MOVING BEYOND 988: A ROADMAP TO AN IDEAL CRISIS SYSTEM

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MOVING BEYOND 988:
A ROADMAP TO AN IDEAL CRISIS SYSTEM

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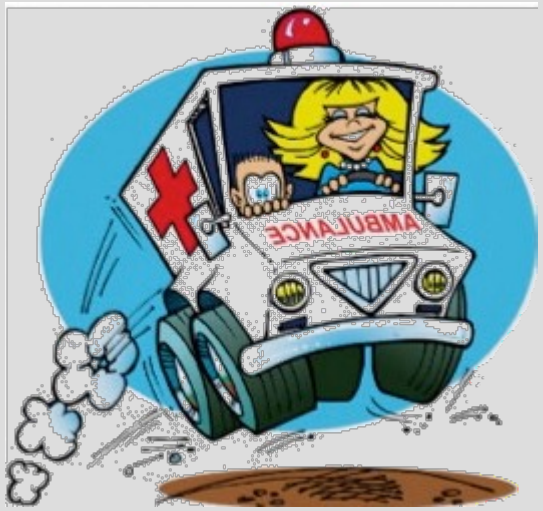
911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."



"I'm suicidal."

POLICE-INVOLVED DEATHS

One quarter

are linked to **mental illness.**·

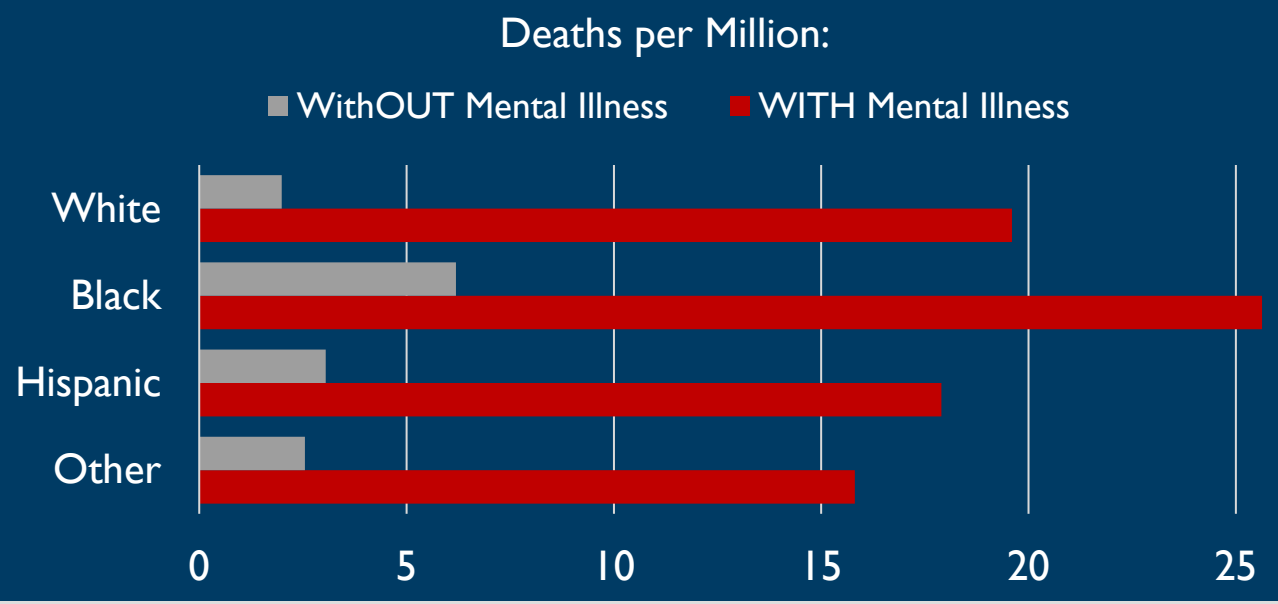
Half

occur in the person's own home.

The effect of mental illness is magnified by race/ethnicity:

Compared to Non-Hispanic Whites, the risk of being killed by police is

- **2.6x** for Black Americans
- **10x** for Black Americans *with mental illness*



Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M.(2018) Deaths of people with mental illness during interactions with law enforcement. Int J Law Psychiatry 58:110–6 https://doi.org/10.1016/j.ijlp.2018.03.003

The "Divert to What?" Question

Individuals experiencing crisis often end up in jail when officers don't have a quick and easy way to connect them to treatment.

Jails Are The New Asylums

- Prevalence of mental illness in jails and prisons is 3-4x that of the US population.
- Sentencing bias (e.g. harsher penalties for crack vs. powder cocaine) magnifies this disparity for people of color.

MYTH

"They'll get the treatment they need in jail."

Only one quarter of men and 14% of women receive formal substance abuse treatment while incarcerated.

- Inmates with mental illness
  - Often do not get needed treatment
  - Incarcerated 2x as long at 2x the cost
  - 3x more likely to be sexually assaulted in jail
  - More likely to be homeless, unemployed, re-arrested upon release

Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. Psychiatric Services. 60(6):761-5.
Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.
Treatment Advocacy Center & National Sheriffs Association (2014). The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey
Dumont DM et al. (2012). Annu Rev Public Health. 2012 Apr 21; 33: 325–339.
Office of National Drug Control Policy

WHEN THE ED IS THE ONLY TREATMENT OPTION…

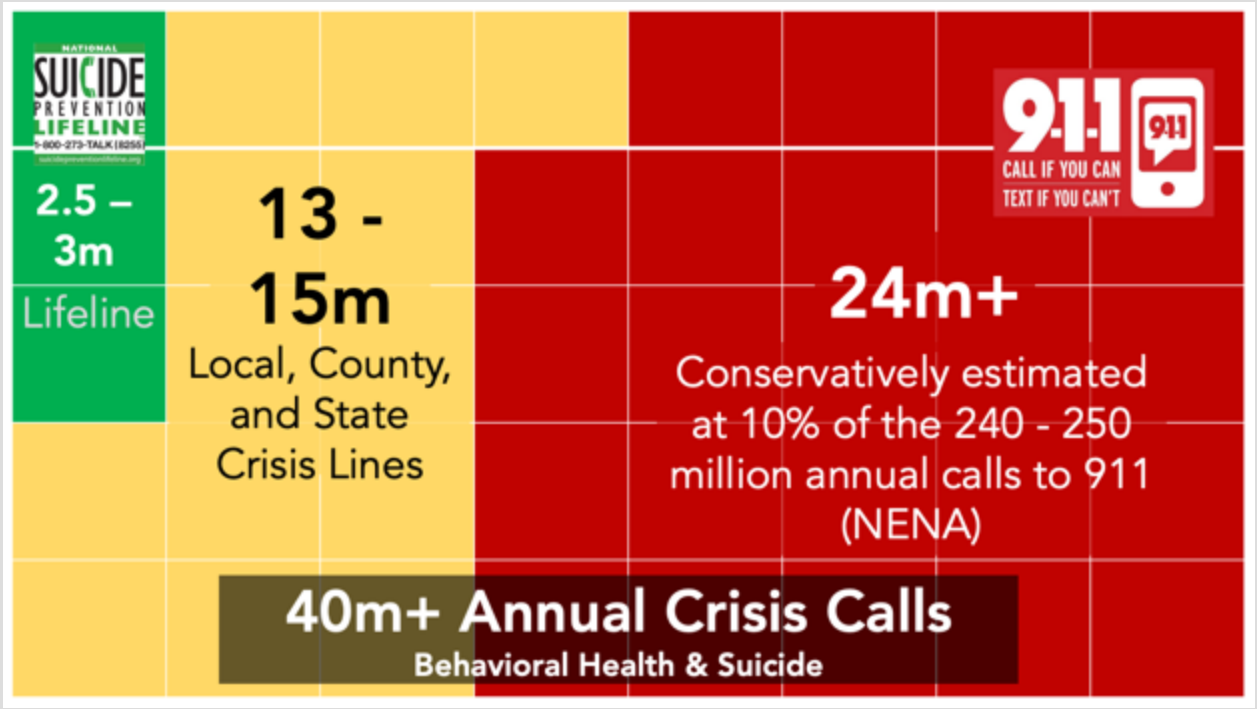
- **62% of EDs report there are no psychiatric services** while patients are being boarded prior to admission or transfer
- Without treatment, the default disposition is transfer to an inpatient psych hospital
  - **84% of EDs report boarding** of psychiatric patients on any given day
- The result:
  - **Increased risk:** Assaults, injuries, self-harm
  - **Increased cost:** $2300/day
  - **Poor patient experience:** Nontherapeutic environment with untrained staff

Officers are often required to wait with involuntary patients – sometimes for hours or days – until they can be transferred to a psychiatric hospital.

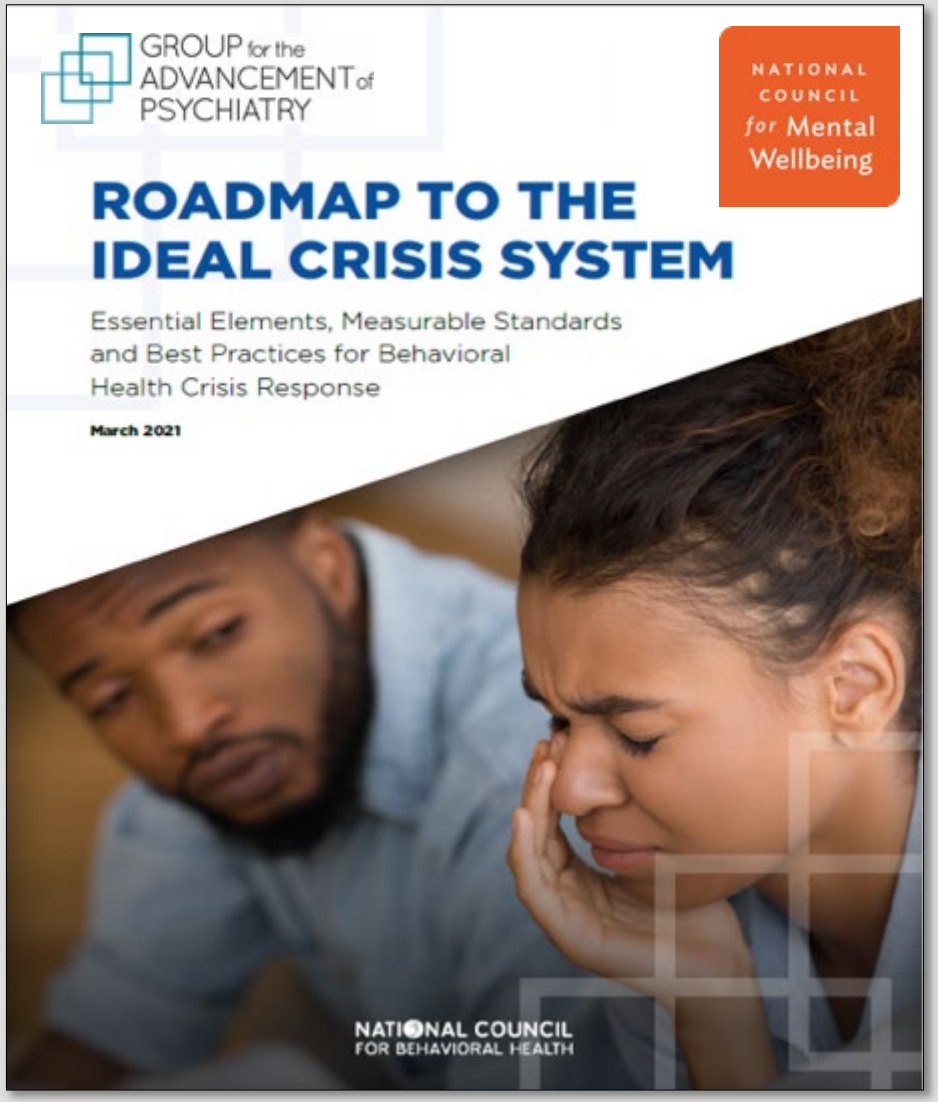
Nordstrom K et al. Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document. *West J Emergency Med.* 2019 Jul 22;20(5):690-695. http://doi.org/10.5811/westjem.2019.6.42422

988: THE NEW NATIONWIDE 3-DIGIT MENTAL HEALTH NUMBER

- **Connects to the National Suicide Prevention Lifeline (currently 1-800-273-TALK)**
- Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
- National standards
  - SAMHSA oversight
  - single national administrator
    Vibrant Emotional Health: www.vibrant.org
- Alternative to 911
- Makes it easier to ask for help
- Lessens stigma by sending the message that mental health is like other health emergencies
- More info: https://www.samhsa.gov/988



https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf



A report of the

Committee on Psychiatry & the Community

for the

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and published by the

National Council for Mental Wellbeing

Jacqueline Maus Feldman MD, co-chair
Ken Minkoff MD, co-chair

Current Co-chairs:
Ken Minkoff, MD & Margie Balfour, MD, PhD

Available at:
https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system & http://www.CrisisRoadmap.com

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www.crisisroadmap.com

ROADMAP VISION

- ***An excellent Behavioral Health Crisis System is an essential community service, just like police, fire and emergency medical services (EMS).***
- Every person receives the right response, in the right place, every time
- ***A BH crisis system is more than a single crisis program.***
- Every community should expect a highly effective BH crisis response system to meet the needs of its population.

GUIDING PRINCIPLES & VALUES OF AN IDEAL CRISIS SYSTEM

Ideal BH Crisis Systems are:

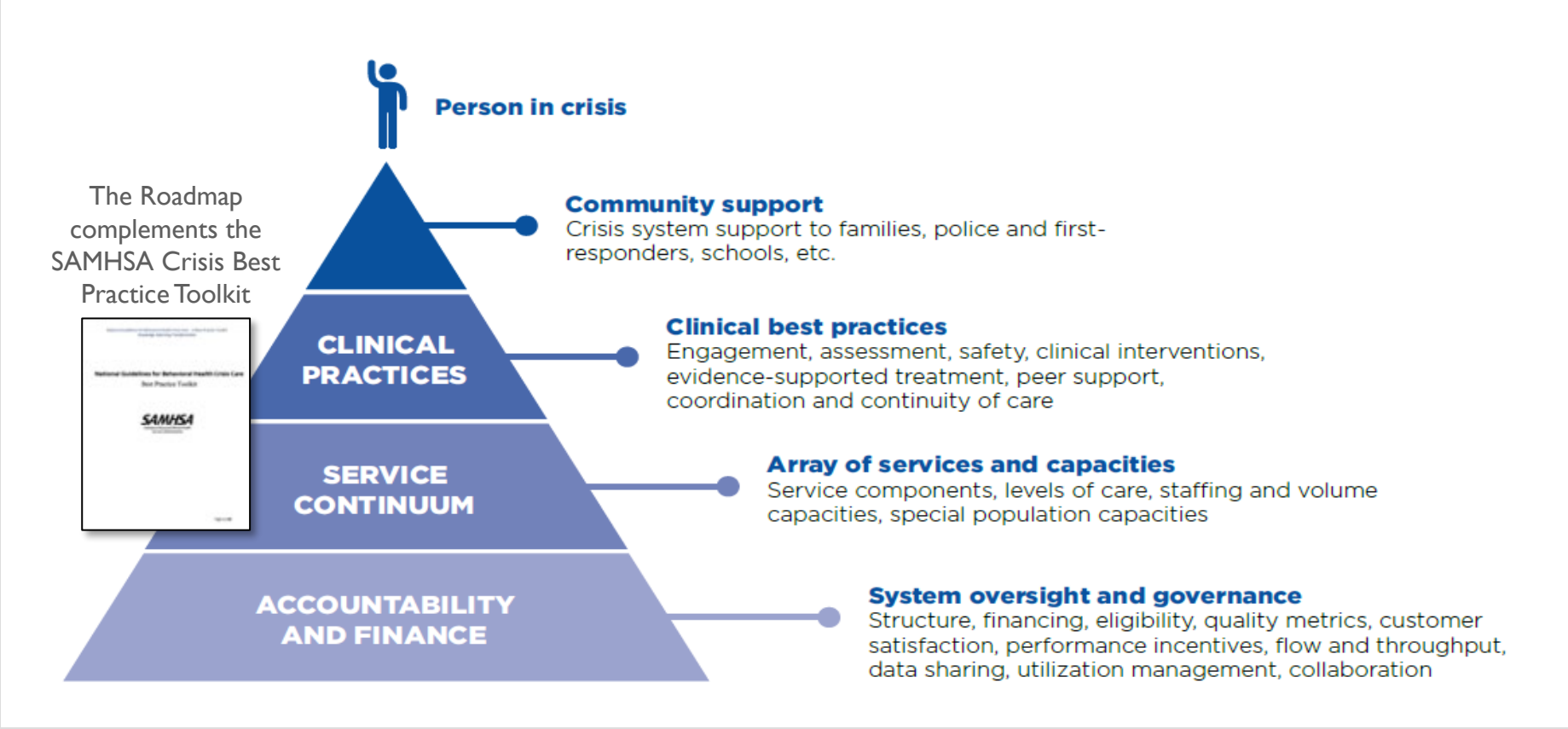
- ***Based on a shared set of values***
  Welcoming and engaging, customer-centered, hopeful, safe, compassionate, empowering, recovery-oriented, trauma informed, and culturally appropriate.
- ***Accountable for all people and populations***
- ***Designed for the expectation of complexity:*** MH and SUD, plus I/DD, health, housing, criminal justice, child/adult protection, etc.
- ***Designed to be clinically effective and cost effective***
- ***Able to use involuntary intervention*** when there is no other way to prevent harm
- ***Organized to share and use data for continuous improvement***

READING THE REPORT

The report describes how implementation of successful systems requires **3 interacting design elements**, along with measurable indicators for the components of each.

These 3 interacting design elements provide the structure for the 3 major sections of this report:

1. ***Accountability & Finance***
2. ***Service Continuum***
3. ***Clinical Practices***



SECTION I: ACCOUNTABILITY AND FINANCE

An ideal behavioral health 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.

This section defines the concept of an **Accountable Entity**, which is a structure and a mechanism for allocating responsibility and accountability that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.

SECTION 1: ACCOUNTABILITY & FINANCE

- There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.
- There is a BH crisis system coordinator and a formal community collaboration of funders, providers, first responders, human service systems and service recipients.
- There is a stated goal that each person and family will receive an effective, satisfactory response every time.
- Geographic access is comparable to that of EMS.
- Multiple payers collaborate so that there is universal eligibility and access.
- There are multiple strategies for successfully financing community behavioral health crisis systems.
- Service capacity of all components is commensurate to population need.
- Individual services rates and overall funding are adequate to cover the cost of the services.
- There is a mechanism for tracking customers, customer experience and performance.
- There are shared data for performance improvement.
- Quality standards are identified, formalized, measured and continuously monitored

SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITIES AND SERVICES

An ideal BH crisis system has

- Comprehensive array of service capacities
- Continuum of service components
- Adequate multi-disciplinary staffing
- To meet the needs of all segments of the population.

SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITIES & SERVICES

- The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.
- Family members and other natural supports, first responders and community service providers are priority customers and partners.
- Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.
- There is capacity for sharing information, managing flow and keeping track of people through the continuum.
- There is a service continuum for all ages and people of all cultural backgrounds.
- All services respond to the expectation of comorbidity and complexity.
- Welcome all individuals with active substance use in all settings in the continuum.
- Medical screening is widely available and is not burdensome.
- There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.
- Telehealth is provided for needed services not available in the local community.
- Program components are adequately staffed by multidisciplinary teams, including peer support providers.
- There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.

SECTION III: BASIC CLINICAL PRACTICE

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.

SECTION III: BASIC CLINICAL PRACTICE

- 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 and intervention.
- "No force first" is a required standard of practice.
- Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.
- Utilizing peer support in all crisis settings is a priority.
- Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.
- Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.
- Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.

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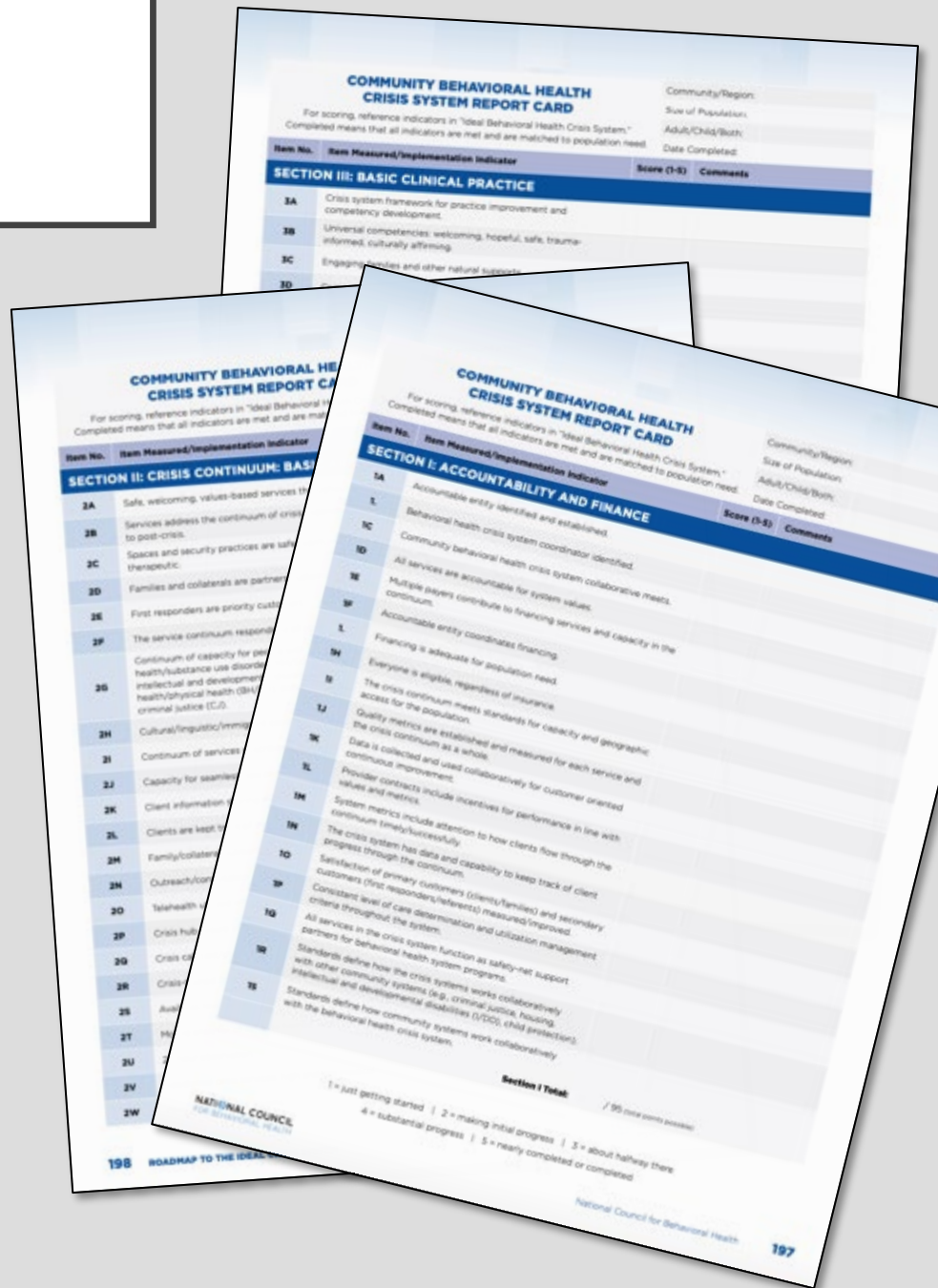
TOOLS TO HELP IMPLEMENTATION

- **Ten Steps** for Communities
- **Ten Steps** for System Leaders and Advocates
- **Six examples** of successful crisis system local implementation
- **Community BH Crisis System Report Card**

  An instrument to assist communities to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.



10 STEPS FOR COMMUNITIES

1. **Identify and convene community partners.**
2. **Read and process relevant sections of the report.**
3. **Develop a local vision.**
4. **Disseminate the vision.**
5. **Identify one or more "Accountable Entity(ies)."**
6. **Create a planning and implementation team:**
7. **Use the Report Card to perform a baseline self-assessment and track progress.**
8. **Create some "Early Wins" by focusing on 3-5 achievable improvement opportunities.**
9. **Gather data on clinical performance, cost and funding opportunities.**
10. **Develop a comprehensive collaborative plan.** *Continue meeting and working towards the goals set out in the plan, using the Report Card to measure progress.*

10 STEPS FOR SYSTEM LEADERS & ADVOCATES

1. **Establish & communicate a systemwide vision of ideal behavioral health crisis systems for all.**
2. **Develop a 10-year implementation plan for working collaboratively with stakeholders & funders.**
3. **Disseminate this report as a guiding document.**
4. **Use the Report Card to perform a baseline self-assessment and track progress.**
5. **Identify performance metrics based on input from system stakeholders.**
6. **Award planning and implementation grants: Develop a process to award planning and implementation grants to community crisis collaboratives.**
7. **Create a framework for identifying and empowering accountable entities.**
8. **Require all-funder participation, including all types of insurance plans.**
9. **Require coverage of and adequate rates for all elements of the crisis continuum.**
10. **Incorporate best practice standards into system regulations.**

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LEARNING COMMUNITIES

- Kansas – Modeling "These conversations help us implement *The Roadmap* principles on a local level"
- Michigan – Aspirational "The other communities help us see where we'll be at in five years."
- Florida – Expert consultation "Ken rolls up his sleeves and does group psychotherapy with us…he's been really helpful"
- Texas – Support "We're sharing challenges and concerns on a genuine level… after Uvalde, how do we maintain safety without becoming a fortress."
- Iowa – Peer-to-peer learning "Don't reinvent the wheel, if another community has solved this issue, let's learn from that."