

Crisis Now

Transforming Services is Within Our Reach





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

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

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Foreword: Message from Co-leads

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

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



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

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

Everyone seems to agree with the problem.

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

Several pioneering states have already shown us a path.

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

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

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Introduction and Overview

Summary of the Problem

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

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

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

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

Include Crisis in Mental Health Reforms

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

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



A Time for Change

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

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

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

The challenge EDs face addressing behavioral emergencies

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

In short, core elements of crisis care include:

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

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

Crisis Care as a Part of Mental Health Infrastructure

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

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

Preventable Tragedies

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

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

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

Some States Are Making Progress

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

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

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

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

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



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

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

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

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

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





Table 1: Modern Crisis Care Changes the Paradigm

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

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

This brings us to our first recommendation:

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



Overview of the Report

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

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

About the Task Force

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



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

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

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

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

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

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

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

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

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

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

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

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



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

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

Learning from ATC Safety

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

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

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

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

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

The ATC Model for Crisis Services

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

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

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

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

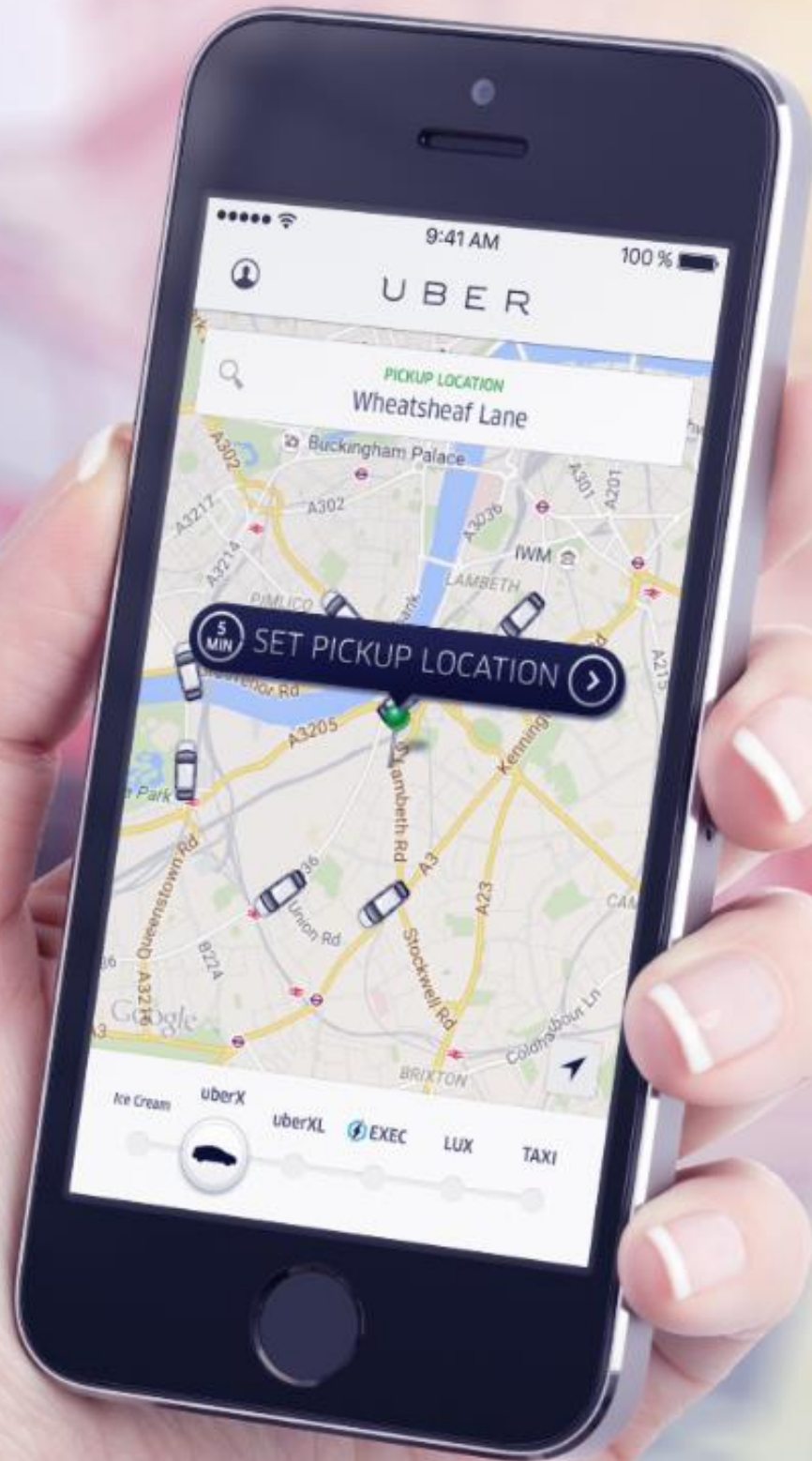
Required Core Elements of an ATC Model Crisis System of Care

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

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

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

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



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

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

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

Status Disposition for Intensive Referrals

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

24/7 Outpatient Scheduling

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

Shared Bed Inventory Tracking

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

High-tech, GPS-enabled Mobile Crisis Dispatch

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

Real-time Performance Outcomes Dashboards

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

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



A Continuum of Care

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

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

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

Table 2: Continuum to Evaluate Crisis Systems and Collaboration

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

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

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



Section 1 Conclusion

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

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



Section 2: Community-Based Mobile Crisis Teams

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

What is Mobile Crisis?

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

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

Goals of Community-based Mobile Crisis Programs

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

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

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

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

Evidence of Mobile Crisis Team Effectiveness and Cost-Effectiveness

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

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

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

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

Task Force Findings on Mobile Crisis Services

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

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

Triage/Screening

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

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



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

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

Assessment

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

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

De-escalation and Resolution

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

Peer Support

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

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

Task Force Spotlight

Becky Stoll, LCSW, VP for Crisis & Disaster Management

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



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

Coordination with Medical and Behavioral Health Services

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

Crisis Planning and Follow-Up

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

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

Section 2 Conclusion

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

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

Section 3: Crisis Stabilization Facilities/Settings

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

What are Crisis Stabilization Facilities?

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

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

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

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

Evidence on Effectiveness and Cost-Effectiveness of Crisis Stabilization Facilities

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



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

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

Task Force Findings on Crisis Residential Facilities

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

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

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

The “Living Room” Model

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

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

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

Peer-Operated Respite

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

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

Section 3 Conclusion

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



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



Section 4: Core Principles and Practices of Modern Crisis Care

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

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

Embracing Recovery

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

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

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

Significant Role for Peers

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



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

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

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

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

Trauma-Informed Care

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

Task Force Spotlight

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

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

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

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

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

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

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

Zero Suicide/Suicide Safer Care

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

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



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

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

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

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

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

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

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

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

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

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

Safety/Security for Consumers and Staff

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

Law Enforcement and Crisis Response—An Essential Partnership

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

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

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

However, in many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health

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

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

Task Force Spotlight

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

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



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

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

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

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

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

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

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

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

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

Section 4 Conclusion

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

Section 5: Financing Crisis Care

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

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

Crisis Care Funding vs. Emergency Care Funding

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

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

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

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

This will not work.

A Financial Crisis for Crisis Care

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



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

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

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

The Problem with Typical Funding Patterns

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

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

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

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

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

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

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

Table 3: Examples of State Funding for Crisis Care

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

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

Patchwork Medicaid Funding

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



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

The SAMHSA report finds:

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

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

An Emerging Opportunity: New Legislation

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

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

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

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

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

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

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

Section 5 Conclusion

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



Report Conclusion

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

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

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

The problem with delaying is...crises are happening now.

Summary of Task Force Recommendations

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

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

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

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

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



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

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



Appendix

Task Force and Support Team Participants

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

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

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

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

Bart Andrews, PhD, Behavioral Health Response

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

Lisa Capoccia, MPH, Suicide Prevention Resource Center, EDC

Lynn Copeland, Georgia Department of Behavioral Health and Developmental Disabilities

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

Susan Dess, RN, MS, Crestline Advisors

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

Bea Dixon, BSN, PhD, Optum WA Pierce RSN

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

Phil Evans, ProtoCall Services

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

Vijay Ganju, PhD, Behavioral Health Knowledge Management

Larry Goldman, DMD, Beacon Health Options

Gabriella Guerra, MSW, Mercy Maricopa Integrated Care

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



Shannon Jaccard, MBA, NAMI San Diego

Helen Lann, MD, Beacon Health Options

Nick Margiotta, Phoenix Police Department

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

Tim Mechlinski, PhD, Crestline Advisors

Steve Miccio, PEOPLE, Inc.

Heather Rae, MA, LLP, Common Ground

John Santopietro, MD, DFAPA, Carolinas HealthCare System

Wendy Schneider, LPC, Behavioral Health Link

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

Becky Stoll, LCSW, Centerstone

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

James Wright, LCPC, SAMHSA



Task Force Schedule

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

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



Timeline of Crisis Innovations

1958

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

1995

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

2003

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

2006

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

2010

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



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

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

2012

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

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

2013

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

2014

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

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

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





2015

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

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Now is the time for crisis care to change.



Crisis Services Task Force