally provided through crisis residences that combine two types of assistance – crisis intervention and residential treatment. **Crisis residences** offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a step-down resource upon hospital discharge.

🖾 *Crisis Stabilization Units (CSUs)*

Crisis Stabilization Unit services are provided to individuals who are in behavioral health crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multi-disciplinary teams of behavioral health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

☉ *23-Hour Beds*

Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

🚐 *Transportation*

Transportation is an essential ingredient of the crisis system that ties all the service components together. The ability to transport individuals in need of crisis services in a safe, timely, and cost effective manner is critical to operations. The requirements for individuals who are authorized to

transport persons in crisis vary between communities and may be determined by the legal status (voluntary versus involuntary) of the individual in need of treatment.

In some circumstances, mobile teams will coordinate transport with local law enforcement or emergency medical vehicles to assist individuals in receiving necessary care. Transportation within a crisis service system may also take other, less expensive forms. For example, crisis systems may arrange with private commercial entities, such as taxi companies, to transport individuals who are willing and able to be transported for treatment, but who lack resources to make the trip. Regardless of how a crisis system decides to provide transportation, there are several key factors for consideration in arranging or providing transportation for individuals seeking crisis services. These factors include:

- Reliability.
- Availability.
- Skill level of those involved in the transport.

☺ Peer Support Services

Peer support services should be infused in the crisis response process to allow an individual access to a supportive person with lived experience. Services should afford opportunities for contact with others whose personal experiences with mental and substance use disorders and past crises allow them to convey a sense of hopefulness first-hand. Peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences and may have particular relevance given feelings of isolation and fear that may accompany a behavioral health crisis.

<u>Continuity of Care and Crisis Care Continuum</u>

A well-designed crisis service cannot and does not exist in isolation. It is essential that each crisis system partner understands their responsibility before attempting to carry out their functions. Thus, cooperation with other health and human service systems is a key ingredient of the overall success of the crisis system. The following section identifies key system partners and discusses their potential role, function, and interface with the crisis system.

Outpatient Providers

In many communities, outpatient providers such as community mental health centers and lead service agencies are considered the primary behavioral health provider or "clinical home" for consumers. For a crisis service system to be effective, it must have the cooperation of outpatient providers to assist in the coordination of services after the crisis episode is resolved or stabilized. The successful transition of a consumer from crisis care to care by an outpatient provider reinforces the continuum of community-based, least restrictive care.

Ideally, the crisis service and outpatient providers will formalize their relationship through **memoranda of agreement** that may address the following responsibilities and expectations:

- Accessibility of outpatient provider staff after-hours to coordinate care and provide information on behalf of persons in their care.
- Role of case management staff in developing crisis plans and discharge planning with crisis service providers.

- Availability of convenient urgent care appointments for new or existing consumers referred for the crisis service and follow-up with consumers who do not keep their appointments.
- Availability of case management staff to participate in treatment planning when a consumer is placed in a short-term diversionary residential crisis/respite service or admitted to the hospital.
- Acceptance of referrals of new consumers from the crisis service within a reasonable period of time, or the availability of blocks of appointment times for the exclusive use of the crisis service.
- Provision of case management services during extended hours to high need consumers.

Hospital Emergency Rooms (ERs)

Quite often persons in a psychiatric crisis interact with hospital emergency rooms before reaching the crisis system. Hospital emergency rooms are required by law to treat the emergency medical needs of anyone who presents to them, including persons in a psychiatric crisis. Some emergency rooms are specifically equipped to deal with the immediate psychiatric needs of emergency room users by calling a **psychiatric consult** or conducting a **simple detoxification**. Some hospitals also have **medical detoxification units** or **psychiatric inpatient beds** to which they can admit persons from the emergency room when they need such care.

A crisis response system can also provide and assist ER personnel with training on the behavioral health and human/social services available in the community and how to access such resources. For crisis response systems that have the authority to manage service utilization and authorize inpatient stays, crisis system personnel will be available by phone 24 hours per day to authorize emergency room decisions.

The frequent overlap of medical and psychiatric emergencies requires that hospital emergency room staff and crisis service system staff coordinate their activities closely. It is essential that all participants in the system have a working knowledge of each other's policies, procedures, roles, and responsibilities. The goal of the mobile team staff should be to help the ER staff as much as possible, while attending to the needs and safety of the person requiring care. Furthermore, mobile team staff must remember that hospitals generally do not have the resources to hold persons in the emergency room whose medical condition has been stabilized but who cannot be safely released to the community because of a psychiatric condition. Nor are hospitals able to wait long periods of time for authorization for admission to their inpatient or detoxification beds.

Law Enforcement – Local Police and County Jail

Other than the collaboration with hospital emergency rooms, the most significant relationship of a crisis response system is with law enforcement. The **goal** of most crisis service systems in their interface with the local police officers is to have the officers in and out of the interaction as quickly as possible. This commitment alone is a very important service feature that encourages police officers to seek treatment for, rather than incarcerate, individuals in need of psychiatric care. Local police personnel are or can become frequent users of the mobile teams, crisis stabilization unit, and walk-in clinics. Depending on the design of the system, officers will call the crisis phone lines to request mobile teams to assist with a community member who has a behavioral health need, is substance abusing, and/or is homeless. The Crisis Phones prioritize

these calls and process information, as well as contact and dispatch a team to assist the officers on-site in the community.

A crisis service system can also provide much-needed **education and training** to new recruits and veteran officers regarding working with individuals who may have a mental illness, as well as providing information concerning how to access the services available. Regular forums should be established between the crisis service system and law enforcement to trouble-shoot, problem solve, and make recommendations regarding system improvements.

One model of a collaborative partnership between law enforcement and mental health providers is the Memphis Police Department's **Crisis Intervention Teams** (CITs). The CIT is a police-based program with specially trained officers who are called to respond to mental disturbances and suicide attempts in the community. CIT officers are skilled in de-escalating potentially volatile situations, gathering relevant history, and assessing information related to medication and social support. The CIT officers have the capacity to transport individuals to the University of Tennessee psychiatry emergency services after the situation has been assessed and diffused. The CIT is considered the most visible pre-booking diversion program in the nation and has been replicated in: Seattle, WA; San Jose, CA; Albuquerque, NM; and Waterloo, Iowa and many communities in Colorado. The CIT is a partnership with local mental health providers, the local chapter of the Alliance for the Mentally Ill, and the Universities of Memphis and Tennessee.

When pre-jail diversion options are not available to officers, it is important for incarcerated persons with mental illness that the crisis service system remain a critical link for jail staff to refer for services consumers whose release is pending. Unfortunately, the majority of police departments in US cities with populations of 100,000 or more do not have a specialized strategy to respond to persons in crisis who may have a mental illness; 24 therefore, procedures and policies must be established to create a connection between behavioral health care providers and law enforcement for individuals getting out of jail as well as a pre-booking service option, either on a voluntary or involuntary basis.

The Courts

In some comprehensive crisis service systems, **court-ordered psychiatric evaluations** are initiated by the crisis service provider. Within the laws of a given state, any responsible adult may apply for a court-ordered evaluation of a person who, as a result of a mental disorder, is alleged to be a danger to self or others, persistently acutely disabled or gravely disabled, and who is unwilling to undergo a voluntary evaluation. In providing this service, the crisis system must have the capacity and authority to begin the necessary legal process for an evaluation even if the consumer does not agree voluntarily. Once determination has been made about the existence of a mental disorder, the court can assess whether treatment is required and in the best interest of the consumer.

The process of obtaining a court ordered evaluation and making treatment decisions requires timely collaboration between the crisis service system and the courts, regarding such details as:
- How the process and paperwork will flow.
- What the orders say.
- When the hearings are needed and where they are held.

- The identification of primary points of contact.
- The regular meeting of principal players to ensure smooth operation of the system.
- How the services will be paid for.

Addressing these issues is vital to the success of a crisis delivery system that incorporates the courts into its service design.

Primary Care Physicians and Health Plans
All crisis service systems will come in contact with consumers who may be enrolled in private or public health plans. It is critical to be aware of the primary health plans in the community and, ideally, establish protocols for communication with **primary care physicians** (PCPs) when care is rendered to their members. PCPs may interact with the crisis service system in a variety of ways, including:
- Identifying individuals in need of behavioral health care and making referrals;
- Seeking help for a consumer about whom they have concerns; and
- Seeking help for a consumer on behalf of a family member, clergy, or other community member.

The relationship between the crisis service system and the PCP or health plan ensures that critical medical information, such as medication type and dosage, is communicated and that the most effective interventions are utilized to resolve the crisis without escalation. Strategies to help facilitate this collaboration include developing educational material together and participating in joint trainings, seminars, and monthly coordination meetings.

Fire Departments – Paramedics and 911
A well-designed crisis service system will interface with the local municipal fire departments at two critical points. First, fire departments may contact the crisis service system for assistance, an interface that generally occurs through the Crisis Phone Lines initially.

Fire personnel call the Crisis Phones and request a mobile team intervention when they have responded to a 911 call that involves a continuing psychiatric crisis. Second, the crisis service system will call 911 (fire, rescue, and ambulance service) to facilitate transportation and emergency medical intervention when a consumer has been identified by the crisis phones, mobile teams, crisis stabilization units, or walk-in centers as having a medical emergency. Operating procedures, clearly defined roles and responsibilities, and timely responses are all key to the success of this overlapping systems relationship.

Social Services - Community Information and Referral
The crisis service system should be available to all persons in the designated community, including those served by county, state, and private agencies and social service agencies. Social service agencies that may come into contact with the crisis system include: Child and Family Services, Adult Protective Services, Adult and Juvenile Corrections, Developmental Disabilities, and Substance Abuse Services.

These agencies will access crisis services on behalf of their clients like any other community resident, generally through the crisis phones or walk-in/urgent care clinics. The crisis phone

system must also have the capacity to continuously update its **database of community agencies**, including the services they provide, their contact numbers, and their access procedures. This capacity is necessary to provide accurate information to consumers who may contact the crisis system regarding non-behavioral health needs. To the extent possible, the crisis phone service should be able to connect the consumer to another community agency that may be able to help. The crisis service system should gather information from community providers on a regular basis in order to maintain relationships and ensure the accuracy of the information in their database.

Schools

On occasion, schools will encounter crisis situations with children, adolescents, or their families during school hours. These situations are opportunities for the crisis service system, as a community resource, to interface with the school system.

Examples include:

- Incidents involving students with behavioral health problems that goes beyond the ability of school personnel to manage.
- Behavior that prevents the involved student or other students to be taught.
- Incidents that affect individual students or the whole student body and require immediate intervention (e.g., a shooting or an accident resulting in death or serious injury to a student or teacher).

A mobile team that serves only children and adolescents or a team with children and adolescents expertise can be dispatched to assist the school, the students, and the families until the crisis is resolved. On-site intervention may the best way to address the problem or a determination might be made to transport the child to his or her home, a walk-in/urgent care clinic, a crisis stabilization unit, or a hospital emergency room. Follow-up may be provided to create an opportunity for further learning concerning behavior management and coping skills. This kind of presence by crisis service providers is one of the best ways to help prevent crises for schools and their students. Crisis services may want to consider devoting staff exclusively to coordinating activities between schools and the crisis service system.

Child-Serving Agencies

Children and adolescents who are served by child serving agencies should have complete access to crisis services, just as any other resident of the community that the crisis system is designed to serve. At times, child-serving agencies are overwhelmed by or untrained in managing the needs of the children for whom they are responsible. These agencies may look to the behavioral health system to remove children from their care rather than helping them to receive the necessary behavioral health services that would enable the children and their caregivers to cope in the situation. Therefore, crisis systems must clearly communicate with these child-serving agencies regarding what they can and cannot do for the children in their care. Working with child serving agencies can be challenging, but these relationships are manageable if the roles, responsibilities, and expectations of each system are known and respected. To further this understanding, crisis service systems should provide training to child serving agency staff on how and when to use the crisis system.

Crisis Service System Financing

The development and delivery of psychiatric crisis services is not an inexpensive proposition. However, if well managed and designed, the cost to serve an individual through a crisis service system is often less than the cost of an inpatient episode of care. How the crisis service system and its components are financed is driven by a variety of questions, including:

- Who is the target population?
- Is the purchaser buying capacity or individual units of services?
- Can the service generate revenue or income from non-traditional sources (i.e., will managed care companies pay for the service)?
- Is the anticipated volume under a purchase of service or fee for service arrangement sufficient to cover operations?
- Who are the traditional payers for the types of services proposed in the crisis service model?
- How will services to consumers without an identified payer source be handled?
- These questions represent a sample of the types of financial considerations communities must evaluate before building a new or restructuring an existing crisis service system.

Crisis service components may be financed through a variety of methods, such as:

- Fee-for-service.
- Grant funding.
- Case rates.
- Sub-capitation.
- Partial capitation.
- A combination or one or more of these financing mechanisms.

Target Populations

When designing a crisis service system, one must keep in mind the intended target population. The system may initially be designed to serve and treat consumers who utilize public mental health services, thus, anticipated volume and payer mix can be projected to develop budgets and consider which methods of reimbursement are available and best suited to finance the service. Similar to an emergency room, most crisis service systems operate utilizing a **"No Reject"** policy, treating all consumers who present in their facilities regardless of ability to pay. Once a crisis service system is open, however, it can quickly become a magnet for a variety of social problems that arise in the community. A crisis service system can easily become the unintended safety net for child welfare agencies, schools, homeless agencies, adult protective services, and substance abuse agencies if agreements are not negotiated in advance. Without careful planning and coordination with other key components of the system and an understanding of who is responsible for serving populations that the crisis system was not originally designed to serve, the system will quickly find itself overwhelmed by demand and in financial peril.

Staffing Requirements

Personnel expenses constitute a major portion of any crisis system's budget. The range of behavioral health professionals, para-professionals, and consumer staff that are required in most crisis service systems include:

- Psychiatrists.
- Registered and Licensed Practical Nurses.

- Masters and Bachelors level Social Workers.
- Addictions Counselors.
- Peer Counselors.
- Mental Health Counselors.

The range of services that are provided by each of these professionals is typically governed by the state and, in some cases, the payer. Staff titles and position descriptions may vary from state to state. In addition, many crisis service systems include security officers in the staffing pattern. The use of psychiatrists in crisis service systems is often a combination of on-site availability and back up or "on-call" consultation, often by telephone, to support and/or approve the clinical decisions of the crisis services staff.

Conclusion

Given the growing prevalence of behavioral health needs in our communities, recognizing the need for comprehensive crisis response systems is timely and critical. Such systems serve the needs of persons in crisis in a manner that emphasizes:
- Rehabilitation.
- Recovery.
- Natural supports.
- Community integration.

The primary **goal** of this outline is to present in general terms the purpose, function, and features of a comprehensive crisis response system. This outline does not subscribe to a "one size fits all" approach to crisis services but instead presents both the basic, required components of a crisis system as well as other special service features that can be tailored to fit the community in which the system will operate.

Finally, critical to the success of a comprehensive crisis system, current and future purchasers and providers of services should not underestimate the value added through **stakeholder involvement** in crisis response systems. Such stakeholders might include: consumers, families, legislators, commissioners, providers, agency heads, funders, and hospital representatives. All of these groups will have a vested interest in how crisis services are designed and delivered and should become active participants in the oversight, management, and evaluation of the system's performance. As a result of the information presented here, it is expected that crisis systems will be able to:
- Appropriately serve more consumers.
- Provide quality services.
- Be cost effective.
- Validate their service delivery systems as a best practice in the behavioral health care field.

Appendix B

Other State Best Practices

The Department studied a wide variety of state models for examples of best practice in crisis services that were considered in designing recommendations for a comprehensive crisis response system.

<u>Texas Crisis Services Redesign</u>

The Texas Legislature appropriated $82 million in FY 08-09 for crisis services redesign. The first phase of implementation was to focus on enabling statewide access to competent rapid response services, avoiding hospitalizations and reducing transportation issues. The funds are used to support services recommended by the Crisis Redesign Committee, and the outpatient competency restoration services dictated under Senate Bill 867, Texas Legislature. The Crisis redesign services will integrate many community organizations that play significant roles in the mental health and state's larger public health care system. Additionally, Local Mental Health Authorities (LMHAs) may use some of the funds to defray transportation costs related to behavioral health crises incurred by local law enforcement agencies. Two processes are used to distribute crisis redesign funds:

- A majority of the funds will be divided among the state's LMHAs, added to existing contracts to fund enhanced crisis services.
- A portion designated as Community Investment Incentive funding will be awarded on a competitive basis to communities willing to contribute at least 25% in matching resources.

Funds are available for the following services:

Initial crisis services. The first priority for funds allocated directly to Local Mental Health Authorities (LMHAs) will be ensuring a minimum level of the critical crisis services that provide rapid and mobile response to crisis situations: **Crisis Hotline** and **Mobile Outreach Services**. This will provide every county with basic crisis response capabilities, including identification, screening and stabilization of patients who can be safely treated in the community.

Enhanced local crisis services. Once the minimum level of initial services has been achieved, local communities come together to develop a plan to use their funds to establish or expand additional crisis services recommended by the committee. This allows communities to enhance crisis service infrastructure for more extensive response and stabilization options, such as:

- Crisis Outpatient Services.
- Children's Outpatient Crisis Services.
- Extended Observation Units.
- Crisis Stabilization Units (CSU).
- Crisis Residential Services for Adults and Children.
- Crisis Respite for Adults and Children.

<u>Georgia Crisis and Access Line</u>

The Georgia Department of Behavioral Health and Developmental Disabilities used a competitive bid process in 2006 and selected Behavioral Health Link (BHL) to develop and

manage a statewide toll-free crisis and access line, now called the Georgia Crisis and Access Line (GCAL). Statewide, GCAL would provide a "no wrong door" approach to access, offering telephonic crisis intervention, 24/7 service scheduling with consumer choice, real-time data and reporting for strategic planning, and a new degree of consistency and transparency. BHL is a private, Georgia-based company whose approach to integrated crisis intervention coordinates brief screening, triage/linkage, mobile crisis, and disaster outreach.

GCAL was launched statewide on July 1, 2006, with a tagline of "A Crisis Has No Schedule." To date, it remains the only statewide crisis and access line in the U.S. that can actively link callers, 24/7, to service providers. GCAL was the first U.S. crisis line to integrate the Substance Abuse and Mental Health Services Agency's (SAMHSA) Suicide Risk Assessment Standards (SRAS) into its call center protocols, enabling staff to view SRAS protocols on database screens during a call to help determine the appropriate level of care. It also earned the Commission on Accreditation of Rehabilitation Facilities' (CARF) first-ever accreditation as a Crisis and Information Call Center. Because BHL provides no direct services, GCAL operates as an honest broker, offering consistency, support, and service choices to those who call for help.

GCAL's services go beyond those of a "hotline" because it offers callers standardized, statewide access to a comprehensive and coordinated system of care. It functions as a safety net for individuals, communities, and the state by linking people to routine mental health, addiction treatment, and other services while providing emergency intervention when needed. Thus, it functions as an integral component of Georgia's comprehensive mental health system, ensuring access to and continuity of care.

The GCAL program has been recognized nationally for setting a new standard of care, supported by emerging research in recent studies by experts from the University of Montreal, Rutgers University, and Columbia University. The GCAL program is a winner of a 2008 Council of State Government's Innovation & Transferability Award. Commission on Accreditation of Rehabilitation Facilities, CARF International featured GCAL in its inaugural Behavioral Health edition of the Promising Practices Newsletter. In 2007 GCAL was awarded SAMHSA's Crisis Call Center Award.

Through the process of handling a single phone call, GCAL staff:
- Conduct screenings to quickly assess callers' needs and risks, while engaging them, offering them choices, and using the least invasive interventions possible.
- Link callers, in real time, to routine services or crisis services (including mobile crisis response, when required). Day or night, callers can be scheduled with an appointment date and time at community mental health providers across the state, based on a schedule of routine and "emergent" appointments supplied in advance by the provider location.

Efficiencies of a statewide approach - In its nearly four years of operation, GCAL has:
- Saved over $70 million by diverting callers to community-based services, preventing the inappropriate use of emergency rooms and state hospitals ("hospital diversions").
- Cut average patient time for intake to services by up to 60 percent.
- Saved $1.2 million/year in operating costs compared to the previous 25-line system.

- Cut the cost of handling a call-a cost borne by Georgia's DBHDD-to about $15 (FY 2009), while providing direct scheduling, linkage, and patient follow-up capabilities not available with other call-system alternatives.
- Removed barriers to service, simplified the appointment process, and reduced patient wait times for service.
- Enforced statewide consistency in the identification and use of appropriate and least-invasive treatment interventions.
- Provided a continuing source of performance data that supports continuous system improvement.

State Statutory Recognition of Behavioral Health Crisis Services
Many states have established behavioral health crisis services that have been established and regulated in state statutes and rules. These are just a few of the highlighted leading examples.

Established Behavioral Health Crisis Services
Oklahoma – establishes a crisis system in statute and regulatory structure in rule.
Minnesota – establishes a crisis system in statute and licensure requirements.
Maryland - establishes a crisis system in statute and licensure requirements.
Louisiana - establishes a crisis system in statute and licensure requirements.

Crisis Stabilization Units - Defined recognized and oversight (licensing).
Florida
Montana
Arizona

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