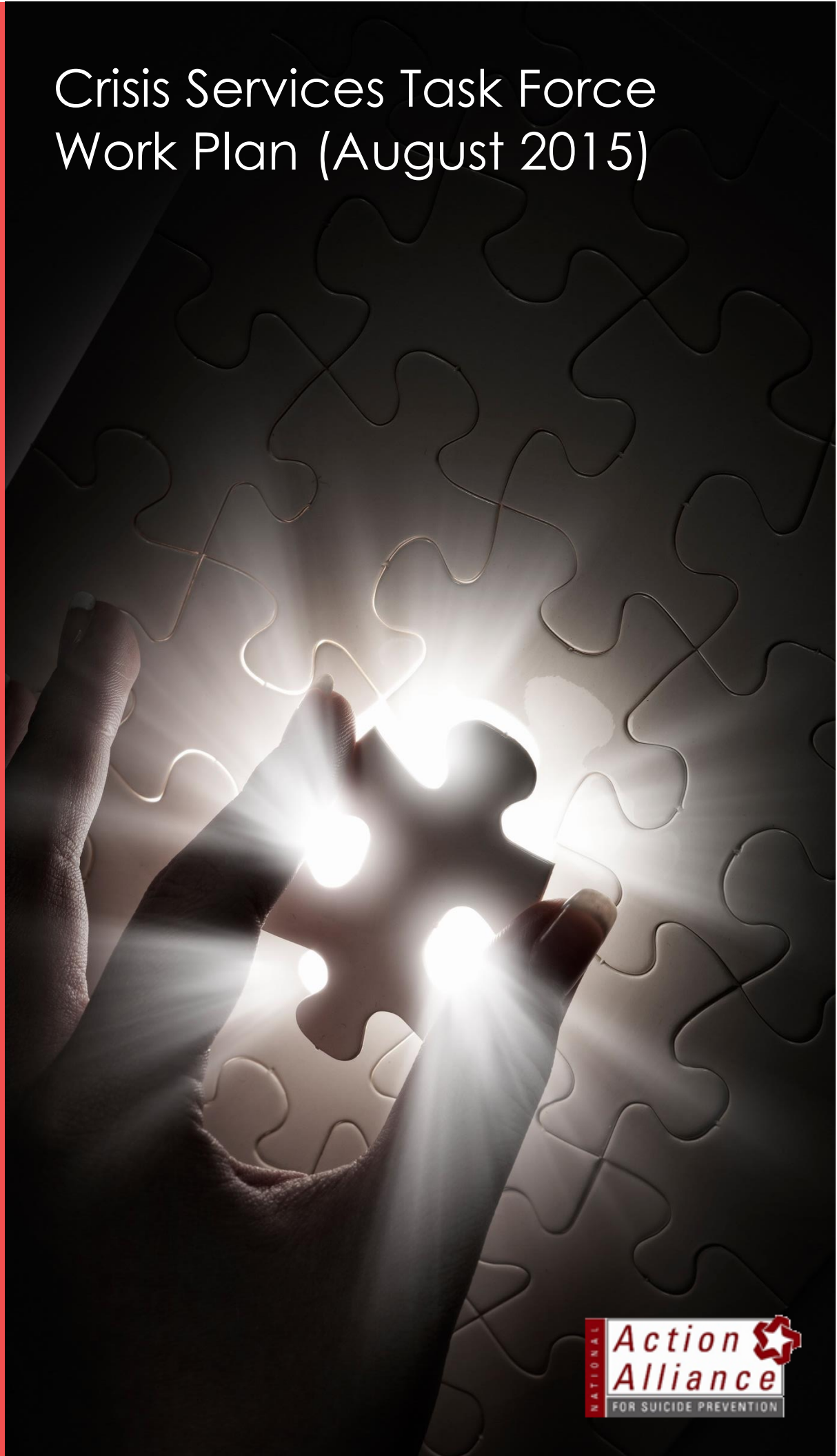
Action Alliance Work Plan

Crisis Services Task Force Work Plan (August 2015)



National Action Alliance for Suicide Prevention

Action Alliance Work Plan

Crisis Services Task Force Work Plan

August 2015

Task Force Name & Co-Leads

Crisis Services Task Force

- David W. Covington, LPC, MBA – EXCOM member; Zero Suicide Advisory Group Co-lead; CEO & President, Recovery Innovations, Inc.; Equity Partner, Integrated Health Resources, LLC
- Mike Hogan, PhD – EXCOM member; Zero Suicide Advisory Group Co-lead; Independent Advisor and Consultant, Hogan Health Solutions LLC

Background

In 2012, the Action Alliance established four key priorities, including **transforming health care delivery** for individuals at highest risk for suicide. The Action Alliance has recruited "early adopters" from health care systems to participate in a breakthrough collaborative effort to transform care to prevent suicide. The Action Alliance has created a toolkit to help these and other systems adopt a "Zero Suicide" approach to suicide care (see http://zerosuicide.com).

That same year, the state of Kentucky challenged the idea that very few individuals who die by suicide are engaged in the public community mental health system of care, estimating that 24 to 30 percent of people who died by suicide in Kentucky in any given year had received services from the public behavioral health system in the 12 months before their death. Similar patterns have emerged in other states conducting such analyses, confirming the need for change if the rising number of deaths for people under care is to be reversed. We also have anecdotes that reveal a rising number of tragedies that might have been averted.

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. Just a week earlier, his son "Guss" stabbed him 10 times and then ended his own life by suicide. This happened only hours after a mental health evaluation determined that Guss needed more intensive services, but unfortunately, he had to be released from custody before the appropriate services could be found.

If aviation safety simply targeted 99.9% effectiveness, there would be nearly 300 unsafe landings and/or take-offs per day. By contrast crisis care in America is fragmented, operates without national standards and many communities lack basic crisis services. Where crisis systems exist, they usually are not utilizing the most basic principles of safety and accountability to ensure individuals do not fall through the cracks. It's time to stop wringing our hands after tragedies, and re-think next generation crisis systems.

Rationale for Task Force

In the late 1990s, there were crisis call centers across the country, but they were fragmented and lacked credibility with even suicide prevention advocates. Staffed with

volunteers, these poorly funded programs lacked technology, data-tracking, and consistent protocols. Many questioned whether there were outcomes that warranted the investment, meager though it was at the time.

15 years later SAMHSA-funded research by the University of Quebec at Montreal, Rutgers and Columbia has changed everything. Standardized protocols are used internationally, and funders are investing millions in statewide, advanced crisis call centers that coordinate care and create more efficient flows and access to needed services. Simultaneously, evidence has emerged that crisis respite centers and other elements of comprehensive crisis care systems can provide safe and less expensive care than inpatient settings, which often serve to provide costly, short term "containment" of people under great stress.

The Crisis Services Task Force will mark the formal beginning of professional orientation and standards development for crisis systems of care and all levels of crisis services, including mobile crisis and facility services like crisis stabilization and crisis respite. It's also an effort to begin thinking about these services as parts of a whole, integrated systems of care, with a major focus to reduce and eliminate suicide, providing vital support 24 hours per day, every day for individuals and families at risk. This task force will create a second major pathway for accomplishing the Action Alliance **transforming healthcare initiative**, using a similar set of proven approaches that will touch a wider audience through the public sector's crisis services and systems.

The Task Force is also timely because of potent changes underway in health care—catalyzed by national "parity" legislation and the Affordable Care Act--that include shifts in responsibility away from state mental health agencies to control by mainstream health systems. The recently released CMS proposed rules on Medicaid managed care signal and will accelerate this shift in behavioral health care away from a being separate, protected industry to being part of mainstream systems. Given that care will increasingly be managed by health plans, it is crucially important to lay down a marker on the essential components of high functioning crisis care and hospital diversion systems.

Period of Performance

The Crisis Services Task Force will work a sprint schedule meeting every two weeks by GoToMeeting Video Conferencing from August 2015 to January 2016, with the objective of eight to ten meetings total.

- ***August 2015:* Introduction and Planning**
  - Complete background research;
  - Establish final task force membership and expertise areas;
  - Identify key target audiences for document and engage their representatives;
  - Identify writer(s), editors, and lead content consultants for the document;
  - Create structure and major sections of the document;
  - Review the revised NSSP to assure alignment
- ***September – November 2015: Environmental Scan & Expert Presentations***
  - Create the document structure as informed by the literature, the task force members and other key informants;
  - Engage other task forces to enlist their participation in this process;

- ***December 2015 – January 2016:*** **Technical Writing and Group Feedback/Iterations**
    - Begin writing of technical guidance document;
    - Finalize writing and editing of introduction and/or executive summary and content area chapters;
    - Finalize outreach and dissemination plan for paper and its recommendations, with key partners within task forces, EXCOM, and partners;
    - Create formatted PDF version and identify need and opportunities for print version
    - Present to EXCOM (January/February 2016);
- ***February 2016:*** **Publication of Final Draft *"Future Crisis Care/Hospital Diversion Systems: What's Essential?"***
    - Fully execute completed outreach and dissemination plan through partners;
    - Present specific action steps for different stakeholder groups at meetings and conferences (e.g. National Council and American Association of Suicidology)

Scope of Work/Objectives

The Crisis Services Task Force will drive the implementation of the revised National Strategy for Suicide Prevention (NSSP), with particular attention to goals eight and nine, and offer another key focus area for behavioral health and healthcare systems to save lives, with deeper penetration in the community at large than the general public sector behavioral health system has access.

The primary outcome of the task force will be a brief (i.e., up to 25 page) white paper, **"Future Crisis Care/Hospital Diversion Systems: What's Essential?" T**he white paper will prompt health plans, Medicaid and behavioral health administrators to consider the next generation of integrated crisis systems and what essential components are required. The hope would be that these recommendations become Zero Suicide in Healthcare expectations related to behavioral health and healthcare. Examples may include:

- 24/7 clinical coverage with identifiable single contact point covering a defined region
- Ability to deploy mobile crisis, control of access to sufficient range and diversity of sub-acute alternatives (respite, etc.), and ability to secure same day/next day outpatient clinical services
- Legally and clinically sufficient personnel to be able to make triage decisions, preferably including control of acute inpatient access
- Clear expectations for routine emergent care for the outpatient clinical providers that interface with crisis care
- Expectations for support and financing of these systems.

Membership

A group of consensus national experts have been invited to participate in this crisis services task force. They include government and health plan administrators, provider executive leaders, people with lived experience and family members of those with serious mental illness:

- Leon Boyko, MBA, MSW, LCSW – Chief of RI Crisis, Recovery Innovations, Inc.
- Bart Andrews, PhD – VP, Clinical Practice & Evaluation, Behavioral Health Response
- Lisa Capoccia, MPH – Assistant Manager, Clinical Initiatives, Suicide Prevention Resource Center, EDC, Inc.
- Lynn Copeland – Director, Office of Provider Network Management, Georgia Department of Behavioral Health and Developmental Disabilities
- Barbara Dawson, MEd – Deputy Director Crisis and Emergency Services, MHMRA of Harris County (Houston, Texas)
- Susan Dess, MS – Principle, Crestline Advisors
- Steven Dettwyler, PhD – Director, Behavioral Health Services at Delaware DSAMH
- Bea Dixon, BSN, PhD – Executive Director, Optum WA Pierce RSN
- John Draper, PhD – President, Link2Health Solutions; Project Director, National Suicide Prevention Lifeline
- Phil Evans – CEO & President, ProtoCall Services
- Vijay Ganju, PhD – CEO, Behavioral Health Knowledge Management
- Larry Goldman, PhD – Senior Vice President, Government Relations, Beacon Health Options
- Gabriella Guerra, MSW – Head of Crisis and Cultural Services, Mercy Maricopa Integrated Care
- Brian Hepburn, MD – Executive Director, NASMHPD
- Shannon Jaccard, MBA – Chief Executive Officer, NAMI San Diego
- Richard McKeon, PhD – Suicide Prevention Branch Chief, SAMHSA
- Steve Miccio – CEO, PEOPLe, Inc.
- Heather Rae, MA, LLP – CEO, Common Ground
- John Santopietro, MD, DFAPA – Chief Clinical Officer BH, Carolinas HealthCare System
- Wendy Schneider, LPC – CEO, Behavioral Health Link
- Cheryl Sharp, MSW, ALWF – Special Advisor for Trauma-Informed Services, National Council for Behavioral Health
- Becky Stoll, LCSW – VP for Crisis & Disaster Management, Centerstone America
- Eduardo Vega, MA – EXCOM member; Executive Director, MHA of San Francisco

In addition, the following persons will lead the development of the task force white paper, participate in the task force meetings and conduct a few targeted subject matter expert interviews as directed:

- Gerald Fishman, PhD – Regional Director Eastern, RI Crisis (Recovery Innovations, Inc.)
- Tim Mechlinski, PhD – Senior Advisor, Crestline Advisors

Advisory Groups

In 2014, the National Council for Behavioral Health hosted the first ever special crisis services track at the Washington, DC conference. In 2015, following the success of a year-long list serve, David Covington and Recovery Innovations partnered with National Council on a nationwide survey of all levels of crisis services, and the summary results were used at the Orlando conference to help establish priorities among crisis services providers.

In addition, SAMHSA's David Morissette and Mary Blake are partnering with Vijay Ganju on a white paper regarding crisis systems that will also incorporate addiction issues. Vijay hosted a special conference on crisis services as part of the National Dialogues on Behavioral Health scope of work in New Orleans in fall 2014, and has been a strong advisor to the process, including identification of national crisis services exemplars. In addition, Cheryl Sharp and the National Council will be strong supporters, and we are working collaboratively on a special edition of the National Council Magazine on crisis services to be published around the time of the March 2016 Las Vegas conference. (In 2012, the special edition "Not Another Life to Lose" included the Revised National Strategy on Suicide Prevention in its entirety.)

Time-line Crisis Services

Since 2012, there has been an unprecedented investment in Next Generation Crisis systems across multiple states, but these new programs owe a debt to the early pioneers.

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."

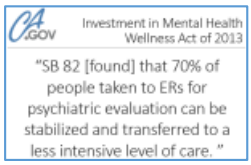
2014

"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 Emergency Department until an appropriate bed is available is unconstitutional and therefore unlawful.

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 their most active email list serves ever.

Air Traffic Control Level 5 System – Crisis Access Holdings, LLC modified the Milbank collaboration continuum (original citation Doherty, 1995) for evaluating crisis system community coordination and collaboration. The model suggests five required elements, including electronic crisis bed inventories.

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 Emergency Department presentations for psychiatric evaluation could be avoided with improved crisis stabilization, mobile crisis and crisis triage.

2012

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. "We can help people from falling through the cracks."

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.

2010

Americans with Disabilities Act & Olmstead – In 2010, 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.

Big Box Full Continuum – In 2006, the Regional Behavioral Health Authority for Tucson and University Physician's 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.

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).

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, mobile crisis outreach team, homeless services and crisis help line.

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. They were first with advanced software, clinical staffing, mobile crisis and a Board of Directors that comprised local CMHCs.

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. 10 years later, Shneidman would form the American Association of Suicidology.