

NATIONAL COUNCIL

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MAGAZINE

2016 ISSUE 1

CRISIS TO RECOVERY

How to Get
Where We
Want to Be

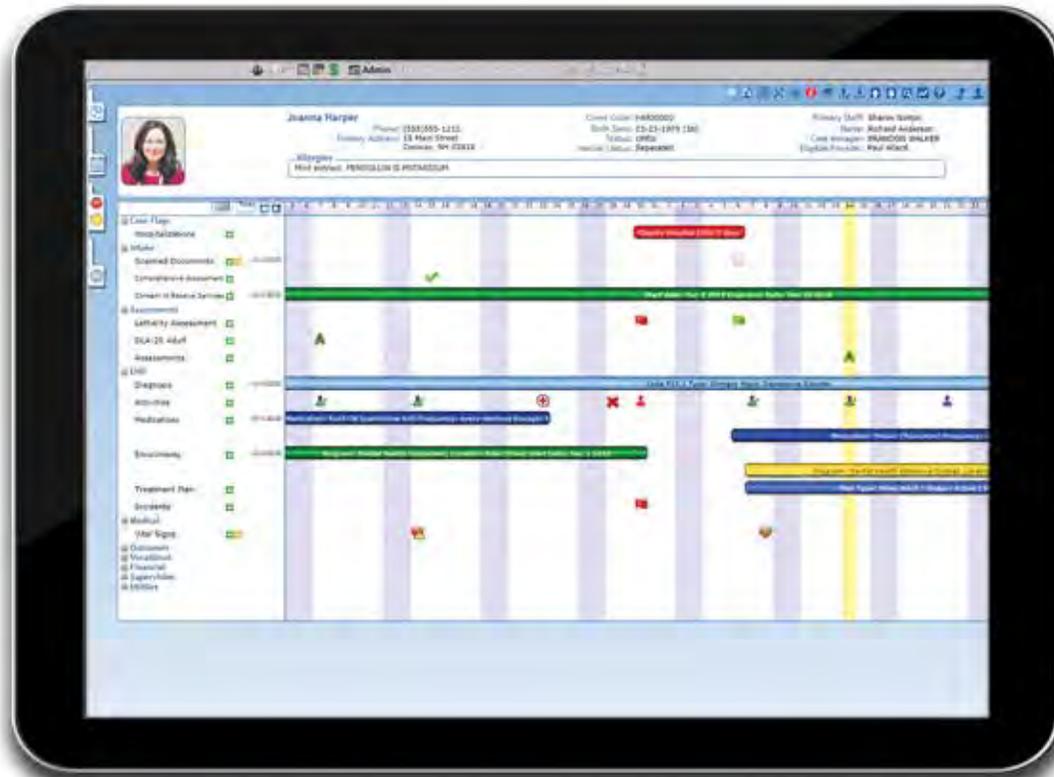
LINDA ROSENBERG PAGE 5

When Crisis
Happens "Now"

DAVID W. COVINGTON &
MICHAEL HOGAN PAGE 6

Moving Toward a
Comprehensive
Crisis System

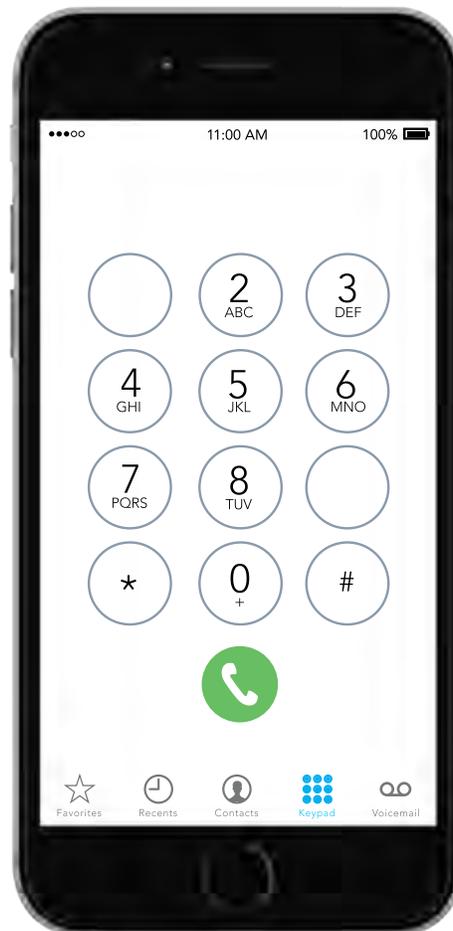
KANA ENOMOTO PAGE 8



Echo's Visual Health Record

The best EHR for Behavioral Health

There's no 911 for a mental health crisis



At BHL, we know that the lives of individuals in mental health crisis can depend on the data. Where is the closest mobile team? Is there a crisis bed available? What has helped in the person's past? 9-1-1 doesn't have these answers, and mental health crisis systems have historically relied on paper, pencil and post-it notes.

BHL operates the statewide crisis and access line, where an integrated technology ensures an air traffic control level of coordination and connection. Where individuals in crisis at 2 am can get an intake scheduled near their home. Where we never let go until the person is safely connected with care. **To learn more, visit www.behavioralhealthlink.com or call us at 404.402.3202.**



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The National Council for Behavioral Health is the unifying voice of America’s mental health and addictions treatment organizations. Together with 2,500 member organizations, serving 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council was instrumental in bringing Mental Health First Aid to the USA and more than 500,000 individuals have been trained. In 2014, the National Council merged with the State Associations of Addiction Services (SAAS). To learn more about the National Council, visit www.TheNationalCouncil.org.



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CRISIS SERVICES:

Far too many people in crisis still wind up in the wrong places with inadequate care and little follow-up, or get no care at all with disastrous consequences.

The distraught young man whose family brought him into the Bronx hospital looked familiar. After a closer look, I realized I had briefly dated him.

I was working in a triage office for a new program to keep people in psychiatric crisis out of hospital emergency rooms, places that could do little more than sedate and restrain them while they waited—sometimes for days—for treatment.

This was the late 1970s. Mental health professionals have known for a long time that it's more effective and far less traumatic to keep someone who is in the midst of a crisis out of the places they too often end up: hospital emergency rooms or even jail.

It's the underlying theme of this issue of the magazine. Article after article shows how crucial community-based services are for people in crisis and the work they do—from preventing suicides to diligently keeping track of patients' progress and making sure they get the ongoing help they need.

There is, for instance, Bart Andrews' story of how it took BHR Worldwide in Missouri six

months of intensive follow-up to convince a troubled kid's parents to get him into therapy. With this kind of commitment, BHR diverts 90 percent of the most troubled from emergency rooms and hospitals to effective community treatments.

Article after article shows how crucial community-based services are for people in crisis and the work they do—from preventing suicides to diligently keeping track of patients' progress and making sure they get the ongoing help they need.

Or there's Leon Evans' recounting of how the Center for Health Care Services created San Antonio's Restoration Center, a "one-stop shop" for receiving people in crisis so they can stay out of jails and emergency rooms. It has diverted almost 100,000 people into treatment programs since 2008, saving taxpayers an estimated \$50 million.

There is more progress to report in other articles. Yet we still have a long way to go.

Far too many people in crisis still wind up in the wrong places with inadequate care and little follow-up, or get no care at all with disastrous consequences.

So it is crucial we educate the public to understand, first, that "crisis" in the context of an addiction or a mental illness does not mean "over in an instant." As we know, it can mean intense work with a patient over weeks and months.

And, second, we must convince people that these crises should be treated with the same urgency and get the same kind of effective response as, say, emergency care for a physical ailment like a broken leg.

We'd be horrified to think someone with a broken bone or a deep gash wouldn't get appropriate treatment quickly. Yet people rarely think about all the people with mental illness or addictions who continue to fall through the cracks of our imperfect systems.

There's one crucial difference, though, between dressing a physical wound and

How to Get

Where We Want to Be



Linda Rosenberg

President and CEO, National Council for Behavioral Health

treating a behavioral one: The extensive follow-up with counseling, therapy and other assistance that the severe mental illness or addiction requires, often involving social workers, psychiatrists and even job counselors.

That's a far more expensive proposition than sewing up a cut and sending the patient home with some antibiotics.

Fortunately, we have important new tools to analyze reams of "big data" that can tell us which interventions work for which people and can help us better target those people most likely to need help.

You'll remember that Nobel-Prize-winning economist's groundbreaking research late last year that gave us a more precise picture of who's more likely to overdose on drugs and alcohol or complete suicide. And surprisingly, even to behavioral health professionals, they're white, middle-aged, working-class men. That use of big data can direct our efforts and potentially save lives. What we think is too often based upon belief, not evidence.

We've all read about Virginia State Sen. Creigh Deeds, who recently sued the state's mental health system for \$6 million after he was told there were no beds for his troubled son. The adult son was released from emergency custody only to stab his father repeatedly and then kill himself. There were beds available, it turned out. Virginia legislators have created a statewide bed registry—using data—so mental health workers can find placement for a person in crisis.

For the past three years, 11 states have increased spending on mental health, including crisis services. One of them is Colorado, where a gunman in Aurora killed 12 and wounded 70 in a movie theater in 2012.

We need to turn these tragedies into positives by taking advantage of the light they shine on people in crisis and the shortcomings of our treatment systems.

Our job as behavioral health advocates must be to convince the public and our elected officials that the problem is literally life-and-death and that with effective treatment, we can save lives and mend ruined ones.

That's how we honor the people we lost. Congress is already aware of the pressing need to help people with addictions and mental illnesses and the need for a full continuum of services in every community. What we need to do is keep the heat on and make it happen, including expanding the Excellence in Mental Health Act to all states.

We're not there yet on crisis care, but we are far closer than when I worked in that triage unit as a young mental health professional.

As for that young man in the Bronx hospital? The mobile crisis team kept him out of the hospital, visited his home and involved his family in group support and treatment with other families. Much improved, he moved to outpatient treatment. Last I heard, he had started looking for a job.

WHEN CRISIS HAPPENS "NOW"

TIME FOR EMERGENCY MEDICAL SERVICES FOR THE BRAIN



David W. Covington | CEO & President, RI International **Michael Hogan** | Independent Advisor and Consultant, Hogan Health Solutions
Co-leads, Crisis Services Task Force, National Action Alliance for Suicide Prevention

Our country's approach to crisis mental health care must be transformed. It is time and we have the tools to prevent tragedies like these:

- **Unspeakable family pain:** In November 2013, Sen. Creigh Deeds (D-VA) told CNN that he was alive for just one reason: to work for change in mental health. Just a week earlier, his son, Gus, stabbed him 10 times and then ended his own life by suicide. This happened only hours after a mental health evaluation determined that Gus needed more intensive services, but unfortunately, he had to be released from custody before the appropriate services could be found.
- **Psychiatric boarding:** The month before Sen. Deeds' family crisis, the Seattle Times concluded its investigation of the experience of individuals with mental health needs in emergency departments. "The patients wait on average three days—and in some cases months—in chaotic hospital emergency departments and ill-equipped medical rooms. They are frequently parked in hallways or bound to beds, usually given medication, but otherwise no psychiatric care." In 2014, the state supreme court ruled the practice of "psychiatric boarding" unconstitutional.
- **The wrong care, in the wrong place, compromising other urgent medical 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

three out of four visits to hospital emergency departments for mental health and addiction issues could be avoided with adequate community-based care.

- **Thousands of Americans dying alone and in desperation from suicide:** In 2015, the National Action Alliance for Suicide Prevention launched the Crisis Task Force with the goal to provide stronger 24/7 supports to the nine million Americans at risk each year. Every day, more than 115 people in the U.S. die alone and in despair.

There are four different compelling reasons why "crisis is now": public safety, civil rights, extraordinary and impactable waste of public funds and the opportunity to address one of our most intractable human problems. The time really is now and the burning platform is clear.

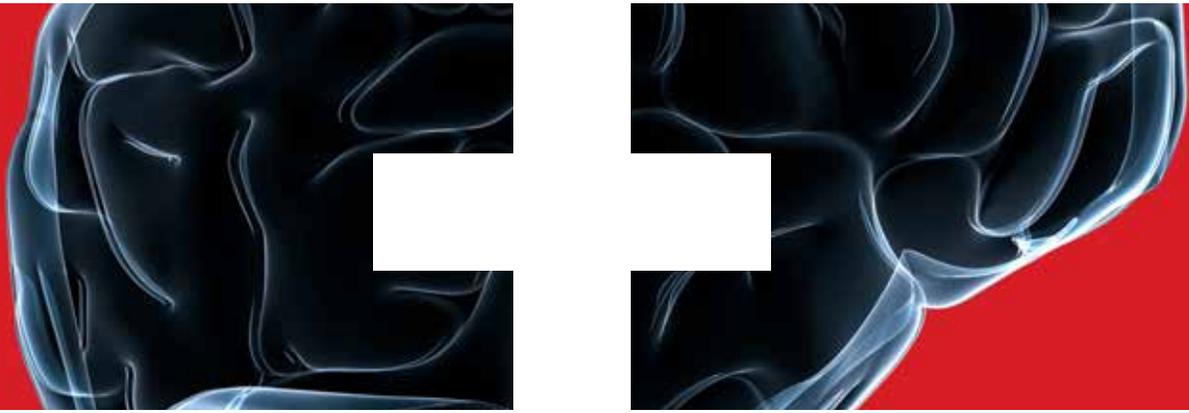
It does not have to be this way. In a few states and communities across the U.S., solutions are in place. But until now we have not had the vision or will to approach crisis care with national resolve and energy.

These three examples highlight what can be done differently with "power":

1. **Power of data and technology.** The Georgia Crisis and Access Line uses technology and secure web interfaces to provide a kind of "air traffic control" that brings big data to crisis care and coordination in real time.
2. **Power of peer staff.** People, Inc.'s Living Room model, peer staffing and retreat model provide safety, relief and recovery in an environment more like a home than an institution.

A NEW APPROACH TO CRISIS CARE

FROM	TO
Absence of data and coordination on emergency department wait times, access, outcomes and crisis bed availability.	▶▶ 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 scheduling.
Emergency departments are the default mental health crisis center.	▶▶ Mobile crisis provides a non-law enforcement response that often avoids emergency department use and institutionalization.
Crisis service settings have more in common with jails.	▶▶ Crisis service settings—the urgent care units for mental health—look more like home settings.
Despair and isolation worsened by trying to navigate the mental health maze.	▶▶ Crisis care with support and trust: what you want and need, where you want and need it.



3. Power of going to the person.

Colorado Access' mobile crisis teams don't 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 in urban, rural and, yes, even frontier areas.

California, Colorado, Georgia and Washington state were driven to new approaches because of vastly different primary drivers, but five key elements stood out:

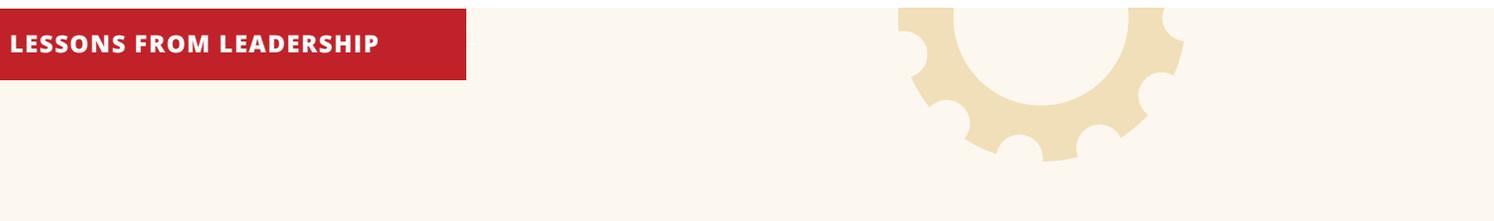
1. Expansion of community-based mobile crisis services to 24/7 outreach and support with a contractually-required response time. (Colorado and Georgia)
2. Introduction of crisis stabilization programs that offer 23-hour observation and sub-acute short-term stays at lower costs without the overhead of hospital-based acute care. (All)
3. Crisis triage call centers with strong use of technology and information across a system of care, leveraging big data for performance improvement and systems accountability while providing high-touch support informed by suicide prevention best practices. (All)
4. Engagement of peer staff, trauma-informed care principles and recovery cultures to improve the experience and outcomes.
5. Involvement of government leaders, with activating legislation in California and Colorado, key engagement of the governor in Colorado and Georgia and the judicial branch (Department of Justice and Supreme Court) in Georgia and Washington state.

There are four different compelling reasons why “crisis is now”: public safety, civil rights, extraordinary and impactful waste of public funds and the opportunity to address one of our most intractable human problems. The time really is now.

Crisis is happening now and we can do far better to respond to it. Our society takes for granted a national emergency medical response system—911 centers with high technology to ensure individuals with other medical problems do not fall through the cracks. This system has transformed stroke and heart attack care. Ambulance services go to the person directly to ensure immediate life-saving care with emergency medical services in every area of the country—urban, rural and frontier. We can do the same for mental health crises.

We must.

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



Moving Toward a

An interview with

Kana Enomoto

Acting Administrator, Substance Abuse
and Mental Health Services Administration



What are the priority areas SAMHSA has defined when it comes to improving crisis services for people with mental health and substance use concerns?

At the Substance Abuse and Mental Health Services Administration (SAMHSA), we recognize that crises cause great disruption for individuals, families and their communities. These are critical times for intervention to get people into treatment and ultimately, recovery.

We want to help communities build, fund and maintain robust crisis services and systems. We focus on crisis systems because we recognize that multiple groups have to be engaged—behavioral health providers, housing agencies, police and other first responders, courts, child welfare, hospitals and others who make determinations about involuntary detainment. Community members, including families, peers and community institutions, need to be involved as they are often aware of who needs to be trained and can help prevent crises before they happen.

We also look at strategies to address specific types of crises, such as suicide (see more in Richard McKeon's article, page 10), disaster crises (through the disaster technical assistance center and emergency grants) and overdose prevention (such as naloxone distribution).

Are there promising crisis services, practices or programs you would like to see more widely adopted in communities across the United States?

We need to do more to promote the use of advance directives for people with serious mental illness to be sure that they have some say over what happens to them when in crisis.

Providers need to work across law enforcement, emergency response, education, businesses and non-emergency dispatch (i.e., 211 lines) to train for immediate response and de-escalation, but also crisis and safety planning. Crisis Intervention Team (CIT) training is effective; we need to be sure that every law enforcement official who would like to have that training has access to it.

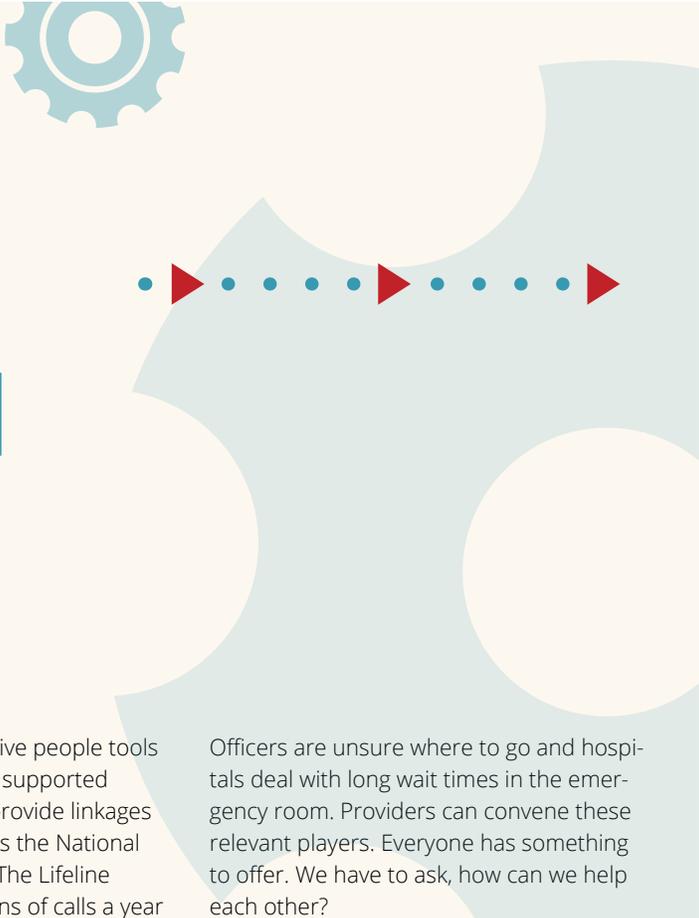
One promising practice is ConnectionsAZ's Crisis Response Center in Tucson. This is a new facility built to provide an alternative to jail and the emergency room. Law enforcement brings in half of the 1,110 people they see per month and they never turn them or walk-in arrivals away. What's unique about this model is that recovery support specialists and peer-run groups provide one-on-one interactions with families, conduct phone follow-up and lead the grievance process. They provide acute care beds and urgent care with mental health and peer services. It's really the best of all worlds.

What partnerships should community behavioral health agencies prioritize to create seamless crisis services?

Community providers play a vital role in making sure linkages occur so that people get well and stay well. Follow-up to releases from the emergency room, jail or prison—times people are at risk and we need to do as much as we can to ensure no one falls through the cracks. That takes resources, workforce and time.

Funding is a huge issue in crisis response because it is unclear who pays for what. When you have a fire at your house, they don't ask you what type of insurance you have. They just show up. And communities have a way to pay for that. In behavioral health we're not quite in the same situation. Communities need to partner with state Medicaid and county public health offices to understand the range of resources available and how to pay for these services for everyone in the community.

Some of the critical partnerships that need to happen are with hospitals. St. Anthony Hospital in Oklahoma City established a mental health admissions office in the emergency department to conduct behavioral health evaluation prior to bed placement. This reduced wait times for people with mental health concerns from two hours to 20 minutes. For the emergency room overall, wait times reduced from 44 to



Comprehensive CRISIS SYSTEM

24 minutes. And the hospital experienced nearly 20 percent reduction in hospital admissions. That simple type of intervention can have a huge impact on your whole community.

Funding is a huge issue in crisis response because it is unclear who pays for what. When you have a fire at your house, they don't ask you what type of insurance you have. They just show up. And communities have a way to pay for that. In behavioral health we're not quite in the same situation.

What are some examples of innovative uses of technology for crisis response/prevention?

People need to have a way to get in touch and have a rapid response when they're feeling distressed. Technology allows us to be with people where they are and to bond in real-time rather than waiting for a 9-to-5 interaction.

We are pleased that people are using our mobile apps. Both Suicide Safe and Disaster Distress are robust tools for first responders and health care professionals to easily assess and refer people wherever they are. Other apps such as Suicide Safer

Home, MY3 and ReliefLink give people tools to ensure they are safe and supported during high-risk times and provide linkages to places to get help, such as the National Suicide Prevention Lifeline. The Lifeline receives millions of calls a year and our 24/7 chat service is really taking off. It is saving thousands of lives.

Predictive technology has a lot of potential. Content analysis of people's chats can detect changes in behavior and language to predict crises. Counselors at Centerstone of Tennessee use biometric sensors in smartphones and other devices to monitor

changes in behaviors or potential risk to check in via a call or do a screening. We have to proceed with caution to ensure people have their privacy protected and ensure providers are comfortable getting and making use of the data.

How can behavioral health providers (and other community agencies) take a leading role in improving the crisis system?

It is not just up to behavioral health. Other systems like Emergency Medical Services (EMS), businesses and hospitals feel the pinch of the challenge of managing crisis.

Officers are unsure where to go and hospitals deal with long wait times in the emergency room. Providers can convene these relevant players. Everyone has something to offer. We have to ask, how can we help each other?

Providers can also help build behavioral health literacy and awareness of resources. Through Mental Health First Aid and efforts like the Campaign to Change Direction, communities are learning to recognize the signs of distress, precursors to crisis and where to go for help.

In five to 10 years, what will every behavioral health crisis system include?

Crisis systems must strive to be comprehensive, to have a unified approach, to adequately share patient information and to ensure continuity of care through all stages of treatment and referrals. We released a paper a couple of years ago, Crisis Services: Effectiveness, Cost-Effectiveness and Funding Strategies (available at <http://store.samhsa.gov>), that outlines the core crisis services once a crisis occurred (23-hour crisis stabilization, short-term residential, warm lines, peer crisis services, etc.). Systems need to include activities oriented to prevention, early intervention, stabilization and postvention. All are important components.

SAMHSA, Safety and the Chain of Care

Richard T. McKeon

Chief, Suicide Prevention Branch, Substance Abuse and Mental Health Services Administration



A priority for the Substance Abuse and Mental Health Services Administration's (SAMHSA's) suicide prevention efforts the past several years has been improving care for those in acute suicidal crisis by promoting continued contact and proactive follow-up following discharge from emergency departments and inpatient units.

There are three reasons why it is vital to assure this kind of "chain of care" during care transitions.

1. The time immediately after discharge from acute care is a period of high-risk for death by suicide, non-fatal suicide attempts and readmissions to acute care.
2. The frequency of receiving outpatient care following discharge is distressingly low.
3. The evidence is strong that intervention during this time period can reduce suicidal behavior.

SAMHSA endeavors to improve the system of care during these high-risk periods using numerous mechanisms and approaches that include:

- Promoting follow-up with National Suicide Prevention Lifeline crisis centers.
- Requiring post-discharge follow-up in Garrett Lee Smith youth suicide prevention grants and adult National Strategy for Suicide Prevention grants.
- Promoting development of care transition protocols in tribal suicide prevention work.

SAMHSA endeavors to improve the system of care during high-risk periods using numerous mechanisms and approaches.

- Incorporating improved post-discharge follow-up and coordination as criteria for Certified Community Behavioral Health Clinics as part of the Section 223 initiative.
- Developing resources to assist financing of care transition services.
- Working with the Center for Medicare and Medicaid Services on a discharge planning toolkit.
- Promoting adoption of the Zero Suicide initiative with maintaining continuity of care as one of the core elements.
- Working with the National Action Alliance for Suicide Prevention to identify best practices and protocols and to promote nationwide adoption of improved post-discharge follow-up and care transitions.

A study of nearly one million veterans treated for depression showed that the highest risk during mental health treatment was the two months following inpatient discharge, leading researchers to identify intervention during this critical period as a high priority. In data from the South Carolina Violent Death Reporting System, 10 percent of all people who completed suicide visited an emergency department within 60 days of their death. At the same time, studies of mental health service utilization through SAMHSA's National Survey on Drug Use and Health by those who attempted suicide show that only 56 percent received any mental health treatment and the majority did not receive any outpatient treatment

following their suicide attempt. A number of studies show that follow-up after emergency department or inpatient units discharge can reduce future suicide deaths and attempts.

By incorporating improved care coordination between outpatient mental health programs, crisis providers, hospital inpatient units and emergency departments as criteria for Certified Community Behavioral Health Clinics, SAMHSA hopes to demonstrate that such excellence in mental health care saves lives and should be a model for the future.

In evaluation studies of Lifeline crisis centers that received small grants from SAMHSA to provide telephonic follow-up services to suicidal callers and those discharged from acute care, callers were found to highly value follow-up services and feel they played a crucial role in keeping them safe and not attempting suicide. Further, grants centers, like Behavioral Health Response in Missouri, incorporated telephone follow-up across multiple programs. The White Mountain Apache tribe provides rapid in-person follow-up—frequently in the home—to suicidal youth seen in the emergency department through a program with the Johns Hopkins

Center for American Indian Health that is supported by SAMHSA Garrett Lee Smith youth suicide grants.

Significant post-discharge follow-up efforts are being undertaken across the country using SAMHSA grants, including efforts among youth and adults in Tennessee where the state works with community mental health agencies such as Centerstone to provide these critical services. In addition to activities directly supported by grants, SAMHSA works on wide scale adoption of improved post-discharge follow-up and care transition by providing webinars and resources on financing these services and demonstrating the potential return on investment they can yield. In addition, by incorporating improved care coordination between outpatient mental health programs, crisis providers, hospital inpatient units and emergency departments as criteria for Certified Community Behavioral Health Clinics as part of Section 223, SAMHSA hopes to demonstrate that such excellence in mental health care saves lives and should be a model for the future.

LIFELINE NETWORK

Bringing Research to
Practice Nationwide

John Draper | Project Director
National Suicide Prevention Lifeline

THE MAGNITUDE

of what we needed to accomplish seemed like scaling Mt. Everest. In 2004, when the Substance Abuse and Mental Health Services Administration (SAMHSA) first awarded the grant to administer what is now the National Suicide Prevention Lifeline network, we needed to assemble a national network of crisis centers to answer calls from anywhere in the U.S. at any time. We also needed national protocols and standards of practice to ensure that no matter where callers in crisis were connected they could expect the same basic type of assistance.

We had two major assets in our favor to accomplish the second goal. First, we had many national experts in crisis and suicide prevention research and training practices to advise us and help establish consensus on best approaches. But our greatest asset was a team of internationally renowned researchers who, as part of the grant, were contracted to evaluate our crisis centers' work as an ongoing iterative process. As we developed new protocols and practices in response to the findings, the evaluation team measured their impact, creating a feedback loop for continuous quality improvement.

Madelyn Gould and her team at Columbia University, Brian Mishara and his team at Université du Québec à Montréal and the late John Kalafat and his team at Rutgers University provided us insights that have broken new ground for crisis hotline practices everywhere. Over the past 13 years of evaluations, mostly performed by Gould and her team, 79 Lifeline centers have participated in 10 separate evaluation processes, leading to eight journal publications.

The findings from these evaluations show that hotlines effectively reduce emotional and suicidal distress during the course of



a call and that these effects can remain for weeks after the contact. There are specific “best practices” that we now know can reduce distress and potentially save lives: establishing good contact/rapport, working collaboratively with people in crisis to take actions that reduce their distress, risk assessment and, for people at imminent risk, actively engaging to take the least invasive actions necessary to keep them safe.

Callers to Lifeline member centers were much more likely to be assessed for suicide risk and feel less distressed by the end of the call than callers contacting non-Lifeline crisis centers.

The evaluators offered other recommendations to improve practices at crisis centers network-wide. They observed that crisis center practices varied widely and that we needed to improve risk assessment by crisis counselors. They also recommended more consistent protocols to help callers at imminent risk of suicide, enhanced silent monitoring of calls and follow-up contacts for at-risk callers. Lifeline created the Standards, Trainings and Practices Subcommittee (STPS) to develop consensus approaches to achieve these recommendations. First chaired by Thomas Joiner, the STPS included evaluators Gould, Kalafat and Mishara, along with leaders in crisis center trainings and practices around the country. For the past 10 years, the STPS and the SAMHSA-funded Lifeline evaluation teams have helped Lifeline and its network achieve the following milestones:

- **National standards for suicide risk assessment implemented across the network in 2007.** This risk assessment framework for all crisis centers, now adopted by all 165 centers in the Lifeline network, consists of the “four core principles of suicide risk” (suicidal desire, suicidal intent, capability and buffers/reasons for living or dying). Follow-up evaluations show that risk assessment practices at the center have significantly improved implementing the framework. The National Action Alliance Task Force on Clinical Care and Intervention has recommended the four core principles as a standard framework for all behavioral health providers.
- **National policy for helping callers at imminent risk of suicide implemented across the network in 2011.** This policy—established on principles of active engagement with callers, active rescue as a last resort and collaboration with other crisis and emergency services—is supported by training throughout the network. Recent evaluations show that centers effectively reduce imminent risk for callers and that training like Applied Suicide Intervention Skills Training (ASIST) (offered through Living Works, Inc.) further reduces risk with people who are considering suicide.
- **Promotion of follow-up contacts to further reduce suicide risk.** Lifeline provides resources and guidelines to promote crisis center follow-up for callers at risk. SAMHSA has provided grants to more than 35 network centers to conduct these services. Subsequent evaluations of center follow-up by Gould and her team determined that these contacts were a factor in keeping more than 80 percent of callers safe, with nearly half stating they were the primary factor in keeping them alive. Now, about 90 percent of the Lifeline network’s 165 centers practice some kind of follow-up with callers.

Soon-to-be-published research by Rand of California-based crisis centers demonstrates that callers to Lifeline member centers were much more likely to be assessed for suicide risk and feel less distressed by the end of the call than callers contacting non-Lifeline crisis centers.

Not only are Lifeline’s best practices applicable to other crisis services seeking to improve quality, so are the processes that produced them. The most essential ingredient in this process has been top-down, network-wide “buy-in” to evaluation for quality improvement. Further, the continuous contact between highly respected suicide prevention researchers and crisis centers has paved the way for research to be more readily applied to practice. These researchers have become champions for crisis center work and centers increasingly support applying research and outcome-based approaches to helping callers. Our Lifeline staff has also been essential in providing technical assistance, tools and research to our centers through the Lifeline’s online Network Resource Center.

In the years ahead, we look forward to establishing and disseminating best practices for online chat, texting and emergency department follow-up, as well as honing model operating procedures that can efficiently sustain best practice services in demanding, fast-paced health care environments.

Tomorrow's Crisis Services

▶▶▶▶▶▶▶▶ Six Trends That Will Drive the Future

Vijay Ganju | CEO, Behavioral Health Knowledge Management

In the wake of tragedies that have demanded national attention, crisis services are at the forefront of behavioral health services priorities at federal, state and local levels. There is growing recognition that existing systems are largely inadequate, especially in the context of a recovery and resilience orientation. Discharges from hospitals and emergency rooms are often destined for failure, crisis interventions can be more traumatic than the original condition and crisis services can strain and stretch other social and community programs.

Several broad trends are emerging.

First, there is a growing consensus that providing crisis services when a person is "out of control" or "a danger to self or others" is insufficient. A broader conceptualization of crisis response must include crisis prevention, early intervention and post-crisis services and supports.

Second, there is recognition that the crisis response system is only as strong as the larger, more comprehensive community behavioral health system. Access to an adequate array of behavioral health services would decrease demand for crisis services.

Third, using inpatient hospitalization and emergency rooms for behavioral health crises is not only often inappropriate, but costly. Alternatives exist and are being developed, some which emphasize recovery and trauma-informed care.

Fourth, peer-operated services are increasingly a cornerstone of the crisis system. Peers manage and operate warm lines, are part of first responder teams, are involved in discharge planning from inpatient and 23-hour hold facilities, operate crisis respite beds and support teams in emergency rooms. New models are also emerging for peer support programs for people with addictions. Family service and support organizations now perform a range of functions in crisis response for children, adolescents and their families.

Fifth, there is a trend to create trauma-informed crisis response systems. People experiencing a crisis often have histories of victimization, abuse and neglect or other significant traumas. Involuntary or coercive

interventions can worsen the situation, especially after involuntary transport, police custody and use of physical restraints and/or seclusion.

Sixth, new partnerships at the state, local or community level and across health and social service agencies are being implemented to develop legislation, policies, management and monitoring mechanisms and funding streams to support, disseminate and sustain new and emerging trends in behavioral health crisis response.

What does this mean for the future of behavioral health crisis response? The figure below depicts a few of the features emerging related to behavioral health crisis response in the future.



THE FUTURE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

EXISTING SYSTEM

FUTURE SYSTEM

Crisis defined by system perspective	•••▶	Crisis defined by consumer or family perspective
"To" or "for" consumer	•••••▶	"With" consumer
Crisis Service	•••••▶	Crisis Continuum
Directed, coercive	•••••▶	Recovery-oriented, trauma-informed
Reduce danger to self or others	•••••▶	Support and safety
Fragmented, multiple agency response	••▶	Coordinated partnerships
Behavioral health/law enforcement	•••▶	Health/behavioral health



A crisis plan should be developed “with” a consumer—not “for” a consumer.



It's important to consider who defines a crisis. For a consumer, crisis often occurs much before intervention—when a person becomes homeless or loses a job—not when certain behaviors or symptoms are manifest. We need a broader definition of crisis that includes:

- **Crisis prevention**—Wellness Recovery Action Plan (WRAP), crisis planning, engagement in treatment and supports.
- **Early intervention**—crisis hotlines, warm lines, family and community support, peer support.
- **Crisis response**—mobile crisis, hotlines, 23-hour observation, crisis residential and respite, peer support, “living room” models.
- **Post-crisis services and supports**—crisis respite housing, crisis residential, non-hospital detox, hospitalization.

Crisis intervention should be available where the consumer is at—not just physically, but where the consumer is on the “crisis spectrum.” A system needs a range of interventions to respond in the context of this new approach—not all of them are necessarily “crisis” services. If a consumer is in crisis because he or she is about to lose housing, a housing specialist may be part of the crisis response rather than a member of a traditional crisis team.

Consumer leaders are at the forefront of developing models for crisis planning, early intervention, crisis intervention and post-crisis support. Crisis response systems of the future should aim to be person-centered, strength-based, non-coercive and self-management-focused. A crisis plan should be developed “with” a consumer—not “for” a consumer.

The current reality is that police and law enforcement remain the primary first responders in many communities. In this sense, police and law enforcement have become a de facto component of the behavioral health system, even though this is not their mission or mandate. Reasons for such involvement include inadequate resources within the behavioral health system and the common fallacy that a person experiencing a behavioral health crisis is a public safety issue. In future crisis response models, primary responders should be public health and behavioral health providers. Police and law enforcement should be responders of last resort rather than primary first responders.

Despite some progressive programs in place, there is still a huge gap between the current reality and the promise. We will need partnerships at all levels to develop the resources and skill sets needed. The danger is to be complacent and stuck in the present.

Crisis intervention should be available where the consumer is at—not just physically, but where the consumer is on the “crisis spectrum.”

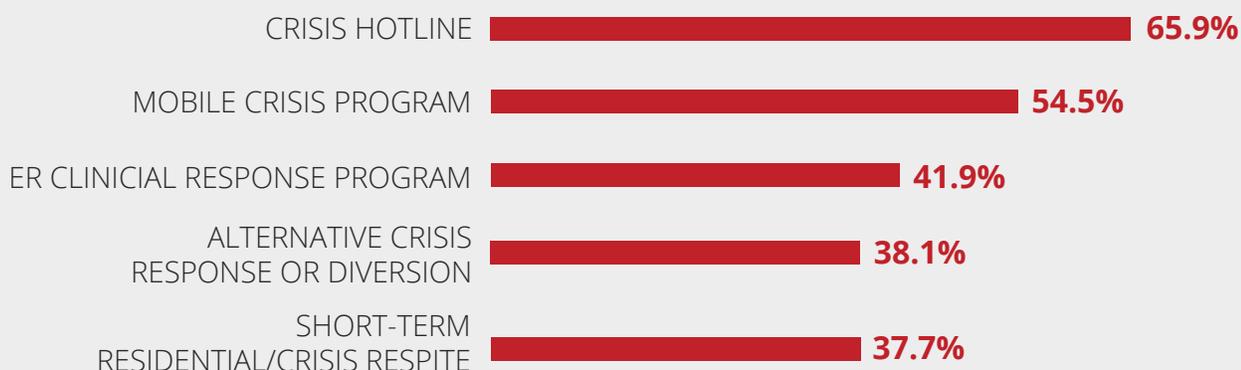
SNAPSHOT

BEHAVIORAL HEALTH PROVIDERS AND CRISIS SERVICES

SERVICES, TRENDS AND BARRIERS

What Crisis Services are out there?

TOP FIVE MOST OFFERED CRISIS SERVICES



A Diverse Array of Services

Crisis services are becoming increasingly diverse. The type of crisis services providers offer also includes:



CRISIS SERVICES OFFERED	%
WARM LINE	31
24/7 WALK-IN CENTER	27
23-HOUR OBSERVATION/CRISIS STABILIZATION	19
LEVEL 1 SUB-ACUTE CRISIS STABILIZATION	14
LEVEL 1 ACUTE CARE PSYCHIATRIC INPATIENT	13
CHAT CRISIS LINE	9
PEER RESPITE	9
TEXT CRISIS LINE	5

Increasing use of Peer Specialists in Crisis Services

28% of warm lines are run by peers

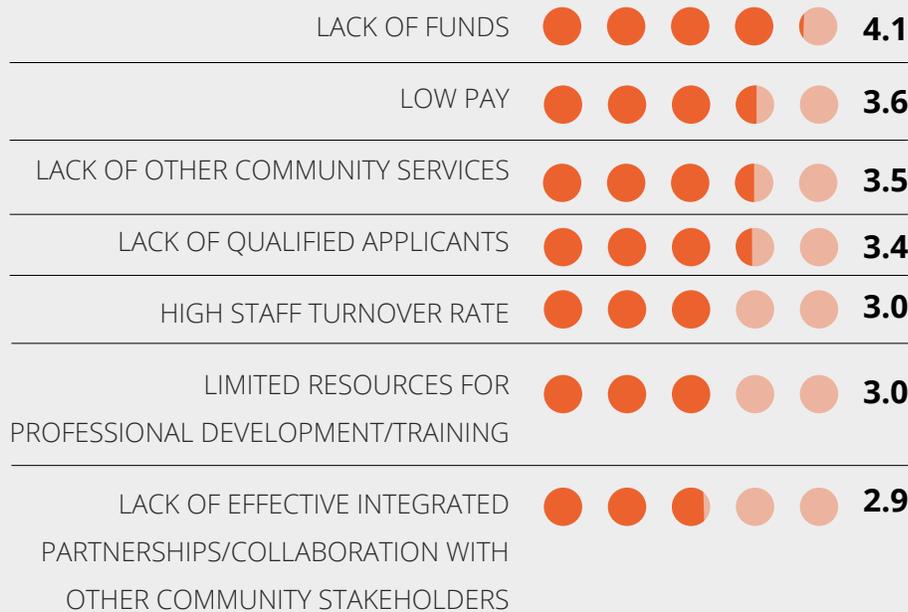


Always Open Crisis never sleeps. Many of these services are offered 24/7/365.

PROGRAM	DAILY (%)	24/7 (%)
HOTLINE	94	92
CHAT LINE	70	72
ER CLINICAL RESPONSE	92	86
MOBILE CRISIS	86	74
WARM LINE	77	71
TEXT LINE	60	37

Barriers to Crisis Care

What prevents treatment organizations from being able to offer crisis services, either round the clock or at all?



WHAT DO BEHAVIORAL HEALTH CENTERS NEED TO UP THEIR CRISIS SERVICES?





LIVE DATA Creates Electronic Air Traffic Control Environment in Georgia

Wendy Martinez Schneider
CEO, Behavioral Health Link

A CRISIS HAS NO SCHEDULE.

They can occur at 2 a.m., on a weekend or on a holiday. How does a system ensure individuals in need get timely access to life-saving services? How do we hold the public safety-net accountable to provide crisis services reliably 24/7/365?

Since 2006, Georgians have relied on the Georgia Crisis and Access Line—a clinically managed phone line designed to help anyone in crisis. As Georgia Crisis and Access Line continued to grow, Behavioral Health Link developed electronic resources in partnership with the state to both support our clinicians with crisis intervention in real-time and referral and assist the state with data tracking. Originally designed to track access to outpatient services, the case-by-case tracking mechanisms have recently grown into electronic processes with dashboard management that allow real-time tracking of access to intensive services like mobile crisis, bed availability in crisis stabilization units and performance.

Picture a person in crisis and an emergency department doctor seeking a bed for the person or a deputy on the street who needs to know where to find the closest available crisis bed. With the very first call, the person speaks to a licensed clinician who

uses active engagement and collaborative problem-solving to help determine the most appropriate service to meet the immediate need. Behind the scenes, the clinician has access to a live, interactive web-based system showing real-time availability of urgent outpatient appointment slots, mobile crisis workers in the person's area and how close they are to being free for a new call, available crisis walk-in centers and vacant crisis stabilization and temporary observation beds.

At this very moment, behavioral health and developmental disability regional and state authorities in Georgia can login to a secure, HIPAA-compliant web portal and view the number of people waiting for a crisis stabilization bed, where they are waiting and how long they have been waiting. Also available is live inventory of available beds across the state and information about which facilities with available beds are reviewing new referrals. A statewide view of mobile crisis activity displays average response times for the day and month to date, current active dispatches and shows how long teams have been on the scene of a crisis, which ultimately can help ensure the safety of the mobile crisis workers and the individuals awaiting their arrival.

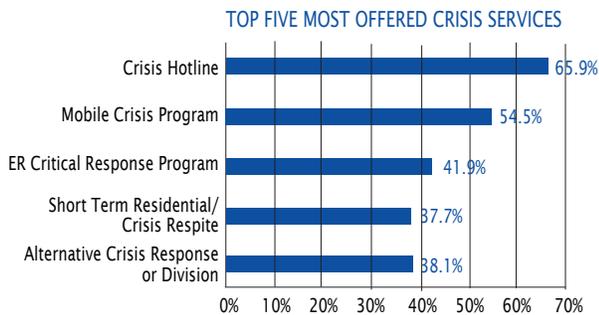
This information is invaluable to state authorities working to ensure that services are being used to their fullest capacity before more costly options like emergency room visits. Private beds contracted with the state or state hospital beds ensure that high-end resources are a last resort. Live data sent via email alerts lets officials know if a person has been administratively denied or denied by multiple facilities despite meeting criteria.

In real terms, it means that the system is designed to facilitate access to services at the right level, as quickly as possible as close to home as possible and to do so in a way that captures data throughout the process to make sure nobody falls through the cracks. The result has been phenomenal: clear reductions in ER wait times, improved direct access to crisis units and crisis walk-in services for individuals identified by law enforcement and probate judges and maximized untapped crisis stabilization unit capacity and increased use of mobile crisis services. This means a better experience for individuals in crisis with as few barriers to care as possible.

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Results from a 2015 survey by the National Council for Behavioral Health

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Crisis Outcomes Coverage

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Pioneering Crisis Services in Delaware: That Was Then and This Is Now

Steven Dettwyler

Director of Community Mental Health and Addiction Services, Division of Substance Abuse and Mental Health, State of Delaware

It's one thing to raise the level of crisis care with judicious use of funding and grants. It's another to sustain it after the grant periods end. In Delaware, we achieved both.

In 2011, a five-year settlement agreement was signed between the U.S. Department of Justice and the State of Delaware with the goal of reforming Delaware's ailing mental health system. The agreement specified five target areas—crisis services, intensive support services, housing, supported employment and rehabilitation services and family and peer supports.

Not only has the progress been remarkable—in a recent report by Mental Health America, Delaware was one of five states with the lowest prevalence of mental illness and the highest rates of access to care—these programs were built to last.

As a result of funding provided as part of the agreement, statewide mobile crisis intervention teams and crisis centers are now staffed 24/7 and provide a viable alternative to hospitalization. Centers, staffed by peers and professional licensed staff combined with mobile teams that respond to people in crisis in less than an hour have substantially reduced the need for hospitalization.

Assertive community treatment, or ACT, teams were originally developed in Minnesota to keep people in the community and in their homes. Delaware adopted this model and now has 14 teams with members

who specialize in psychiatry, nursing, housing, addictions, benefits and employment. They're making a big difference.

Finally, along with revising psychiatric emergency detention laws, Delaware has reduced long-term use of hospital beds and created new housing opportunities, including peer-staffed crisis apartments for individuals at risk for hospitalization and state funding for housing vouchers.

The changes are nothing short of remarkable, but what sets Delaware apart from many other states is a commitment to creating funded programs that will survive long after the funding ends. Delaware's strategies can help other states in their quest for long-term solutions—not just for crisis, but all programs.

Delaware was one of five states with the lowest prevalence of mental illness and the highest rates of access to care—these programs were built to last.

Contracts and standards are written for licensure, certification and even program staffing to provide continuity and maintain quality when funding ends. When applying for grants, it's critical to tell the government how programs will be sustained and

implement those plans. It's also wise to work very closely with Medicaid—because of its many resources—and to align Medicaid resources properly with services needed by the community to fully realize that synergy. When state money is also available for behavioral health, a “mixture” of funding can support a more permanent and progressive system. As an example, the Delaware aligned Medicaid funding with state general revenue funding and aligned behavioral health services with physical health services.

The legal framework is also key. Delaware formerly had a weak, loosely defined law to structure psychiatric emergency detention and get people into treatment. After collaboration with legislators, the law was modified with great results. Consider changing laws that impair the ability to get and keep people in services.

Thanks to long-range planning and awareness of how different programs can work together toward the same goal, Delaware is a stronger and more vibrant state when we benefit from the talents and skills of all of our residents.

ZEST FOR LIFE

Working for Zero Suicides in Texas

In Texas, state-wide commitment to crisis services ensures consistent and ample funding as well as uniformly high-quality services. The Texas Department of State Health Services (DSHS) was appropriated \$31.7 million by the 84th Texas Legislature to expand crisis services for the 2016 to 2017 biennium and \$50 million to expand private psychiatric beds across the 2016 to 2017 biennium.

Zero suicide isn't just a goal in Texas—it's a federally-funded pilot project to provide a framework of evidence-based practices in suicide prevention. Twenty-two of the 39 state-funded local mental health authorities (LMHAs) are participating in Zero Suicide in Texas—ZEST—based on the national Zero Suicide Model to ensure that suicidality is identified, screened and treated directly. The goal is to embed Suicide Safer Care best practices into crisis services and enhance treatment based on the concept that all suicide deaths are preventable for people under care.

Denton County MHMR (DCMHMR) is the performance site for the ZEST grant and responsible for pilot innovations. Between Jan. 1, 2014, and Sept. 30, 2015, 1,193 young people, ages 10 to 24, were screened using a best-practice suicide-screening tool and risk assessment process. Collecting data about suicide attempts and the number of suicide-related deaths in an agency or county will help design targeted interventions to reduce suicide in a way that will work best in



Jenna Heise
State Suicide Prevention
Coordinator, Texas Department
of State Health Services

the Texas system. To ensure consistent data across all 22 pilot sites, a workforce survey assesses skills and training needs as well as the strengths and barriers to implementation.

In FY 2015, 249,259 people received community mental health services through DSHS and 78,098 received crisis services.

All those entering mental health services funded by DSHS receive a uniform assessment—the Child and Adolescent Needs and Strengths (CANS) assessment—to determine appropriate treatment and supports. An evidence-based suicide-screening tool—the Columbia Suicide Severity Rating Scale—is embedded in the CANS. If it is determined that an individual is at risk for suicide, they receive an evidence-based risk assessment and a safety planning intervention. They also have access to crisis intervention services, pharmacological management, safety monitoring, crisis transportation, crisis follow-up and relapse prevention and family partner supports.



SAFETY FIRST: Out of Tragedy Comes a Program to Protect Outreach Workers

David Kludt | Supervisor, King County Crisis and Commitment Services
Former Mental Health Program Administrator,
Washington State Department of Social and Health Services

On November 4, 2005, Marty Smith, a designated mental health professional, was murdered while responding to a residential call in Poulsbo, Wash. In Washington, these professionals conduct investigations and can order an initial 72-hour involuntary detention. Smith was attempting to admit a man for a mental evaluation when the person being evaluated became enraged and turned on him.

The state's close-knit mental health community responded with shock and sadness to the loss of one of their own, but with a willingness to share opinions and develop a constructive plan to help prevent similar tragedies from happening in the future. Here's how that transpired.

In September of 2006, the Washington Division of Behavioral Health and Recovery hosted two safety summits for a statewide group of stakeholders that included mental health professionals, mental health administrators, law enforcement, union representatives and a member of the state House of Representatives.

The intent was to share ideas on issues related to safety of outpatient community mental health workers. It was also an opportunity for those who knew Marty to continue the grieving process and try to gain something positive from the senseless tragedy.

From Ideas to Changes

Initially, there was a resounding call for more frequent standardized statewide training for mental health outreach workers. Participants also said it was important to make information accessible to outreach workers

before they see clients so that risks can be appropriately assessed. Additionally, they recommended optional outreach in pairs. In 2007, the Washington state legislature passed the Marty Smith Bill, requiring all community mental health agency workers in direct contact with consumers receive annual training in safety and violence prevention. The bill also mandated that the Washington State Department of Social and Health Services develop the training with stakeholder input. Other important provisions allowed for two-person outreaches and required use of communication devices during any community outreach.

Shortly after the bill passed, as the divisions program administrator, I contracted with the Washington Institute for Mental Health Research and Training to establish a steering committee to help develop the curriculum and produce training materials for the Marty Smith Safety Training program.

This was a mutually collaborative process incorporating the knowledge and experience of experts from law enforcement, mental health agency staff and administrators. As a result, training videos and ancillary training materials were developed.

From 2009 through 2012, the Division of Behavioral Health and Recovery and the Washington Institute for Mental Health Research and Training conducted six two-day Marty Smith Safety Trainings and two one-day refresher trainings throughout the state, using a "Train the Trainer" model. The idea was that following the initiation period, all training would be done by the

agencies themselves. The in-person trainings augmented the training videos and provide specific instruction in the areas of verbal de-escalation, personal safety and safe outreaches.

Making Us All Safer

While program users reported that the curriculum was well prepared and produced, it lacked a formal evaluation of its efficacy. So, in fall 2011, the Division of Behavioral Health and Recovery contracted with the Washington Institute for Mental Health Research and Training to conduct an extensive evaluation. Participants were asked to rate the safety training on topics that included training effectiveness, perceived ability to handle potentially violent situations, training value and materials.

Ninety percent of respondents described training as "effective to very effective" in increasing feelings of safety in work-related situations and increasing confidence when dealing with violence. Participants rated the program as a successful method for disseminating needed information.

In 2014, online versions of the training materials became available to community mental health agencies and workers. Along with the other provisions of the law, every year all mental health agency staff at a licensed agency must complete safety training.

We're proud of the steps we've all taken to become better—and safer—at our jobs, and we think Marty would be proud, too.



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The “Show Me” State Shows that One Phone Call Isn’t Enough

The availability of follow-up care with youth and adults has had a huge impact on the crisis systems’ ability to divert from inpatient services and police/emergency responses. BHR is diverting over 95 percent of crisis callers who complete full behavioral health assessment from this costlier and restrictive option.

Bart Andrews | Vice President of Clinical Practice/Evaluations, BHR Worldwide

Young people in four counties can access crisis services by phone, text or chat 24/7.



600%
increase in youth served



400%
increase in mobile outreach services provided to youth



85%
of youth with increased risk of suicide/danger to others linked to care within 48 hours



76%
of youth in crisis linked with ongoing services within 14 days

The call came from a family member trying to find help for “James,” a teenager who was struggling academically, socially and emotionally. The caller claimed to be a family member and legal guardian—not a parent—and needed help connecting James to services. Sounds simple, right? It was not.

The caller was not a biological family member, was not a legal guardian and the biological parent refused to assist in connecting James with services. Yes, social services had been contacted—many, many times. But James was not 18 and there was no way to connect him to services without guardian consent.

In a typical crisis system, referrals would have been provided, but no services would have been engaged and nobody but James and the caller would have known. Fortunately, St. Louis has Behavioral Health Response’s (BHR) Youth Connection Helpline. All youth in covered areas are automatically enrolled in follow-up services. They receive ongoing telephonic case

management and support until the crisis is resolved and the young person is linked with services. In this case, it took six months of ongoing contact, repeated mobile outreaches and excellent rapport-building to engage the parents and get James linked with appropriate services. This would not happen in a world without follow-up.

All youth in covered areas are automatically enrolled in follow-up services. They receive ongoing telephonic case management and support until the crisis is resolved and the youth is linked with services.

In 2010, BHR started its first follow-up program for people at risk of suicide with funding from the Substance Abuse and Mental Health Services Administration’s National Suicide Prevention Lifeline follow-up program. BHR quickly created, implemented and expanded follow-up at

every opportunity. BHR now has four youth follow-up programs and two adult follow-up programs that cover the entire eastern region of Missouri and more than two million lives, providing follow-up services to thousands of clients.

The availability of follow-up care with youth and adults has hugely impacted the crisis systems’ ability to divert from inpatient services and police/emergency responses. BHR diverts more than 95 percent of crisis callers who complete full behavioral health assessment from this costlier and restrictive option. With the addition of follow-up services for all callers who receive mobile outreach services, BHR is able to divert more than 90 percent of adults receiving mobile outreaches (the most acute crisis callers) from emergency and hospital services.

Missouri crisis agencies are working hard to innovate through expanding follow-up, using innovative technology and public health approaches to improving wellness in the “show me” state.

Burrell Behavioral Health
and Ozark Center are two examples of how
the “Show Me” State responds to crisis.



Burrell Behavioral Health

Jim Rives

Vice President for Corporate Development, Burrell Center

BHR's transition to follow-up based crisis services provides one example of innovation in crisis services, but Missouri is fortunate to have other pioneers in the crisis community. Burrell Behavioral Health, based in Springfield, Mo., started a program that provides iPads to Crisis Intervention Team-trained (CIT) police officers, so they can get a face-to-face behavioral health consultation while out in the field. This led to elimination of response lags from the traditional mobile outreach and rapid and voluntary engagement by persons who, in many cases, refused care. While CIT is important, timely engagement in appropriate mental health care is critical to improving outcomes for those individuals experiencing mental health crises and reducing law enforcement encounters. The Virtual-Mobile Crisis Program is proving to be an important tool at this interface.



Ozark Center

Debbie Fitzgerald

Director of Crisis Services, Ozark Center

At Ozark Center in Joplin, Mo., a crisis team already distinguished by its response to a tornado in 2011, joined the Zero Suicide Initiative and quickly integrated its core principles into daily operations. One of the most important steps was identifying the top 20 high utilizers of crisis services at both locations and doing a careful case review to determine possible gaps in care. This resulted in focus areas of transitions of care and enhanced follow-up after contact with crisis services and/or discharge from inpatient care. A new position, engagement specialist, provides emergency case management for patients being discharged from inpatient care.



Leading the Way to Comprehensive Community Crisis Care

Gabriella Guerra | Crisis and Cultural Services Administrator, Mercy Maricopa

Where does the crisis system begin and where does it end?

What are the ideal outcomes of an effective crisis system?

Who are the key partners and what are their roles?

These were among dozens of questions tackled by Mercy Maricopa Integrated Care's Crisis 360, a four-month long, multisystem analysis of crisis care in metropolitan Phoenix that involved more than 40 stakeholders. This groundwork helped pave the way for expansion and remodeling of crisis care in Arizona's most populous county.

Mercy Maricopa is responsible for psychiatric crisis care for all of the county's four million residents. When it became the public system administrator in April 2014, the county already was ahead of the curve with a centralized 24/7 crisis line, mobile crisis teams, coordination with crisis-intervention trained law enforcement and two urgent psychiatric centers.

But we recognized that we needed to address duplications and gaps, so we created a group to tackle the problems. The team was composed of all the players—representatives from crisis service and outpatient providers, psychiatric and acute care hospitals, police and fire departments, schools, the Veteran's Administration, the state's child welfare agency, corrections and probation services, along with peer and family members. Two core work groups—one for children and one for adults—met each week to review literature, data and best practices from Hawaii to Wisconsin, and pound out recommendations.

We challenged ourselves to ask how we can improve things for the client. The team

approach of Crisis 360 helped us identify our opportunities. We added resources, but it allowed us to target those resources.

One challenge was that outpatient service providers had traditionally relied on crisis care rather than managing escalating issues themselves. Crisis 360 recommendations included contract adjustments and performance measures that improve care coordination during and after a crisis and encourage outpatient providers to keep people out of hospital emergency departments and urgent psychiatric centers.

The Crisis 360 team also examined overuse of involuntary treatment and ways to avert crises through quick and appropriate outpatient response.

We challenged ourselves to ask how we can improve things for the client. The team approach of Crisis 360 helped us identify our opportunities.

The recommendations to support members and families, with specific timelines for implementation, included:

- Develop crisis respite care, additional short-term stabilization for specialty populations and pre- and post-crisis stabilization services.

- Enhance coordination with other systems, including private health plans, child welfare, Veteran's Administration, first responders, courts, corrections, schools and hospitals.
- Ensure people not already enrolled in the public system are fully engaged in services post-crisis.
- Adjust performance incentives and contracts, including decreasing hospital "holds," emergency department usage and hospital admissions and real-time notification of crisis episodes.

Among the key lessons that emerged from Crisis 360 was the critical need to establish close collaborations with various systems, groups and agencies that may touch someone in crisis, as well as listen to people and their loved ones who have used crisis services.

System collaboration only works if community members and families are the focus. We will continue to make sure that their voices drive our decision-making.

Improving the well-being and safety of our communities is everyone's responsibility.

At Magellan, we take it seriously.

For more than two decades, Magellan Healthcare has been transforming fragmented crisis systems into a comprehensive and unified crisis continuum. These safety net services include renewed provider accountability and a focus on meaningful outcomes, as reflected in our **award-winning** suicide prevention program and **nationally recognized** work with Crisis Intervention Teams (CIT) International.

The proof is in the numbers.*

- 7,000+ people diverted from emergency departments/jail to crisis stabilization or receiving centers
- 57% drop in crisis stabilization unit admissions through the work of our peer recovery navigators
- 99% decrease in use of crisis services through our peer-run respite program
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* Statistics from Magellan's public sector behavioral health markets



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HEALTHCARESM

NO WRONG DOOR

INTEGRATION OF LAW ENFORCEMENT WITH CRISIS STABILIZATION

Leon Boyko

Chief Recovery and Crisis Services Officer, RI International

Nick Margiotta

President, Crisis System Solutions



Communities must have ready access to resources that help protect the individual and the community, while avoiding unnecessary and costly uses of emergency departments and harmful incarcerations.

The partnership with law enforcement needs to be much more than merely training police on behavioral health issues. It is imperative that crisis intervention team (CIT) programs are the foundation for developing meaningful collaborations with community behavioral health. Communities must have ready access to resources that help protect the individual and the community, while avoiding unnecessary and costly uses of emergency departments and harmful incarcerations.

RI Crisis implemented an aggressive performance improvement effort in several sites across the country to ensure their “no wrong door” philosophy worked in practice and that a “no-force first” approach to handling acute behavioral health crises ensured seamless admissions and handoffs from first responders. Using certified peer-support specialists who provide support and reduce anxiety during all stages of the process greatly improved guests’ experience.

These centers now divert thousands of individuals annually from law enforcement, reducing emergency department admission and incarceration. RI Crisis’ Peoria facility doubled the police-initiated visits in less than six months and first responders are now diverting 250-plus individuals a month, with an average handoff time of under five minutes, effectively bypassing emergency departments and jails. During the explosive growth period, recipient satisfaction remained over 88 percent and fewer than 5 percent of recipients had a restrictive intervention.

When operated correctly and consistently, providing a front-door solution to individuals in crisis, fewer individuals need to use higher levels of care. Demonstrating these outcomes is critical to driving costs away from costly emergency department visits and ongoing “boarding” stays. Crisis receiving centers can provide a dramatic return on investment for health care systems if they ensure seamless accessible front-end diversions.

Too often, people experiencing a behavioral health crisis end up interfacing with law enforcement for a variety of reasons—not the least of which is that the public knows the “911 system” better than the community crisis line. Whatever the reason, police officers across our country are not only involved in behavioral health issues, but are frequently on the front lines of behavioral health crises.

At RI Crisis, a division of RI International, we view law enforcement as a critical partner and key customer of our services. By helping meet their needs, we have mobilized a huge stakeholder to help further our mission and reduce unnecessary incarceration and expensive hospitalizations.

Recovery response centers that focus on a welcoming “no wrong door” admission process are a proven model to provide readily available crisis care in a community-based setting by increasing opportunities to stabilize individuals in the least restrictive setting and avoid the need for any jail or hospital/emergency department utilization.

After successfully opening seven recovery receiving centers in several states, three key challenges were identified: lack of accessibility due to capacity, admission processes/barriers or uncertainty regarding admission; “creaming” admission practices, ensuring that those who were in the most need nearly always wound up in a hospital/emergency department or jail setting and improving guest experience.

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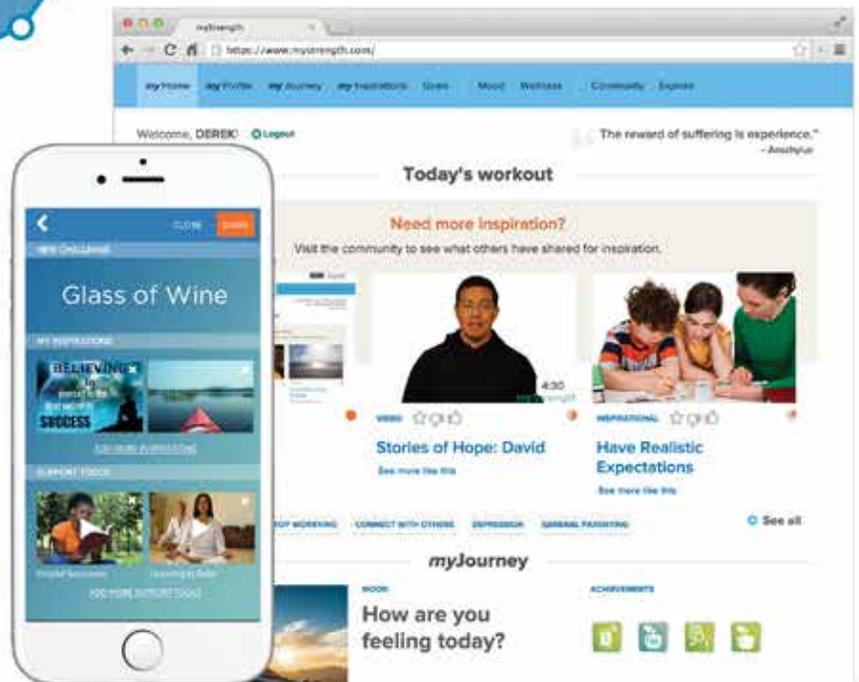
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—Carl Clark, CEO, Mental Health Center of Denver

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Collaboration with Law Enforcement is a Hit

How mental health training improves first responses to crisis

Barbara Dawson

Deputy Director, Comprehensive Psychiatric Emergency Program Division, The Harris Center for Mental Health and IDD

For the millions of people who regularly watch hit television crime shows like “NCIS,” “Criminal Minds” and “CSI,” America’s law enforcement officers appear consumed with trying to outsmart the bad guys. Maybe so, but in real life they’re helping people suffering from mental illness and substance abuse instead of locking them up.

And although not riveting television drama, this newer direction is rapidly changing things for the better in Harris County, Texas, home of Houston. The center relies on state and county funding for the second-largest uninsured population and the lowest per capita of funding for mental health.

The Harris Center for Mental Health and IDD has established a cohesive partnership with local law enforcement and their comprehensive psychiatric emergency programs (CPEP). Specific collaborations include:

Crisis Intervention Response Team

(CIRT): A CIRT officer or deputy partners with the center’s licensed mental health clinician in the only program of its kind in Texas, and one of three nationally, to respond to the people with the most severe mental illness in the community. Prisoners can

also be assessed at city jails, and involuntary commitments can be transported from local center clinics to emergency psychiatric facilities. The Houston Police Department (HPD) has 12 teams while the Harris County Sheriff’s has eight.

Onsite responses to mental health-related calls sent less than two percent of individuals to jail, while 35 percent received psychiatric services. All other encounters were resolved on-scene or required no action.

Mobile Crisis Outreach Teams (MCOT):

In conjunction with CIRT, the center’s mobile outreach services provide first response and follow-up in the community and call in a CIRT team when required.

Chronic Consumer Stabilization

Initiative (CCSI): The center collaborates with the HPD—with its 5,300 sworn officers—to serve those diagnosed with serious and persistent mental illness resulting in frequent police encounters. Case managers redirect to the appropriate crisis service. The CCSI has reduced 911 calls to law enforcement by 70 percent and psychiatric admissions by one-fourth. Currently, 60 individuals need regular help.

Homeless Outreach Team: To reduce the homeless population, the center’s case managers and Houston police street officers collaborate with local government agencies and providers. Consumers get help with housing, social services and mental health treatment. The team even uses off-road vehicles and bicycles to enhance accessibility. Community policing keeps the community safe—and that includes the homeless.

911 Crisis Call Diversion Program: This new two-year pilot program supported by the Episcopal Foundation and Houston Endowment has already proven itself. Mental health phone counselors divert consumers away from police interaction toward more appropriate levels of care. This

new effort places a clinical team lead and trained phone counselors at HPD dispatch to respond to mental health-related code calls.

Normally, 911 calls require dispatch, but now a trained counselor can conduct a full assessment on the phone to help resolve the issue, establish a safety plan and follow-up. At least 9,000 dispatched calls last year did not require police action.

Mental Health History in the Making

The move toward improving outcomes between law enforcement and those with mental disorders took root nationally in the 1980s and in Harris County in 1991. The HPD is one of six national law enforcement/mental health “learning sites” dedicated to developing models to improve responses to those with mental illness. Curriculum specs still include hours of intensive training for all officer categories, while the police department’s Mental Health Division aligns with other community advocates such as Mental Health America and the National Alliance on Mental Illness (NAMI).

Officer Frank Webb is a sustaining force in the evolution of the partnership. He and his colleagues know that, like it or not, police are in the mental health business and that working with the center helps improve community safety. Still, all participants acknowledge they’d like find ways to be “more comfortable” with each other.

They’d also like to expand licensed clinician teams within the city, have more facilities for those in crisis and homes for those on the street. Also on their to-do list: collaboration with the fire department and other first responders and more registered nurses involved with consumer care.

OFFICERS IN CRISIS

Sharon Curran

Associate Executive Director of Clinical Services, Lenape Valley Foundation



Lenape Valley Foundation (LVF) is the primary crisis services provider for Bucks County, Penn., an area of some 620,000 residents about an hour's drive north of Philadelphia. In 2009, LVF developed the county's only crisis intervention team (CIT), a jail diversion program designed to improve the outcomes of police interactions with people whose behavior is influenced by mental illness, substance use or related conditions. More than 400 law enforcement officers now know how to recognize psychiatric distress, de-escalate crises and link people with appropriate treatment.

While the program helped foster recovery and reduce recidivism for thousands of individuals, a growing number of police officers now turn to the program to help themselves and their families. This unexpected development came about as officers began to know and trust CIT staff. As officers went through the weeklong training and learned to recognize the signs of mental illness, they started to confide in training instructors about their own struggles with mental health issues or those of family members.

Officers frequently show signs of post-traumatic stress disorder related to their work. Whether involved in a shooting or witness-

ing an act of violence, they describe feelings of depression and anxiety that begin to interfere with their ability to do their jobs. Often an isolated incident doesn't trigger the stress disorder; it is an accumulation of violent incidents experienced over time. Sometimes, because anger issues are likely to erupt at work or at home, a spouse or law enforcement partner suggests that they consider seeking help.

To protect their privacy, outreach by law enforcement officers to CIT staff is often informal. Confidentiality is critical for every client, but it is especially so for police officers. In Pennsylvania, officers who have been involuntarily committed are not permitted to carry a gun, a consequence that for many officers could spell the end of their careers.

As officers went through the weeklong training and learned to recognize the signs of mental illness, they started to confide in training instructors about their own struggles with mental health issues or those of family members.

Police officers need and deserve special consideration when seeking treatment. They cannot afford to have contact with people in treatment who they may encounter in their police work. LVF makes different levels of treatment programs available for first

responders. The goal is to tailor programs that both protect their privacy and work best for their particular needs.

Like the general population, law enforcement officials battle the stigma of mental illness, but the stigma they face is often more pronounced. Colleagues who become aware of an officer's mental health problem may believe he or she is incapable of doing the job or is simply unfit for duty. The good news is that as more officers learn the facts about mental health issues, they become more open minded and believe that treatment does work.

CITs nationwide should prepare for this unforeseen but welcomed consequence of working closely with law enforcement. LVF formed a mutually supportive partnership with police officers and other first responders, as this is a unique opportunity to serve first responders—the professionals who deal with many of the same stresses faced by behavioral health workers.

OVERCOMING A CRISIS OF CONFIDENCE

INCREASING PEER INVOLVEMENT IN CRISIS SERVICES

Eduardo Vega

CEO, Mental Health Association of San Francisco Bay Area

Director and Principal Investigator, Center for Dignity, Recovery and Empowerment

WE ARE AT A TIME OF CRISIS IN MANY WAYS.

Too many people are unserved; too many face injustice and poverty. Every year, one million people attempt suicide and 40,000 die.

Crisis services for mental health are at a pivotal point. We have too much to do, too much to change, too much to manage, too much unknown. We also have the opportunity to make a better future and redefine what is acceptable in the present.

There is a deplorable gap for people who have experienced suicidal ideation and those who continue to deal with it on a recurring or chronic basis. The failure of our communities, families and peers to be there in a meaningful way at our darkest hour is haunting. The shame and stigma that reinforce isolation when people are at their worst and the lack of viable support must be addressed. Too many people—more, it seems, every year—are not making it through that decisive moment to recover lives of dignity. Too many, mental health patients or not, can't access, see or believe that we can provide support to bring them out of darkness and despair.

Programs focus on containment, stabilization and reduction of the worst negative symptoms of distress. What we need are programs that are able to support people at their most difficult moments and help them through crisis with understanding. For people experiencing crisis, community-based alternatives that treat a client's unique experience as something to work with, rather than against, have greater capacity to support personal learning, healing and growth.

Those of us who have been there can be excellent resources to others at their hardest moments. Peers can relate in different ways to offer messages of hope and recovery and work to self-manage, coach and collaborate with providers in unique ways.

In a few settings, peer specialists are part of police or other first-responder joint-responder teams. Other peer-based programs include integrating peers on mobile crisis and outreach programs, peer-support groups for those in crisis and wellness recovery action plans for self-care and crisis planning.

For people experiencing crisis, community-based alternatives that treat the unique experience of the client as something to work with, rather than against, have greater capacity to support personal learning, healing and growth.

Many communities are just now trying peer respite settings. Rose House in upstate New York and related extended-stay peer respite "homes" have proven valuable in reducing and preventing crisis. New York City's Parachute program, funded through a CMS innovation grant, is testing integration of peer support through hotlines and site-based peer respite in all five boroughs. Pure peer respites run by consumer-run organizations and hybrid programs that include non-peer clinicians or managers continue to show value by keeping people housed and reducing repeat hospitalization and utilization costs for public sector clients.

The idea that people with diagnoses and histories of psychiatric hospitalization could be helpful to others in crisis—even suicidal—would have seemed revolutionary, perhaps ludicrous years ago. Unfortunately, most peer respite programs, peer-support groups, warm lines and other programs are reluctant to work with people during their toughest moments.

To date, only one peer respite program accepts people with active suicidal thoughts and on a very limited basis. Framed as risk-management or liability concerns, this fear of suicide often prevents people from receiving compassion and understanding from providers or peers outside the "box" of inpatient care. Stigma has kept peer-support groups for people with suicidal thoughts and feelings unexplored, undervalued and often treated with suspicion.

The crisis is one of confidence and community. It is a moment of intense challenge for us to face and struggle through together. If we can move through this crisis as a nation, as people, as peers, as providers and as communities, we can make great change happen. And we can save many lives.

We have the opportunity to put a new model of care into place that we know can work. To energize hope and progress with alternatives for crisis support, to make accessing help in time of need something that doesn't come with fear, shame or troubling implications. We can ensure that people in distress get the care they need when, where and how they need it to move through their toughest moments to recovery and hope.

Crisis Averted The Power of Peers

Steve Miccio
CEO, PEOPLE, Inc.

There is hope.
You are not alone.

Even though every story is unique, there are others who have faced, endured and overcome similar mental health crises (overwhelming emotional distress and/or trauma). They are your peers and they can help. There is hope!

This is the promise of Rose House, one of four crisis respite houses operated by Projects to Empower and Organize the Psychiatrically Labeled, Inc. (PEOPLE, Inc.), serving six counties in New York.

The mission of the Rose House model hospital diversion program is to avert crisis by providing individuals in the community easy access to support based on the concepts of independence, empowerment and active involvement with treatment and recovery.

As a model hospital diversion/respite program, it offers options for managing or working through difficult times while living in the community. It is a safe, supportive, empowering alternative to traditional services and inpatient admissions that is person-centered and respects the choices of the individual. And, like all PEOPLE programs, it is peer-operated with peer companions providing a level of support and understanding that can only come from someone who has lived through crisis and adversity.

Our objective is to teach people how to think about crises during or prior to critical events. Through the education process and mutual engagement, we have reduced the number of emergency room and in-patient hospital admissions.

Through dialogues, surveys and outcome measurements conducted over the 15 years that Rose House has operated, four major components have emerged that we believe lend to our success: engagement, a philosophy of wellness and recovery, a trauma-informed environment and mutuality of lived experience through our peer companions.

Engagement: During the engagement phase, we explain the purpose of the house and clearly discuss expectations for both the house and the guest so there is no ambiguity. While environment and philosophy are important building blocks supporting the design, engagement is vital to creating a safe, empowering and self-determined learning community. Successful engagement allows guests to move from crisis to calm. Ultimately, it will lead toward a more self-determined and improved quality of life with new ways of thinking about crisis.

Philosophy of Wellness and Recovery: Many of the staff at PEOPLE, Inc., lived through traumatic experiences within the mental health system and are living proof that recovery is possible. All of our core values reflect our beliefs and behaviors toward wellness, and we constantly train and reinforce our values and beliefs.

Environment: Each house is trauma-informed, physically pleasant and welcoming with ample privacy and the opportunity for one-on-one engagement with a peer companion. Above all, they are comfortable and safe. The staff at each house takes great care to ensure that all areas are welcoming and engaging. A weekly survey ensures

that all aspects of a trauma-informed environment are maintained.

Mutuality: The term mutuality means that we have lived experiences of trauma and diagnoses of mental health issues. When a guest comes to one of our houses, it offers an immediate connection and bonding that delivers a different or improved level of trust and transparency where people feel safe talking about difficult issues. This engagement and relationship helps educate guests about alternative ways to speak with a therapist, psychiatrist or provider to achieve different results. It also offers an open environment to share challenges and successes in people's lives resulting in a calmer and more focused strategy in moving toward wellness.

Additional services that have grown out of the original diversion/respite include assigning mobile peer companions to visit people in their homes, a training program, 24/7 warm/support lines, social activities and meetings in the community and follow-up or "bridging" services to ensure that guests utilize supports in the community to reduce or eliminate the need for emergency crisis services.

The Rose House diversion/respite have reduced emergency room and in-patient visits for more than 94 percent of the people using our services. It has also resulted in a continuum of care and integrated partnership with many traditional services in our communities. We work closely with local treatment providers and mobile teams to ensure that we serve every person all of our communities efficiently and effectively.

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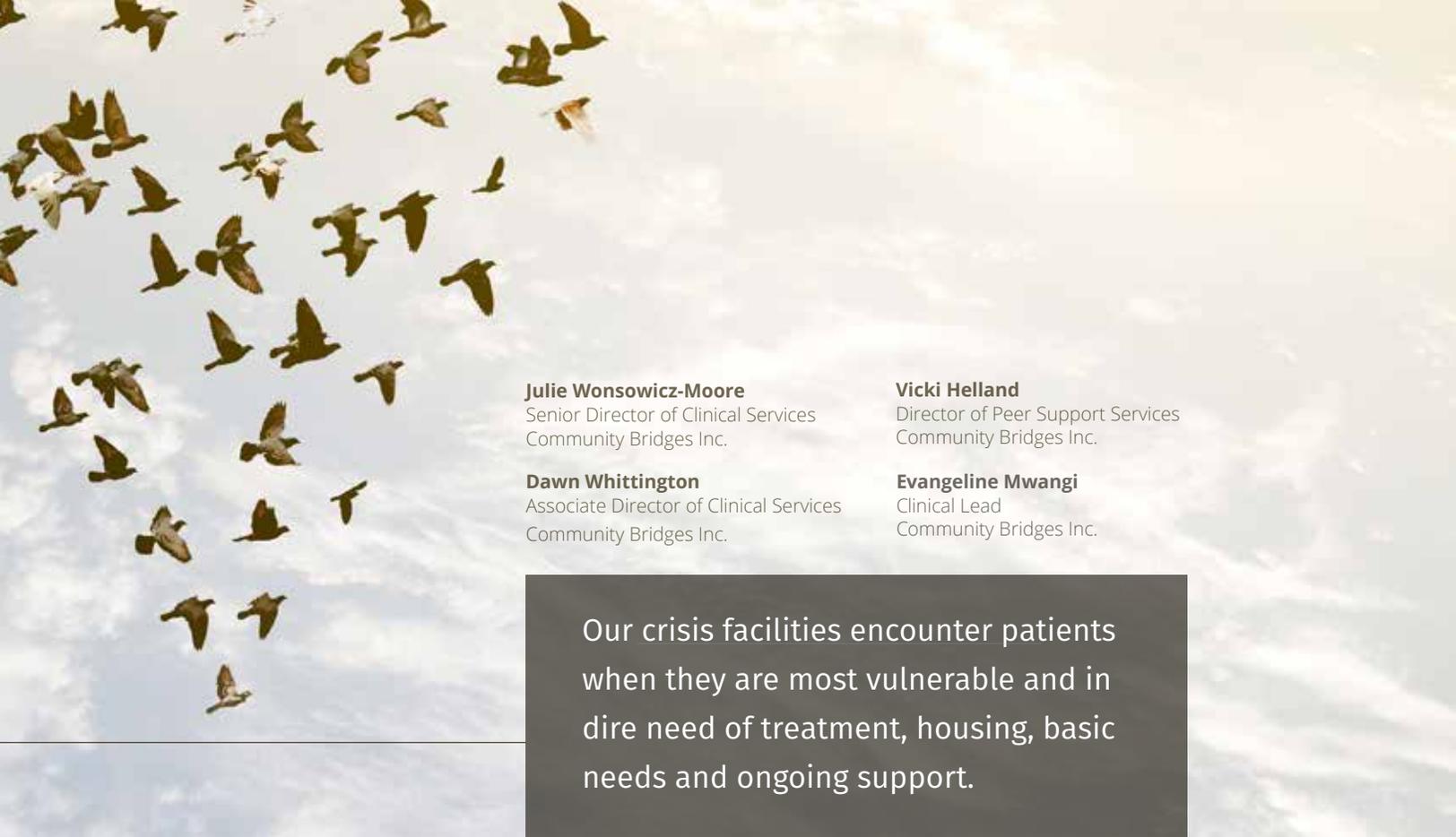
Crisis stabilization is at the crossroads of the war on chronic homelessness, mental illness and substance abuse.

At Community Bridges, Inc., we offer a continuum of fully integrated medical and behavioral health care services, including inpatient and outpatient detox, crisis response teams, 23-hour crisis observation units, outpatient programming and peer support and navigator services. Crisis stabilization services include emergency interventions that can last up to 23 hours and provide relief for hospital emergency rooms and emergency psychiatric centers.

Our crisis facilities encounter patients when they are most vulnerable and in dire need of treatment, housing, basic needs and ongoing support. We noticed the same individuals frequenting our facilities and knew we needed to take a different approach to support them toward recovery.

We developed an intensive treatment team consisting of peer support specialists and navigators, program and nurse managers, clinical leads and director-level staff and compiled a list of patients with multiple admissions. When one of the patients on the list presents at one of our facilities, the team mobilizes to meet with the patient.

Make-up of the team varies from site to site; however, there is always a peer navigator. This position is one of the most crucial elements to the team because the peer navigator uses shared experience to instill hope and establish trust and rapport.



Julie Wonsowicz-Moore
Senior Director of Clinical Services
Community Bridges Inc.

Dawn Whittington
Associate Director of Clinical Services
Community Bridges Inc.

Vicki Helland
Director of Peer Support Services
Community Bridges Inc.

Evangeline Mwangi
Clinical Lead
Community Bridges Inc.

Our crisis facilities encounter patients when they are most vulnerable and in dire need of treatment, housing, basic needs and ongoing support.

“Jeff’s” story illustrates how this team makes a difference.

Following his release from prison, Jeff was homeless and drinking daily. He was admitted to Community Bridges facilities on numerous occasions during a 90-day period. In February 2015, Jeff met with our intensive treatment team to talk about what they could do to make a positive impact in his life. With Jeff, the team addressed his needs, set goals and established an initial plan to meet these needs and goals. His peer navigator worked with him every step of the way to make sure he could get to meetings, doctors’ appointments and counseling sessions. Jeff’s treatment started with visits nearly every day to make sure that he was doing well and to see if he needed anything. Slowly, the team became more than support—they became family. As he settled into his new life away from alcohol, he needed fewer visits and he achieved more of his goals.

Jeff is now employed by the group recovery center where he lived after the initial team meeting. He says he can finally look in the mirror in the morning and is happy. Since his first meeting, he has not had any crisis admissions and is seven months sober.

Our mission is to maintain the dignity of human life. Jeff’s story is one of many that inspired us, in collaboration with fellow crisis agency La Frontera EMPACT, to develop the Comprehensive Community Health Program. The program now has 68 members who receive the same lifesaving services as Jeff with plans to grow to 500 members.

At the **Safe Harbor** Peer-Run Crisis Diversion Program, safety and support are only a phone call or quick visit away.

Many organizations run crisis support programs, but Safe Harbor is unique. The program is led by peer support specialists—people who have experienced mental illness and are in recovery.

Safe Harbor, operated by Community Alliance in Omaha, Neb., assists adults with mental illness who are experiencing crisis-inducing stress that does not require immediate psychiatric care or hospitalization. It operates a warm line that receives calls 24/7 and a guest facility with the ultimate goal of diverting a psychiatric hospital stay.

Community Alliance developed a 56-hour training curriculum with six core modules in a face-to-face classroom environment to prepare peer support specialists to defuse crisis situations and create a safe environment to plan the next steps in treatment. The training incorporates Wellness Recovery Action Planning (WRAP) and Living Well to provide the core skills and competencies required of a peer support specialist.

It enables them to use their own personal recovery experiences to

help others set and achieve their own goals, establish positive relationships, encourage independence and reinforce the importance of self-care and advocacy. Graduates are prepared to take the Nebraska exam to become state-certified peer-support specialists.

Equipped with these highly qualified peer support specialists, Safe Harbor receives approximately 900 calls to the warm line and 30 in-person visits per month. The average guest stay is around three-and-a-half hours, but as a crisis diversion program, guests can stay up to 24 hours.

When people call or come in, Safe Harbor staff doesn't attempt to define the crisis—they let the individual define what it means for them.

When people call or come in, Safe Harbor staff doesn't attempt to define the crisis—they let the individual define what it means for them. The peer support specialist may simply invite them to rest for a few minutes in one of the recliners in the Relaxation Room and listen to soft music. When the person in crisis is ready, peer staff begins a conversation about pressures, stress and anxiety. They then

work together to develop a plan and make connections to resources in the community.

The program is a natural fit for Community Alliance whose mission is to serve adults and equip them to live, work, learn and contribute in their communities. They hope the program will continue to grow and have a significant impact on the admission percentage at local hospitals as more and more patients are diverted from the hospital and are able to stay home by using Safe Harbor.

Peer Support Makes for a Safe Harbor



Aileen Brady | Chief Operating Officer, Community Alliance

The training culminates with a graduation to inspire participants and prepare them for the work ahead. Not everyone begins paid employment after completing the curriculum, but it positions people in recovery to gain employment.

Safe Harbor works constantly to add more people into the trainee pipeline. Not only does training help prepare graduates for employment, it ensures a pool of trained individuals for the program.



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Michelle Jermunson

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Intellectual

Recognizing creative abilities and finding ways to expand knowledge and skills

Environmental

Good health by occupying pleasant, stimulating environments that support well-being

What does someone in crisis do if they don't fit the criteria for admittance to a crisis stabilization facility? How does someone returning home from a psychiatric hospital continue recovery? What does someone without a vehicle do to access support? In Gallatin County, Mont., the answer to all these questions and more is, "A recovery coach comes to them."

In Gallatin County, recovery coaches are in long-term recovery and complete 40 hours of peer support and 40-hour crisis intervention training (CIT). In addition, they participate in continuing education and receive clinical supervision. Any person who has mental health challenges, addiction, substance abuse issues or co-occurring disorders can be referred to the program.

Since officers and deputies are often the first to encounter individuals in crisis, Montana's Peer Network partnered with the local law enforcement CIT to help people who could use additional support through the recovery coaching program. The recovery coach is another tool law enforcement can bank on.

Law enforcement lets people in crisis know about the program. If they are interested, the recovery coach follows up and sets a meeting. Meetings may take place in the person's home, at a coffee shop, on a hiking trail, in a hospital room, over the phone or anywhere that works for both the individual and recovery coach.

Recovery coaching focuses on the individual's ideas for recovery in the framework of the Substance Abuse and Mental Health Services Administration's eight dimensions of wellness. Each meeting is different. One may involve chatting over a cup of coffee, working through a crisis, building a recovery plan, resourcing to services in the community, skill building, going for a walk or advocating for the rights and needs of the individual. There is incredible power in just being with someone and providing support through self-directed recovery.

One person joined the program after a year of near continuous hospital, behavioral health unit and crisis stabilization center stays. She met weekly with a recovery coach and now it has been more than a year since she had a crisis-related stay. She volunteers, manages her own budget, has a healthy support system, maintains a good relationship with her family and has a self-directed, fulfilling life.

Another person called law enforcement multiple times a week. After recovery coaching, he made no calls to law enforcement. He got two jobs, sold his house and eventually moved closer to his family.

Meetings may take place in the person's home, at a coffee shop, on a hiking trail, in a hospital room, over the phone or anywhere that works for both the individual and recovery coach.

This program also supports law enforcement and other agencies by helping coordinate and share information. People tell the recovery coach what might be helpful if another crisis arises—things like ideas for how to de-escalate, people to call and things to avoid. This information is then supplied to the appropriate agencies, with the individual's consent. This approach decreases time on crisis calls and helps divert individuals from more intense and costly crisis intervention.

The coordination of recovery coaching and community education helped divert an estimated \$298,502 from law enforcement, the state hospital, local crisis center and psychiatric evaluations in the first 18 months. The program cost for those 18 months was just \$118,000.

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Speaking from Experience:

The Gift of Peer Specialists



Andy Burr and Ashley Perry with Cheri Donovan.

Michael J. Yates

Director of Development,
Ridgeview Behavioral
Health Services

“Peers bring a unique interaction that clinicians can’t provide. It is simply the gift of lived experience. They are crucial members of the team in helping people who are in crisis.”

—Andy Burr

Life is not always easy and sometimes we need a little help along the way.

Trauma, unemployment and a 16-year history of periodic hospital care defined Cheri Donovan’s life. She remembers these challenges all too well. Today, she speaks with the gift of lived experience as a certified peer recovery specialist and a member of Ridgeview Behavioral Health’s mobile crisis team.

“The stigma that surrounds seeking mental health treatment is so strong,” she says. “I know what it’s like. People in crisis need to know that they are important and that they can get better one small step at a time. It’s so important to know you’re not alone.”

For individuals hurt by life’s challenges and living with mental illness or addiction, peer specialists like Cheri give the gift of having been there. They speak with vulnerable courage and people listen. As Cheri explains, “I’m there to provide empathy and support because when you’re sitting in a crisis under extreme stress, it’s hard to trust people and not feel judged.”

Ashley Peery, lead clinician at Ridgeview, describes how peer specialists add value to the team, “When I conclude my clinical crisis assessment and step away to network with community resources, peers can step in during this very vulnerable, tender time. Through their lived experience, peers help address a person’s anxiety, fear and loneliness to support the transition to a hopeful outlook and the appropriate level of care.”

Ridgeview’s peer specialists complete a rigorous specialized training recognized by the Tennessee Department of Mental Health and Substance Abuse Services based on recovery and resiliency principles. In addition to serving as role models, peer specialists work closely with mental health clinicians and psychiatrists to complement the care of the crisis team and provide support for clients in outpatient and inpatient settings.

Cheri sees her role with the mobile crisis team as very different from the traditional role of peer support, “When doing traditional peer support services, I see folks

immersed in their recovery and healing—they’re getting better. As a team member, my contact is a brief window of time when individuals may be their sickest and things may feel most bleak and

painful. I’m there to support their transition to a road of better mental health and recovery.”

Andy Burr, director of Ridgeview, says, “Peers bring a unique interaction that clinicians can’t provide. It is simply the gift of lived experience. They are crucial members of the team in helping people who are in crisis.” He also notes that the certified peer specialist staff earned a 95 percent rating.

Peer specialists play a crucial role by offering hope and comfort to individuals experiencing acute mental health crises as members of Ridgeview’s mobile crisis team. They offer a compassionate voice and steady hand through the lens of lived experience.

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VIRTUAL TEAM TAKES PATIENTS OUT OF THE ER AND INTO TREATMENT

John Santopietro

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Carolinas HealthCare System

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Assistant Vice President
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Carolinas HealthCare System (CHS) is not a community mental health center. It is a big, not-for-profit, integrated system with 39 hospitals, 900 care locations, 60,000 employees and a budget of more than \$8 billion.

That said, up to one in five of the one million patients served yearly by the service system present with a mental health problem.

This is no more evident than in the 35 emergency rooms at CHS. North Carolina has twice the number of patients stuck in emergency rooms with psychiatric crises compared to the rest of the country, with wait times averaging 30-40 hours. Our system was no different.

When CHS created a service line for behavioral health in 2013, the idea was to identify problems like this and find solutions.

CHS has done telepsychiatry consults in rural emergency rooms as far back as 1997, but that wasn't enough to solve this problem. A team was formed in 2013 to find a solution. As with most PDSA (plan-do-study-act) improvement projects, it started with an objective measure of the problem—an average wait time of 40-plus hours for patients presenting to ERs with

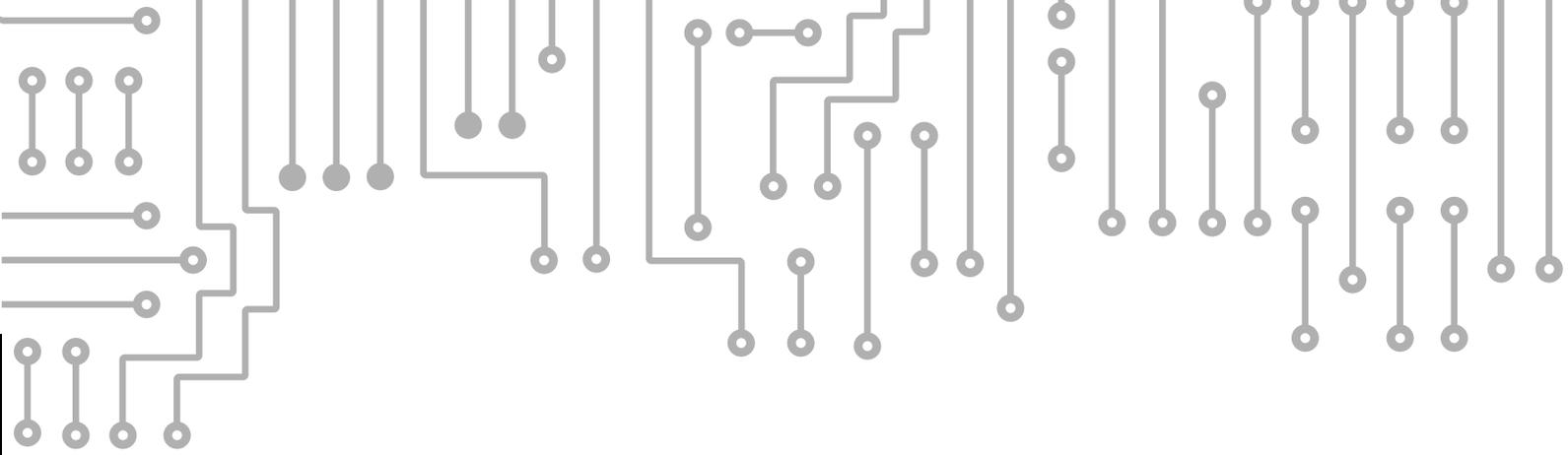
mental health problems. Then it set about to find a solution.

The fix was a small but strategic team, deployed "virtually." This team—comprised of a small, rotating group of psychiatrists, nurses, social workers and an incredibly talented and well-respected bed manager—is located not in the medical emergency rooms but back at behavioral health headquarters. The team now proactively "rounds" on patients in 19 medical emergency rooms by monitoring the electronic medical records and communicating via phone and video with emergency department staff and patients.

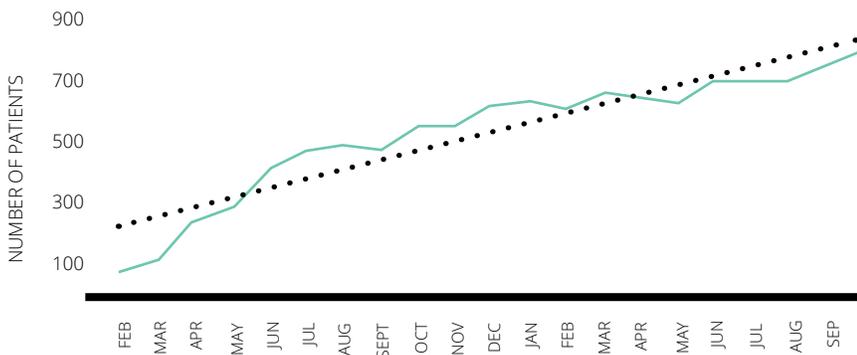
The emergency department physicians allow our psychiatrists to enter orders directly in the medical records after telepsychiatry evaluations so there is no unnecessary wait for treatment to start. We also contract with a company that transports patients requiring hospitalization (both voluntary and involuntary) where previously the patient would wait hours for law enforcement to do so.

This group, in effect, provides team-based psychiatric care for patients in 19 emergency rooms and has resulted in a dramatic decrease of 50 percent in the average length of stay—from 44 hours to 22 hours in the first year. The current median is 17.2 hours.

THE EMERGENCY ROOM IS GENERALLY THE LAST PLACE SOMEONE WANTS TO BE WHEN IN CRISIS.



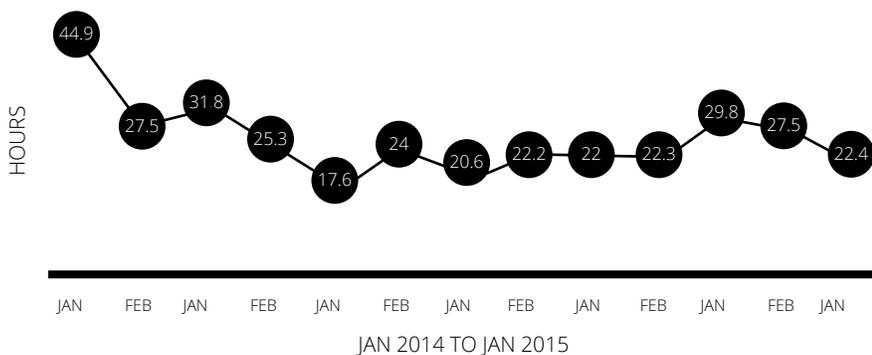
PATIENTS PLACED BY CENTRAL PLACEMENT TEAM



The emergency room is generally the last place someone wants to be when in crisis. Where patients would spend hours or even days without the care of a psychiatric team, they now get coordinated and personalized care quickly. This means faster treatment and stabilization right in the emergency department and those who need hospitalization wait less.

The team-based, virtual, offsite care has had added benefits. It is much easier to scale, easier to develop team cohesion and easier to leverage workforce to, for example, manage the shortage of psychiatrists we face in all states. The offsite team also has an economy of skill—like leveraging the wizard-like talent of our best bed manager across a system instead of confining the person to one silo. It also eliminated duplication of effort—instead of multiple simultaneous and competing referrals to hospitals, now we prioritize those patients strategically as a system, based on who most needs hospitalization and target referrals.

PSYCHIATRIC EMERGENCY DEPARTMENT LENGTH OF STAY



In the end, this isn't rocket science. This is the care our behavioral health workforce provides day in and day out. The difference is that our team found a way to bring this care to the patients stuck in the "far away" outposts of our system's medical emergency rooms. Our work isn't done—17 hours is still too long for an emergency room visit. But we are well on our way.

**IN THE END, THIS ISN'T ROCKET SCIENCE.
THIS IS THE CARE OUR BEHAVIORAL HEALTH
WORKFORCE PROVIDES DAY IN AND DAY OUT.**

When Help Isn't Requested

Using Telehealth During Involuntary Holds



Abigail Tucker

Clinical Director, Community Reach Center

When Coloradans with mental health, substance use or emotional problems wonder, “When can I get help?” Community Reach Center answers the question—sooner rather than later.

Colorado Crisis Services is a statewide initiative to strengthen Colorado’s mental health system championed by Gov. John Hickenlooper and supported by the Colorado Department of Human Services, Office of Behavioral Health. As a provider partner with Colorado Crisis Services, Community Reach Center launched a 24/7/365 walk-in crisis center in Westminster, Colo., on Dec. 1, 2014, and a crisis stabilization unit in March 2015.

Anyone can call the Colorado Crisis Services Support Hotline 24 hours a day or access one of the six walk-in crisis centers in the metro-Denver region. Since opening the walk-in crisis center, we’ve helped more than 800 people on their journey to mental health—including visitors to our state’s powdery ski slopes who have contacted us during crises while they’re away from home.

A New Use for Telehealth

But, as we know, not everyone in crisis will reach out for help or support. In Colorado, only certain professionals—including law enforcement, licensed therapists and nurses—can involuntarily hold an individual for 72 hours for an emergency assessment and evaluation if there is evidence of imminent suicide or homicide.

During that period, a psychologist, psychiatrist or physician must complete a second assessment to determine whether involuntary commitment is still required or if the crisis is ameliorated and the individual can return to outpatient care. Until a year ago, this process took place primarily in emergency departments staffed by health care professionals.

Instead of traumatizing clients by sending them back to the ED to remove their hold, a plan can be implemented without delay.

Thanks to the innovative and progressive thinking of Rick Doucet, CEO, and Tamara Player, COO, Community Reach Center became the first crisis program in Colorado to institute telehealth services for involuntary assessment purposes.

Now, a person on 72-hour hold receives assessment, treatment, case management and peer support services—all in the same location at our walk-in center. When the crisis team determines that the individual no longer needs involuntary treatment and a discharge plan developed, we use telehealth so that a qualified professional can complete an evaluation from wherever they are. Our community emergency departments (EDs) do an amazing job saving lives, but unlike community health providers, they

aren’t always oriented to the philosophy of trauma-informed care.

Getting People Back to their Lives Faster

Telehealth technology supports rapid response and fiscal sustainability of crisis services. Its use also means that instead of traumatizing clients by sending them back to the ED to remove their hold, a plan can be implemented without delay. That’s especially important when holds are dropped on a weekend or in the middle of the night and the client is ready to be treated voluntarily. Telehealth is smart economics since we know it’s not financially sustainable to staff a unit full-time with a psychologist or psychiatrist to do assessments or dispense medications.

Through secure telehealth technology, health care professionals already employed at the walk-in crisis center can conduct a “face-to-face” interview from their off-site location, since a psychologist is always on call.

This efficiency does so much to ensure clients get “back to their lives.” That means getting back to work, family and additional mental health resources without having to remain in the crisis unit the next business day. Telehealth expands our geographical reach and gives our clients one-on-one attention when they need it most.



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Texting Puts Help at their Fingertips

Based on an Interview with

Liz Eddy

Director of Communications and Events, Crisis Text Line

THE AVERAGE AMERICAN SENDS AND RECEIVES 32 TEXTS PER DAY.

The average teenager sends a staggering 3,339 texts and girls send nearly 4,000 every day! And this text-hungry demographic opens every single one. Texting is the most popular data channel in the world.

Now texting has become an emotional lifeline for thousands of teens nationwide who are bullied, abused or engaged in family conflicts they often can't avoid. Crisis Text Line was founded on the premise that it makes sense to meet people, especially teens, where they are, on their cell phones while texting. If they're experiencing depression, eating disorders, sexual abuse or suicidal thoughts, they want and need someone to "talk" to right now.

Now they can do just that.

Crisis Text Line users are 70 percent young people and 30 percent older. It receives about 40,000 texts each day—and has responded to over 13 million since start-up—and it's growing exponentially.

A Great Idea

Here's how it works. Users text 741741 from anywhere at any time and receive a quick initial response from a trained crisis counselor who utilizes proven techniques such as active listening, empathy and paraphrasing to help them move from a "hot moment" to a "cool moment." With the near-term crisis in check, for long-term help they receive referrals to counseling and other services as they move toward a sustainable solution.

Communication is entirely by text and is totally anonymous. Texts are free with major mobile carriers and time spent doesn't appear on the user's cell phone bill. It's important to note, however, that T-Mobile's prepaid plan doesn't allow a "short code" like the line's 741-741.

The founder and CEO of Crisis Text Line, Nancy Lublin, knows this is a logical and highly effective way to help mitigate crises in today's high-tech world. She knows people may have all the gadgets they want, but that they still have problems.

She founded Crisis Text Line in 2013 when she was also CEO of DoSomething.org, the largest online youth organization for social change. That group frequently utilized texting, and one unforgettable text message from a girl being raped by her father spurred the concept of Crisis Text Line. It was an idea whose time had definitely come. Within four months, it was available in every U.S. area code.

Turn Up the Volunteer Volume

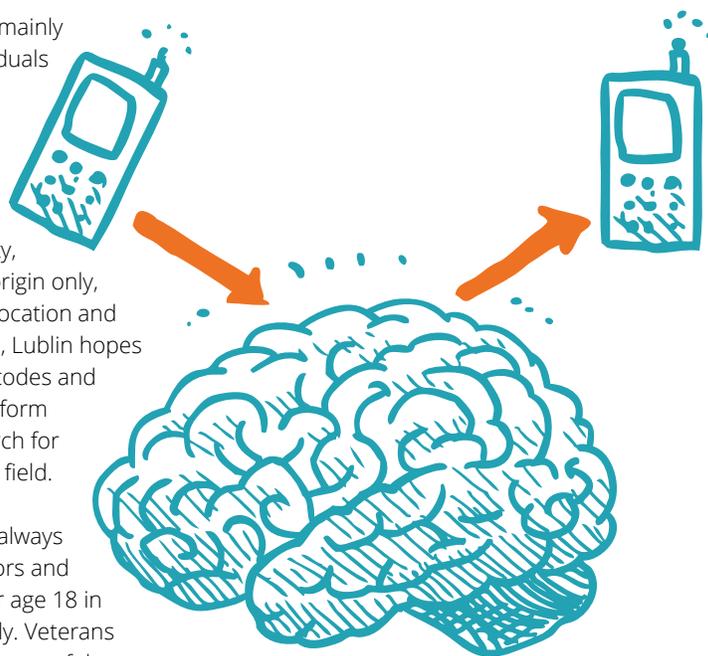
Thanks to the incredible power of social media, Crisis Text Line has spread the good word without traditional marketing. A few of its posts have gone viral on Reddit and Facebook, with users sharing how much the service benefited them or someone else.

Crisis Text Line is funded mainly by foundations and individuals who support the running and maintenance of its platform and technology, as well as data analysis. Because of the service's promise of user anonymity, data are shown by state origin only, even as algorithms track location and word choice. In the future, Lublin hopes to aggregate data by ZIP codes and to share it at no cost to inform schools, policy and research for the greater mental health field.

As it grows, the service is always looking for more counselors and welcomes volunteers over age 18 in the U.S. and internationally. Veterans comprise a strong component of the counselor community, especially those with disabilities, as do the deaf and hard-of-hearing.

Crisis Text Line users are 70 percent young people and 30 percent older. It receives about 40,000 texts each day and has responded to over 13 million since start-up.

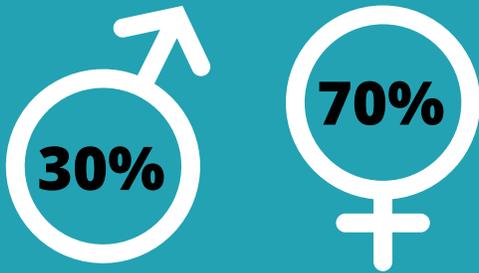
Prospective counselors fill out an application and, if approved after a background check, undergo 34 hours of training. They connect with a trainer and role-play with classmates before the final evaluation. Once on board, they work remotely four hours a week with a Web-based platform, so counselors need a reliable Wi-Fi connection and computer. Thanks to the power of cell phones—and of Crisis Text Line counselors—no one has to be alone in crisis any more.



AN UP-CLOSE LOOK AT CRISIS TEXT LINE



Who Texts?



How Many?

12 Million

Almost Messages Received

1 Million Per Month



Peak Trends by Time of Day

6:00 – 9:00 a.m.

Sexual Abuse.

12 Noon and 10 p.m.

Suicidal Ideation.

7:00 p.m.

Family Issues.

Why do People Text?

Depression	27.7%
Stress	21.4%
Suicide	20.0%
Family Issues	16.7%
Romantic	13.6%
Self Harm	12.3%

It's a Growing Business



Today

1,389

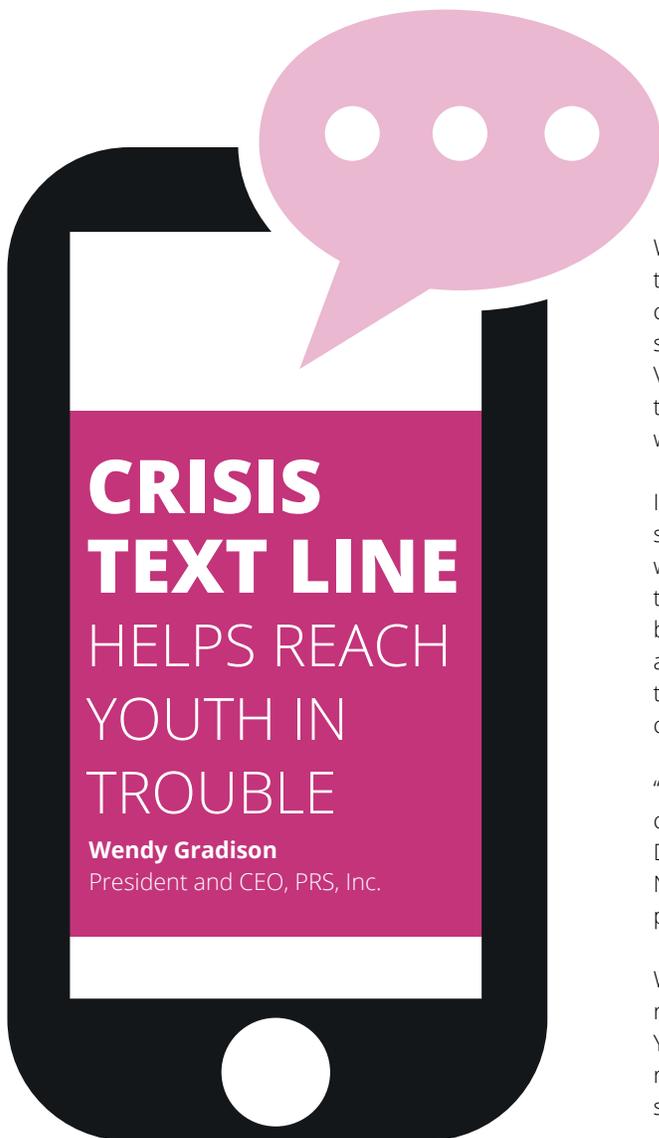
Trained Volunteer
Counselors

.....

1 Year Ago

99

Trained Volunteer
Counselors



No community is ever really prepared for a youth suicide crisis.

When the Fairfax County Public Schools (FCPS) in Fairfax, Va., lost four students to suicide within two weeks in the spring of 2014, the first reaction was fear and concern. But the community knew it needed to act fast to prevent more deaths. The school system approached PRS CrisisLink, the local crisis hotline located in northern Virginia, to consider creating a crisis textline to provide a new access point for youth to reach out when they experience suicidal thoughts—one that would connect them with local mental health care through developed partnerships.

In June 2014, PRS CrisisLink launched a crisis textline for FCPS, the 13th largest school system in the United States. Texts received through a computer platform allow crisis workers to work remotely and with up to two texters at a time. This increases capacity to serve more people with less staff. By October 2015, nearly 35,000 text messages had been exchanged and the textline expanded regionally, providing service to four counties and several cities 24 hours a day. Nearly 25 percent of young people contacting the textline were experiencing current thoughts of suicide and experiencing a high level of crisis. Nearly 90 percent said they felt better after speaking with a crisis worker.

“In a hurting community reeling from suicide loss, PRS CrisisLink provides a safe, consistent and caring place for young people to share their struggles,” says Program Director Laura Mayer. “They can text when they are home alone or with friends. No matter what, they always have access. The textline reaches young people on a platform they feel most comfortable—texting.”

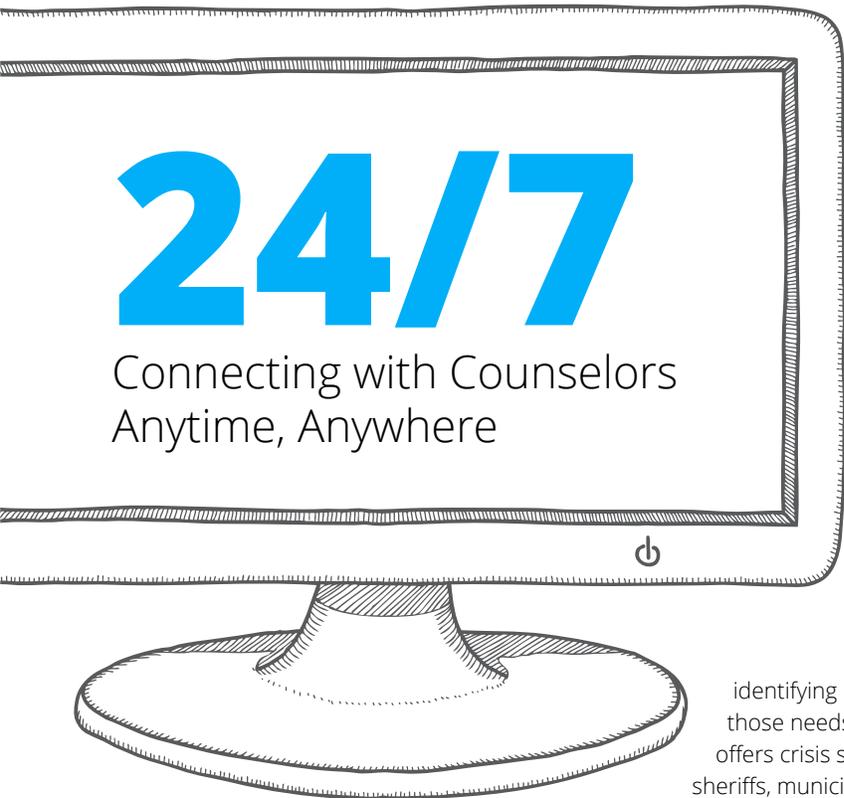
When we think about crisis mental health and treatment, communities have to recognize that delivery of care cannot always be in the therapy room for 50 minutes. Young people need help now. They need to know who they can call at any time and receive immediate help and hope. Our textline fills that gap and adds an additional safety-net for a community in crisis.

PRS CrisisLink recognized that to be successful, a collaborative community was essential to ensure that mental health access points and public safety answering points were communicating. Mayer explains, “We needed best practices in place beyond the walls of our crisis center. We needed partnerships, education and appropriate funding to ensure the best quality service we could provide.”

PRS CrisisLink used the National Emergency Number Association’s standard operating guide for suicide calls to start conversations with their local 911 centers. Using familiar standards reduced communication issues and supported their own internal processes. PRS CrisisLink also engaged the school system and mental health teams in local government community services by collaborating quarterly and providing feedback directly from youth experiences. Finally, the agency collects data to use in presentations community-wide to describe firsthand what youth have identified as challenges to needed care and supports. This data represents the community’s youth and shows administrators, parents and policy makers what youth are saying to inform decisions.

A year after the launch of the textline, PRS CrisisLink has handled over 6,000 text conversations and exchanged over a quarter of a million messages. Collaboration, effective marketing and funding have helped thousands of young people in crisis start their journey towards help.

Young people need help now. They need to know who they can call at any time and receive immediate help and hope. Our textline fills that gap and adds an additional safety net for a community in crisis.



24/7

Connecting with Counselors Anytime, Anywhere

Arnold A. Remington

Program Director, Targeted Adult Service
Coordination Program

When Nebraska law enforcement officials encounter people exhibiting signs of mental illness, a state statute allows them to place individuals into emergency protective custody. While emergency protective custody may be necessary if the person appears to be dangerous to themselves or to others, involuntary custody is not always the best option if the crisis stems from something like a routine medication issue.

Officers may request that counselors evaluate at-risk individuals to help them determine the most appropriate course of action. While in-person evaluations are ideal when counselors are readily available, officers often face crises in the middle of the night and in remote areas where mental health professionals are not easily accessible.

The Targeted Adult Service Coordination Program began in 2005 to provide crisis response assistance to law enforcement and local hospitals dealing with people struggling with behavioral health problems. The employees respond to law enforcement calls to provide consultation, assistance in recognizing a client's needs and help with

identifying resources to meet those needs. The no-charge offers crisis services to 35 sheriffs, municipal and other departments in 16 rural counties in the southeast section of the Cornhusker state.

Six months ago, the program offered select law enforcement officials a new crisis service tool: telehealth. Cideo conferencing makes counselors available 24/7, even in remote rural parts of the state. Officers can connect with on-call counselors for face-to-face consultations through a secure telehealth connection via laptops, iPads or Toughbooks in their vehicles.

The technology, which is in use in select jails and police and sheriff departments, is proving to be a win-win for both law enforcement officers and clients. Officers no longer have to wait for counselors to arrive for consultations. In rural communities, it is too common for officers to wait for up to two hours for counselors traveling from long distances. Online video conferencing gives officers the freedom to connect with counselors anytime, anywhere.

Telehealth also supports the Targeted Adult Service Coordination Program's primary goal of preventing individuals from being placed under emergency protective custody. The program maintains an 82 percent success rate of keeping clients in a home environment with proper supports. The technology promotes faster response times that mean more expedient

and more appropriate interventions for at-risk individuals, particularly those in rural counties.

So far, the biggest hurdle has been getting law enforcement officers to break out of their routines and adopt the technology. Some officers still want in-person consultations, a method that is preferable when counselors are available and nearby. But when reaching a counselor is not expedient and sometimes not even possible, telehealth can play an invaluable role.

Police officers' feedback on telehealth has been mainly positive. Officers often begin using the new tool after hearing about positive experiences from colleagues. As more officers learn that they can contact counselors with a few keystrokes from their cruisers, telehealth will continue to grow. The Targeted Adult Service Coordination Program plans to expand the technology next year by making it available to additional police and sheriff departments.

Telehealth has furthered the Targeted Adult Service Coordination Program's goal of diverting people from emergency protective custody and helping them return to being successful, contributing members of the community. This creative approach to crisis response provides clients with better care and supports reintegration and individual autonomy.

A Blended Concept An Ideal Alternative to Emergency Departments

Sheree Lowe

Vice President, Behavioral Health, California Hospital Association

Like people in other states, Californians with urgent mental health needs often have no alternative but to go to medical emergency departments. With their bright lights, chaotic atmospheres and noisy equipment, emergency departments do not provide the kind of calming environment conducive to healing for people struggling with psychiatric crises.

Emergency departments also have few staff trained in mental health, a serious problem given the large and growing volume of patients in need of behavioral evaluation. Of the 400 hospitals the California Hospital Association represents, more than 1.1 million patients in emergency departments required some level of behavioral health intervention in 2011. Behavioral health visits to these emergency departments increased 47 percent from 2006-2011 and trend data indicate that this number will continue to increase every year.

While the vast majority of people arriving at emergency departments with behavioral health needs do not have physical health conditions that qualify as medical emergencies, there are often no alternative behavioral treatment settings available on a 24/7 basis. This void forces hospital emergency departments, including those without behavioral health clinicians, to become the only available resources in many California communities.

Some California counties offer an innovative, effective and efficient treatment model that provides dedicated emergency behavioral health evaluation and treatment service. Known as psychiatric emergency services, the model is proving to be a more suitable

alternative for people in mental health crises. About 10 psychiatric emergency services departments currently operate in seven California counties.

With their bright lights, chaotic atmospheres and noisy equipment, emergency departments do not provide the kind of calming environment conducive to healing for people struggling with psychiatric crises.

Whether a psychiatric emergency services program is located in the community or the hospital grounds, it provides a far more calming and welcoming environment than an emergency department. Interiors typically have pleasing décor, low lighting, soft music and open spaces designed to foster healing and recovery.

Psychiatric emergency services programs provide accessible, professional and cost-effective services to people in psychiatric and/or substance abuse crises. Psychiatrists and other mental health professionals provide care on a 24/7 basis. Standard services include screening for all emergency medical conditions, medication management, laboratory testing, psychiatric evaluation and assessment, crisis intervention and stabilization and linkage with resources and mental health and substance abuse treatment referral information.

A psychiatric emergency services program can significantly improve access to quality care while decreasing costs to the health care system. When patients suffering from mental health disorders are taken to emergency departments, they often languish with no psychiatric assistance or intervention for hours or days until a mental health professional arrives to provide a psychiatric assessment. Then, they typically wait for an available inpatient psychiatric bed. These gaps in care delay treatment for patients and tie up staff time and beds in already overburdened emergency departments.

A recent study showed that the psychiatric emergency services model decreased boarding times more than 80 percent compared to overall California boarding times and led to stabilization and discharge without needing inpatient admission over 75 percent of the time.

The goals of health care reform include improved access to care, improved quality of care and improved timeliness of care, along with fewer hospital admissions and reduced costs. The psychiatric emergency services model helps meet all these goals. If replicated across California, the state could immediately improve patient outcomes, alleviate patient backlogs, free up ambulances and other emergency transportation providers and reduce the time that law enforcement officials spend in hospital emergency departments.

A psychiatric emergency services program is not a “medical emergency department” or a “community clubhouse model,” but rather a blend of both. It is community-based and based on the recovery model concept. It’s where healing begins.

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- Linda Rosenberg

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Pioneering Crisis System Solutions in Georgia: Managed Care Integration

Lawrence Goldman

Senior Vice President, Government Relations,
Beacon Health Options

James O'Leary

Vice President, Strategy and Development,
Beacon Health Options

Behavioral health crises and the risk of suicide touch us all, young and old, male and female, from every racial and ethnic group. Fortunately, there are well-established crisis alternatives that support individuals in their efforts to seek help and take an active role in their own recovery. These alternatives can produce better outcomes than crisis interventions that take place after a person is already in acute crisis. By providing services on an ongoing basis—before acute crisis occurs—we can help end the revolving door of hospitalization, incarceration and suicide. This not only improves people's lives; it also saves money.

In 2015, Beacon Health Options launched the Georgia Behavioral Health Administrative Services Organization (ASO) Collaborative to support and respond to Georgians in crisis while creating a new paradigm for safety and recovery. The goal of this crisis intervention process is to always know how to locate an individual in crisis, never lose contact and ensure

and verify that there is a safe hand-off to a third-party provider or service. Beacon, a behavioral health management company, working with the Georgia Crisis and Access Line (GCAL), leveraged state-of-the-art technology and an integrated software infrastructure for tracking all callers to ensure a warm hand-off to address the crisis event and build connection to care delivery.

The Collaborative's processes support a high assurance approach that:

- Embraces key objectives for safety, suicide prevention and recovery seamlessly.
- Empowers individuals and does not re-traumatize them.
- Perpetuates individuals' strengths, not failures, and instills hope.
- Provides faces and voices of lived experience that instill hope and a real example that recovery is possible.
- Promotes accountability with a track record that is data-driven, including technology to inform and ensure success.

- Provides services grounded in a specific expertise in crisis intervention for behavioral health and developmental disabilities.
- Shifts focus from the system to the individual.
- Uses peers as a key strategy of engagement and follow-through.

Prior to forming the collaborative, the system did not know with certainty, where individuals were receiving services so they were often unable to engage their direct caregivers/providers in time of crisis.

With the close integration of GCAL and behavioral health management services, the collaborative is able to act as a true single point of entry for high intensity crisis services, including:

- Working with all emergency rooms to facilitate transition/discharge by making urgent appointments at community crisis providers.

By providing services on an ongoing basis—before acute crisis occurs—we can help end the revolving door of hospitalization, incarceration and suicide. This not only improves people's lives; it also saves money.

- Tracking urgent community appointment capacity and presentation rates of individuals served.
- Tracking provider engagement rates of referrals of hospital/crisis stabilization units (CSU) discharges and urgent appointments.
- Coordinating care with assertive community treatment (ACT) and intensive case manager (ICM) teams by making referrals or engaging the team when their member is in crisis.
- Using enrollment information and last-time-served information to inform decisions and carry out short-term crisis plans.
- Using crisis plans and psychiatric advanced directives in an individuals' electronic health record to fulfill the person's preference and help keep them on their personal recovery path.
- Involving an individual's provider in crisis care, a process that is rarely possible in the current system due to disconnected information.
- Using medical and treatment history information generated from Medicaid claims state encounters to inform the referral process.
- Tracking state hospital referrals the same way CSU tracks referrals, which gives CSUs access to view individuals waiting for state hospital care and the ability to accept these referrals when their beds open to avoid unnecessary admissions and long waits.

Charles is a 45-year-old man living in Atlanta. He has a history of multiple psychiatric hospitalizations and crises interventions and is exhibiting auditory and visual hallucinations. He is resistant to engaging in mental health treatment. His mother contacts the GCAL call center and reports he suddenly stopped taking care of himself and has been seen talking to himself more frequently. She says Charles is drinking more and believes he may be using drugs again. She is afraid he will hurt himself.

While on the phone, call center staff accesses authorization data and claims/encounter data analysis through the ASO's integrated care management system that identifies Charles as a high-need individual. With this information—prior to his next crisis presentation—outreach is scheduled and a crisis prevention plan developed along with a referral to the appropriate level of case management.

In the future, if Charles shows up in the emergency room, GCAL staff will have access to a crisis prevention plan created by Charles with the help of a peer and/or the ICM clinician.

A TRAUMA-INFORMED APPROACH TO CRISIS SERVICES

Cheryl Sharp

Senior Advisor for Trauma-Informed Services,
National Council for Behavioral Health

HOTLINES AND MOBILE RESPONSE TEAMS

are integral parts of crisis services, but are those programs conducted in the most respectful and compassionate way possible? Are we conscious of how we act and what we say when involved with someone in crisis? Are we intentional in trying to minimize the trauma a person in crisis may be experiencing?

Trauma-informed care should be the thread that weaves through crisis services. Most people in crisis experience considerable trauma and have likely suffered traumatic events in their lives. For people with behavioral health problems, trauma is a nearly universal experience.

How common is trauma? The Adverse Childhood Experiences (ACE) study in 2012 showed that:

- 59 percent of the general population experienced at least one traumatizing childhood event.
- 80 percent of people in psychiatric hospitals are victims of physical or sexual abuse.
- 65-plus percent of people in substance abuse treatment report childhood abuse or neglect.
- 90 percent of women with alcoholism were sexually abused or suffered severe violence from parents.

SAMHSA's definition of individual trauma includes three key elements:

1. Trauma results from an event, series of events or set of circumstances that

is experienced by an individual as overwhelming or life-changing and has profound effects on the individual's psychological development or well-being, often involving a physiological, social and/or spiritual impact.

2. Trauma may result from emotional abuse, neglect, seeing a parent incarcerated, witnessing violence or even being involved in a car accident or a natural disaster. Whatever the cause, trauma's impact is deep, life-shaping and, particularly for people experiencing violence events, self-perpetuating.

3. Trauma can also affect crisis staff. Clinicians with histories of their own trauma may wish to avoid re-experiencing painful memories. They may respond personally to a client's emotional distress and view the behavior as a threat. They may even perceive a client's fear of closeness as a trigger of their own loss, rejection and anger.

Sometimes crisis service itself can be re-traumatizing. Callers to a crisis hotline may have their trauma exacerbated if they end up on hold for 30 minutes. A person in crisis who is handcuffed by police and treated like a criminal often feels less safe and more fearful. Seclusion and restraint can be extremely traumatizing and may only serve to worsen a person's emotional state.

The principles of a trauma-informed approach to crisis services include safety, trustworthiness and transparency, collaboration, empowerment and giving



TRAUMA-INFORMED CARE SHOULD BE THE THREAD THAT WEAVES THROUGH CRISIS SERVICES.

clients a voice and choice in their care and recovery. Treatment approaches must be recovery-oriented in crisis situations.

Trauma-informed organizations actively work to cultivate healing, safe, calm and secure physical environments with supportive care. Agencies should have a system-wide understanding of trauma-informed care and trauma's prevalence and impact. Trauma-specific services should work to maintain respectful, hopeful, honest and trusting relationships with clients.

Trauma-informed care can have broad and penetrating effects on a client's personhood. The approach has shown to decrease medication dosage, the number of critical incidents and seclusion and restraints. Organizations implementing the system should see increases in the diagnosis of post-traumatic stress disorder. They should also see increased patient and client satisfaction as well as internal and external customer satisfaction.

The good news is trauma is treatable. Healing and recovery is possible if we don't allow crises to define clients, but rather view these events as moments in their lives. We need to create a "behavioral environment" where staff intentionally conveys the opportunity for choices and empowerment for those in crisis.

10 STATEMENTS ALL TRAUMA-INFORMED CARE ORGANIZATIONS SHOULD ANSWER YES TO:

1. We are committed to increasing awareness and understanding of the principles and practices of trauma-informed care.
2. We want to ensure that we address the needs of those affected by trauma as an integral part of our strategic plan.
3. We want to ensure that we screen and assess for trauma for all we serve in a way that is sensitive and respectful.
4. We want to offer our customers a range of evidence-informed interventions and services that address trauma-related adaptations and difficulties provided by knowledgeable, skillful and culturally respectful staff.
5. We want our policy and procedures to be informed by the experiences and perspectives of consumers and involve them as employees/volunteers/advocates.
6. We want to ensure that our social and physical environment promotes healing and avoids re-traumatizing clients.
7. We want to ensure that our entire workforce is educated about trauma-informed care and know how they contribute.
8. We want to raise awareness of trauma-informed care with other organizations, programs and service systems that interact with our consumers.
9. We want to create an environment that supports staff who may experience work stress and vicarious trauma.
10. We want to use data to monitor and sustain our improvements.

Creating a **HUB** to Connect the Community

Jessica Fenchel

Senior Director, Adult Behavioral Health,
Access Services

When crisis happens, people can be caught between the silos of different providers and systems. Community agencies of all kinds—behavioral health providers, hospitals, police, homeless shelters and others—often struggle to develop a full picture of circumstances leading up to crisis.

How can communities better connect? The HUB: a semimonthly 90-minute meeting of people from agencies across the community to discuss cases of people in crisis or who may be at risk. The group includes members from local police, probation, children's crisis programs, homeless shelters, emergency rooms, psychiatric hospitals, the school district, victim services, women's centers, family services, mental health agencies and more.

Each meeting starts with a review of follow-up to cases from the last meeting; then, anyone can bring a new scenario to discuss. The group discusses each de-identified scenario for eight to 10 minutes and identifies risk factors, such as substance use, medical issues, risk of homelessness, etc., that may need to be addressed. The relevant agencies that have purview over the case can then plan an intervention separately outside of the meeting.

Basic, de-identified details of each case are captured in an Excel sheet to track the relevant factors, demographics, lead and supporting agencies, services and follow-up actions. Our program manages the data, but police and other groups can also manage and provide data.

STARTING FROM EVIDENCE

The idea for the HUB came from a promising program to help reduce the number of police interactions in Saskatchewan, Canada. Similar to the Canadian model, the group grew from a conversation with the police

chief in Norristown, Pa., the largest city in our service area and the jurisdiction with the highest number of police incidents.

The goal is to address complex human and social problems before they become police problems or crises. Police see the highest incidence of our social issues and bring most of the new scenarios to the group. As we've deepened our understanding of patterns that lead to potential crises, other agencies present more cases, such as overuse of services in emergency rooms or how drug-seeking behavior is exhibited.

STEPPING BEYOND WHAT YOU KNOW

Providers need to go beyond thinking about what they can do within their license or within their agency, and start thinking about how other community resources can help. Often, multiple agencies will know the same person. Our group started by looking at the people or their families who call police the most often and exploring all their potential needs. Through the HUB, we realized that we are actually a community rich in resources; the hard part is to get together to coordinate.

Starting the group meant first finding four or five people at other agencies committed to the value of collaboration and working together to map out our community to see who else needed to be involved.

There is no direct cost for the meeting, but we're all donating some time. Each agency gives at least three hours monthly to attend the meetings, and the time investment is more than worthwhile. The people we discuss are likely to reach a crisis point. We can come together proactively, or spend much more time reactively.

DRIVING REAL RESULTS

Through this connection, we start to understand the situations that form

crises and to see patterns. We are then able to use this information to prevent crises from happening. We are getting to know one another and building trust and approachability across our agencies through a better understanding of what we do.

Our clearest measure of success is the dramatic decrease in repeat calls to the police department. The police haven't reported additional calls from 70 percent of the repeat callers initially identified. Police cases overall are dwindling, in part because repeat cases are being resolved and because they now know where to direct people.

People are getting resources more quickly. This is partly due to the accountability factor that comes with tracking follow-up. You don't want to show up at the next meeting without any outcomes.

We also get the chance to talk to each other about important topics. We now have a relationship where we can go to the police to talk about how to provide information in domestic violence situations or how to talk to victims in a trauma-informed way.

CONTINUING TO IMPROVE

We are seeing more diversity in the agencies that attend and those who bring forward case studies—such as from housing and juvenile probation. We'd also love to see more participation from across agencies to affect change in the culture of the agency, not just the individuals who attend meetings.

The group is about becoming a part of the community, building our capacity and bridging services. People want to be a part of it and keep coming back because they value the connections made.

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As resources dwindle, the demand for behavioral health crisis intervention continues to increase. Centerstone combines innovation and technology to provide comprehensive crisis care to 20 mid-Tennessee counties. We believe we must offer a multilayered system in order to maximize our resources and provide quality, timely care.

The first element of our system is a virtual Crisis Call Center operating 24/7/365 and staffed by master's-level clinicians and peer specialists. Staff receives a full system of operation in their home, eliminating facility expense. This set-up allows us all the capabilities the staff has in one of our locations: silent monitoring, recording of calls, supervision and staff interaction. From 2014 to 2015, the Crisis Call Center handled approximately 30,000 calls, with staff responding telephonically and diverting approximately 63 percent from needing a face-to-face crisis assessment.

To provide around-the-clock coverage in our 20 contracted counties, Centerstone operates three Mobile Crisis Outreach Teams (MCOT). While some MCOTs across the United States have very defined target populations and response locations, our crisis service contracts with the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and the three managed care organizations operating our Medicaid program (TennCare) require us to respond to any location regardless of payer status.

Often, these crisis assessments occur in local emergency departments where individuals in behavioral health crisis tend to migrate. With the availability of innovative technology and partnerships with the Healthcare Corporation of America and TDMHSAS, Centerstone provides crisis assessment in many emergency departments via telehealth capabilities. Laptops and iPads are used for initial crisis assessments

follow-up and care coordination operated in our Crisis Call Center. To add this service, Centerstone approached Blue Cross Blue Shield of Tennessee Health Foundation for pilot funding. A one-year pilot, including an evaluation component, showed providing enhanced follow-up to those deemed high risk had a clinical as well as fiscal impact. The majority of individuals became engaged in and stayed established in care, did not



Being There 24/7/365

Becky Stoll

Vice President, Crisis and Disaster Management, Centerstone

Sarah Brawner

Account Supervisor, DVL Seigenthaler

and for physician interviews, at potential hospital placements or for patients being referred on an involuntary status. In fiscal year 2104 to 2015, these teams conducted 5,730 face-to-face assessments.

With the combined services of the Crisis Call Center and the MCOTs, Centerstone has an overall diversion rate of 85 percent for those who approach our agency in acute crisis. The final layer in our system is enhanced

repeatedly represent to emergency departments and no one in care died by suicide. With the groundwork laid, we partnered with TDMHSAS to secure a five-year Garrett Lee Smith grant for ages 10 to 24 with follow-up at 30 days, and a three-year National Strategy for Suicide Prevention (NSSP) grant for ages 25 to 64, with follow-up for one year. Individuals within these grants are assigned to one of three service packages: **1)** phone follow-up, **2)** telephonic and face-to-face follow-up or **3)** telephonic follow-up and a technology package within the NSSP grant for those with a chronic medical condition. The technology package provides a Fitbit and an iPhone preloaded with an application developed by Centerstone, specifically for this project.

We are excited about the opportunity these grants offer to not only provide sound follow-up support for extended periods of time, but to be able to evaluate the key components most effective in assisting this fragile population.



CENTERSTONE OF ILLINOIS: Centralizing Crisis Response

Verletta Saxon

Clinical Manager, Centerstone of Illinois

Centerstone of Illinois provides 24/7/365 crisis assessments, counseling and links services to youth and adults at local emergency departments, homes, schools and other community environments in Franklin, Jackson, Jersey, Madison, Perry and Williamson counties.

In 2012, we learned that 70 percent of the individuals experiencing a behavioral health crisis were sent home and referred for outpatient services and that local resources for adults who needed additional community support instead of psychiatric placement were non-existent. We were challenged to think of new, innovative and cost-effective ways to serve these individuals.

In July 2013, Centerstone of Illinois opened the doors of the Centerstone Crisis Center in rural Carterville, Ill., a specialized service for adults and youth experiencing behavioral health crises in the community. The Crisis Center offers onsite crisis assessments for individuals of all ages along with community stabilization for adults experiencing a behavioral health crisis.

Providing crisis assessment at this centralized location means reduced wait time, availability of peer support staff, follow-up services, reduced cost and immediate service provision. After the assessment, a referral can be made for outpatient behavioral health services, linkage to a psychiatric unit or to the Centerstone Stabilization Unit (CSU). The CSU is a short-term eight-bed community placement that provides case management, assessment, individual and group counseling, 30 days of follow-up and limited nursing care.

All Centerstone of Illinois services provide hope, growth and improved quality of life for individuals in crisis.



CENTERSTONE OF FLORIDA: Measuring Success

Mary Ruiz

CEO, Centerstone of Florida

To say Centerstone of Florida's reach in its Tampa Bay community is extensive is an understatement. The organization provides behavioral health services to one out of every 30 families.

And in 2009 the organization took a big step to curb overutilization of inpatient and jail settings among people facing a mental health or substance use crisis. That's when the organization partnered with the Florida Department of Children and Families and Central Florida Behavioral Health Network to launch a crisis behavioral health home for adults experiencing multiple inpatient admissions.

The Centerstone Crisis Behavioral Health Home focuses on care management for behavioral, medical and social challenges confronting clients and their families. The health home provides behavioral health services, facilitates criminal justice diversion and provides family therapy, education, housing, transportation, financial and recovery services. Partnerships with community services support transition from the behavioral health home in just a few months.

According to a 2011-2014 evaluation, the Centerstone Crisis Behavioral Health Home was highly successful in reducing crises requiring inpatient care. A three-year study tracked the episodes of care for 203 individuals six months before initiating behavioral health home services and six months after services concluded. The results were dramatic:

- 73 percent reduction in unplanned crisis admissions (from 322 to 88)
- 99 percent avoided planned state hospital commitments (174 of 176)
- 96 percent of individuals involved in the criminal justice system diverted from jail (22 of 23)
- 91 percent reduction of homelessness (from 55 to 5 people)

The analysis concluded that the Centerstone Crisis Behavioral Health Home provides a missing level of care between inpatient and outpatient. Most enrollees—89 percent—were able to succeed in the community with traditional outpatient clinic services after discharge from health home services.

Community-Based Alternatives to a System's Acute Care Needs

Steve Fields

Executive Director, Progress Foundation

Betty Dahlquist

Executive Director, California Association
of Social Rehabilitation Agencies

The most successful crisis residential programs emerge from a broad-based strategy of effective alternatives to hospitals, jails and other institutions.

Current efforts to reform mental health care in the United States revolve around a perceived lack of inpatient psychiatric beds to assist those experiencing a mental health crisis. The solution is to develop community-based diversion strategies, including outpatient crisis stabilization centers and crisis residential treatment programs.

One such program is Progress Foundation's Dore Street Urgent Care Center in San Francisco, a community-based response that provides acute behavioral health services, including 24/7 emergency crisis stabilization center and a 14-bed crisis residential program.

The Urgent Care Clinic provides assessment and triage responding to acute or escalating psychological crisis. By working closely with the San Francisco Police Department and other points of acute intervention, it diverts individuals facing involuntary treatment in an institutional setting to a community alternative. The Crisis Residential Treatment Program provides diversion from and an alternative to psychiatric, inpatient confinement in an intensive, 24-hour therapeutic environment. It primarily serves clients with a major mental health diagnosis and co-occurring substance abuse and/or physical health challenges.

The most successful crisis residential programs emerge from a broad-based strategy of effective alternatives to hospitals, jails and other institutions. The San Francisco area is fortunate that the public mental health system views diversion from hospitalization as a priority and the crisis response system is part of a long-term strategy to implement a diversion policy.

Without adequate coordinated follow-up services available, an acute crisis program will face many of the same challenges as traditional hospital service to ensure the lasting effects of intervention. Crisis residential programs that do not have transitional residential treatment programs too often must refer clients to inadequate housing or poorly supported living settings.

Acute crisis residential treatment programs do not require traditional medical model staffing patterns to be effective. Moving beyond a traditional staffing hierarchy allows a program to recruit staff, licensed or not, who are at ease with clients experiencing extreme psychiatric distress. In fact, mixing a variety of experiences and perspectives can enhance the probability that clients will connect with one or more staff member during their stay.

The multiple crisis residential programs operated by Progress Foundation in urban San Francisco and rural Sonoma County serve as acute diversion programs with a "no-refusal" goal for admissions. This means that the program does not screen out specific types of client behavior (e.g., recent suicide attempts, violence or recent alcohol or substance abuse). In the rare situations that the program is not able to successfully divert, it is because of particular individualized situations, not behavior.

The Progress Foundation programs are based on a clinical practice called "social rehabilitation," which emphasizes daily living skills, developing social-relational skills and the values of recovery and rehabilitation within a normalizing environment.

Moving beyond a traditional staffing hierarchy allows a program to recruit staff, licensed or not, who are at ease with clients experiencing extreme psychiatric distress.

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It's a Group Thing

BEHAVIORAL HEALTH CARE *IN TRANSITION*

Rebecca Strauss | Groups Coordinator, Turning Point Behavioral Health Care Center



Nothing lasts forever, not in life, and certainly not in the current, ever-evolving health care landscape. Here at Turning Point, state budget cuts have inspired innovation and determination about ways to operate so our low-income, vulnerable population does not feel a reduction of services.

Recovery-based mental health services help our clients of all ages feel and function better. In November 2014, approximately 10 percent of our clients with serious and persistent mental illness received troubling news: they no longer met medical necessity requirements for psychosocial rehabilitation (PSR) services and were given 90 days to complete their PSR groups and transition to a lower level of care.

In PSR groups, clients learn skills for coping, anger management, relaxation and stress management, independent living and socialization to support their recovery and function better in their lives.

Clients expressed feelings of abandonment and confusion at the discontinuation of this critical program and the loss of the productive

structure they depended on to help maintain emotional stability. They felt singled out. Many required additional therapy sessions to process the change without decompensation, such as preventing a relapse of self-harming behaviors. The symptoms of another escalated and required psychiatric hospitalization.

Instead of feeling a loss, our clients feel they've gained a new resource.

Protection of Connections

Clients looked forward to the productive structure and the skills-building learning provided in these groups, giving them purpose and a reason to "get up in the morning." For some it was their first life experience of interpersonal kindness, friendship and mutual support. Substantial research has shown that isolation can cause an increase in negative thoughts, symptoms and maladaptive behaviors. The opportunity for connection was a stabilizing factor in their lives.

As a client-centered mental health provider that survives on reimbursement for services, we had to be innovative and smart with any potential solution.

After deliberation and discussion, we fittingly created the "Transitions Groups" program. It complemented our mission to assist people in navigating change that is potentially frightening and disabling, yet replete with promise and hope. We knew that protecting their connections to structure, learning and to Turning Point were vital.

A Group Thing

The Transitions Groups are therapeutic groups that use a particular theoretical framework to address specific problems such as low self-esteem, poor impulse control, depression and anxiety. Transitions Groups allow clients to practice skills they learned in PSR while aiding in their transition to more community-based supports.

We facilitate four Transitions Groups that help our clients build self-esteem, manage emotions, address attachment histories and process thoughts and feelings in a safe and supported group setting. This program provides a supportive bridge of group therapy services for those who lost PSR coverage and those who graduated from the PSR program.

Now instead of feeling a loss, our clients feel they've gained a new resource. At Turning Point, the Transitions Group exemplifies our ability to be resilient in the face of adversity. Out of our challenge came a new program that promotes recovery, autonomy and problem solving for our clients.

It's a good example of "where there's a will, there's a way." Our Transitions Groups reflect an invitation to participate without judgment, to explore and imagine life with openness and to give and receive feedback to others.

Life is about transitions and we're committed to helping our clients make the most of the transitions in their lives.

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A Continuum Alternative to Prisons and ERs

Leon Evans

President and CEO, The Center for Health Care Services

Bexar County was at a crossroads.

Our jails and emergency rooms had become de facto treatment facilities for people with mental illnesses. The Bexar County Jail was overcrowded and administrators had to send detainees to other counties for housing. The San Antonio Police Department was spending upward of \$600,000 annually on overtime, as police sat in hospital waiting rooms with their detainees with mental illnesses.

We knew there had to be a better way.

We began teaching our law enforcement personnel to recognize the signs and symptoms of mental illness through crisis intervention training in 2002 and the next year we opened a small crisis unit at a downtown hospital.

In 2008, we opened the Restoration Center with a simple mission: provide a one-stop shop to treat those in crisis so they could stay out of jails and emergency rooms. Since its creation, The Center for Health Care Services has diverted over 98,000 Bexar County residents into treatment programs, saving taxpayers more than \$50 million dollars.

It's a true continuum of care.

The Sobering Unit takes people using substances off the street, bypassing the judicial system. Law enforcement simply drops off those individuals, who are monitored by emergency medical technicians and recovery support specialists, until they become sober. Staff then uses motivational interviewing. Multiple admissions are never viewed as a failure—people are treated with dignity and respect, whether they are here for the first time or the 100th time.

The residential detoxification unit is a licensed, accredited 28-bed facility offering medical oversight and recovery support for people withdrawing from substances. Residencies typically last three to seven days, but vary depending on an individual's symptoms. Detox helps people complete safe withdrawal from alcohol and substances, encourages them to continue treatment and motivates them to develop a healthy lifestyle.

The Crisis Care Center is a 16-bed, walk-in mental health clinic that is open 24/7 with onsite direct care staff that includes psychiatrists, licensed clinical social workers, licensed professional counselors and nurses. The Center for Health Care Services also provides crisis services through the crisis hotline and with mobile crisis outreach teams.



There is nothing magical about what we do in San Antonio and Bexar County. We count on community partners to make our system work.

The Minor Medical Clinic offers sutures, x-ray services and medical clearance to those who need minor medical treatment before being transported to jail. This service reduces emergency room wait times and gets police back on the street. The clinic is open 24/7.

Opioid Addiction Treatment Services is a licensed, accredited outpatient narcotic treatment program for people addicted to opioids such as prescription pain medications and heroin. Participants must be at least 18 years old, meet diagnostic criteria for opioid dependence and have a one-year history or more of opioid dependence.

Our specialized Mommies Program is an intensive substance use program that helps mothers recover from addiction in order to care for their children.

The newest addition to the Restoration Center is the CenterCare Clinic, an innovative health care clinic offering primary care services to people receiving treatment for mental health and/or substance use disorders. The clinic houses four exam rooms and seven staff members, including a medical director, physician assistant and nurse practitioner. Providers oversee a wide range of medical services from minor procedures, including well-women checks and preventative vaccinations to hypertension, diabetes and other acute and chronic conditions.

In addition, the Restoration Center offers:

- Intensive outpatient substance abuse treatment
- HIV prevention, intervention and outreach
- A drug court
- A U.S. probation program
- Ambulatory detoxification
- Co-occurring psychiatric and substance use disorder programs

There is nothing magical about what we do in San Antonio and Bexar County. We count on community partners to make our system work. And like any successful partnership, we communicate honestly and frequently about what works and what does not. We celebrate our successes and fix our failures so that we can provide an integrated, efficient and compassionate continuum of care for the most vulnerable in our community.

Our Restoration Center programs have improved the public safety-net and helped reduce unnecessary emergency room and jail visits, saving millions in taxpayer dollars. More importantly, we've returned almost 100,000 people back to our community to live independent and productive lives.

RESPONDING TO FIRST-RESPONDERS in Santa Fe

Based on an interview with:

Laurel W. Carraher | Psychotherapist
Mark Boschelli | Clinical Services Administrator
Presbyterian Medical Services

2014 Statue of Hope, James Tylera | Santa Fe, NM

TOO OFTEN FIRST RESPONDERS ARE ILL-PREPARED TO COPE WITH POTENTIAL CRISIS SITUATIONS.

Firefighters in Santa Fe, N.M., didn't know how to respond when a frightened and confused young man kept appearing at the firehouse. Several times, they transported him to the hospital nearly 30 minutes away, but they needed a solution and contacted Laurel Carraher, a member of the Santa Fe Crisis Mobile Crisis Response Team (MCRT).

Carraher learned that the young man was receiving services at the community mental health center affiliated with MCRT and went to the firehouse to talk with him. What could have escalated to crisis proportions wound up with Carraher, the firefighters and the young man sitting around the dinner table to work on a plan.

The crisis response team is a partnership between Santa Fe County and Presbyterian Medical Services (PMS), a licensed, qualified, integrated behavioral health and primary health care provider. The 24-hour, seven-days-a-week toll-free crisis hotline has operated for almost two decades out of the Santa Fe Community Guidance Center. When law enforcement and first responders call

the crisis line, "hot" calls go directly to the mobile response team. Two partner teams are dispatched and meet first responders to provide assessment and intervention, usually arriving within 20 minutes.

While each situation is unique, real-time interaction with first responders in the field has been invaluable in de-escalating situations, educating first responders and preventing hospitalizations. While primarily used by law enforcement and first responders, the service is available to schools, the local National Alliance on Mental Illness chapter and people concerned about their loved ones.

Mobile crisis teams are more effective at diverting people from psychiatric hospitalizations and better at linking people to outpatient services, which can reduce costs by up to 25 percent. Linking people in crisis to community services is a core function of the team.

Carraher works with clinicians in the Guidance Center and across the county to provide immediate access to services. During normal business hours, that means a warm handoff to a social worker or psychiatrist. For people seen after hours, there is a team debriefing the next day and Carraher coordinates services immediately.

The MCRT averages 25 calls a month—a number that has proven sustainable and manageable for providing connection with services and follow-up. Currently, the team is funded for three additional years, and law enforcement has seen such a benefit that there has been talk of additional support through the sheriff's office.

While each situation is unique, real-time interaction with first responders in the field has been invaluable in de-escalating situations, educating first responders and preventing hospitalizations.

New Mexico Makes Every Second Count



Phil Evans | President and CEO, ProtoCall Services

The first, most important element of an effective crisis system is simply being available. Every second counts when the next call could be the most important a person will ever make. Having too many or too few resources has different, but equally concerning, consequences. Focus on operational efficiency, scalability and “just-in-time inventory” ensures both accessibility and sustainability.

Sounds easy enough, but the barriers can be significant. Few states need crisis services more than New Mexico, where the suicide rate is 59 percent higher than the U.S. average. New Mexico is the fifth largest state, but has a population of just over two million. In rural and frontier areas, the closest provider is often hours away, leaving many feeling isolated and disconnected. Clearly, developing statewide access to crisis services has been crucial.

The success of ProtoCall's New Mexico Crisis and Access Line (NMCAL) in this challenging context is the result of three critical features.

1. State-Level Vision and Leadership

NMCAL, a key recommendation of a statewide task force convened by the New Mexico legislature, began in January 2013 with support from the executive branch. The state's ongoing leadership opened the door to a growing number of collaborative initiatives that have been the most important contributors to NMCAL's success.

2. Scalability

One of the most innovative attributes of NMCAL is integration with ProtoCall's national network of crisis centers. A service center in Albuquerque with New Mexican clinicians and staff provides an important local presence. Because the call centers are fully integrated, the next available clinician regardless of location answers a New Mexico call. The reverse is also true; the Albuquerque call center is staffed

beyond what's required for New Mexico calls because those clinicians also assist callers from outside the state.

This structure helps ensure a professional clinical response in an average of 13 seconds, as well as uninterrupted 24-hour availability. NMCAL's ability to leverage these economies of scale—40,000 calls a month, across three call centers and nearly 100 clinicians—has extended immediate access to some of the most isolated areas in the country.

3. Local Awareness and Customization

Creating economies of scale that ensure speed and uninterrupted access is one challenge. But tailoring that service to the specific needs of each community makes NMCAL's model work. Software and decision support tools allow clinicians to manage calls on more than 250 separate numbers. Licensed clinicians answering calls from any of our centers, conduct intakes, provide emergency triage services, facilitate routine and crisis referrals and, when available, access a consumer's wellness recovery action plan (WRAP). When combined with our telecommunication and software infrastructure, we achieve the best combination of customization and scalability.

The New Mexico Crisis and Access Line launched in February 2013 with fewer than 200 phone calls a month. Today, the NMCAL crisis and warm lines respond to nearly 2,500 phone calls a month. The Albuquerque call center continues to grow and now employs 15 of ProtoCall's 130 staff nationwide.

The state continues to lead efforts to expand NMCAL's role in the crisis system, including:

- Creating and implementing a statewide public awareness campaign, “Here to Hear You,” which uses social media, TV, radio and outdoor advertising to reach people.
- Directly funding the after-hours call center services for community behavioral health centers across New Mexico, removing a cost and service burden from community-based providers.
- Launching NMCAL's statewide Peer2Peer Warm Line, operated by paid certified peer support specialists to provide recovery support.

National organizations are taking note of New Mexico's efforts. According to Mental Health America's annual rankings of mental health services by state, New Mexico improved from 46th to 36th overall in 2015. This comes on the heels of recent news that more New Mexicans than ever before are accessing behavioral health services through Medicaid expansion and implementation of Centennial Care, the state's Medicaid managed care plan with integrated behavioral health.

ProtoCall's experience in New Mexico demonstrates that a localized level of service can be provided within the context of statewide and national call centers. Moreover, in environments where vast rural and frontier areas exist—a common trait in states with the nation's highest suicide rates—a focus on scalability, seamlessness, efficient and effective service delivery and state-level leadership is essential.

— **MAGELLAN:** A NATIONAL PRESENCE RESPONDING TO LOCAL NEEDS —

Magellan Health is a health care management company that responds to the challenges of today's fast-growing, highly complex and high-cost areas of health care. Strong partnerships with stakeholders, including health plans, employers, government agencies, members, service providers and fellow employees, allow Magellan to address the unique needs of the communities they serve.

The Mental Health Association of New York City's Here2Help Crisis Contact Center and Elwyn Mobile Crisis Services in Delaware County, Penn., demonstrate how, by working with stakeholders on the frontlines, Magellan can leverage their corporate strength to deliver high-quality services on a local level at a manageable cost.

USING TECHNOLOGY TO IMPROVE ACCESS TO EVIDENCED-BASED COGNITIVE BEHAVIORAL THERAPY

Anitha Iyer
Clinical Director
Here2Help Connect

Kathryn M. Salisbury
Executive Vice President
Mental Health Association
of New York City

Technology is transforming the behavioral health landscape. Too many people do not receive the care they need because of logistical or linguistic barriers. Technology is breaking down these barriers by delivering vital evidence-based care, support and resources when, where and how consumers want it.

Internet-based cognitive behavioral therapy (iCBT) is ideally poised to help transform the health and behavioral health delivery systems by increasing access to better care, producing better health outcomes and lowering the cost of care.

The Mental Health Association of New York City (MHA-NYC) partnered with Magellan's computerized cognitive behavioral therapy (CCBT) program formerly known as Cobalt Therapeutics to increase access to quality behavioral health care by providing telephonic, text and chat supports in both English and Spanish in combination with a proprietary suite of programs for depression, anxiety, insomnia, substance abuse and obsessive compulsive disorder. Their goal was to support and enhance program completion, consumer satisfaction and provide important safeguards for individuals in crisis.

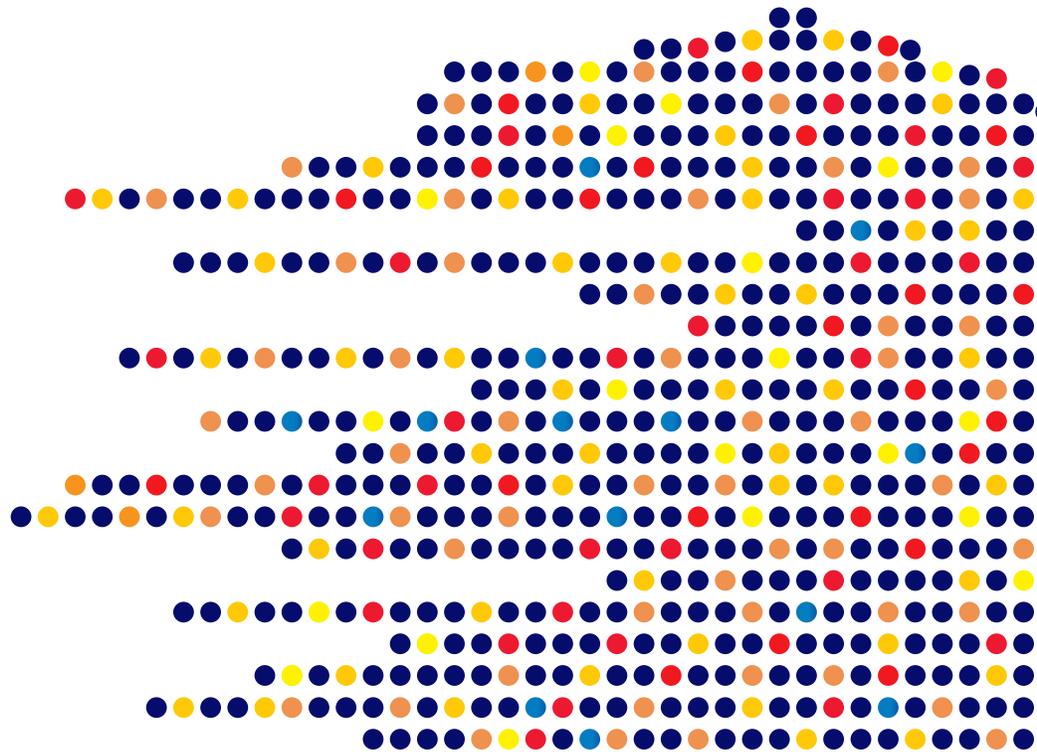
Comprehensive telephonic and web-based supports at Here2Help Crisis Contact Center is provided by trained mental health professionals who apply evidence-based clinical techniques like active listening, motivational interviewing, collaborative problem-solving and practice of effective coping skills. Applying time-tested, evidence-based techniques to a technology-based medium allows clinicians to provide care that is in-step with the needs of an increasingly technologically savvy community.

Since 2014, MHA-NYC successfully delivered iHelp: New York to more than 4,000 New Yorkers in distress and is providing iCBT as a wellness offering for employees of a large Fortune 500 company. Standardized measurement tools showed a 64 percent improvement in symptoms from pre-test to post-test. Higher than average engagement by Spanish-speaking users was particularly encouraging and may represent a unique opportunity to fill the shortage of Spanish-speaking clinicians trained in cognitive behavioral therapy.

The time-limited nature, demonstrated clinical efficacy and ability to reach populations that would not have access to care or who are not comfortable engaging in office-based care, make Internet-based cognitive behavioral therapy an important tool for engagement in care.



Internet-based cognitive behavioral therapy (iCBT) is ideally poised to help transform the health and behavioral health delivery systems by increasing access to better care, producing better health outcomes and lowering the cost of care.



— THE IMPORTANCE OF COLLABORATION IN CRISIS CARE —

John Muehsam

Director, Elwyn Crisis Services

A collaborative approach to behavioral health creates a wide net of preventive care and treatment to ensure care and treatment to individuals who frequently fall through the cracks in Delaware County, Pa. Elwyn Mobile Crisis Services' Delaware County Crisis Connections Team (DCCCT) partners with Magellan Behavioral Health of Pennsylvania; the Delaware County Department of Health and Human Services, Office of Behavioral Health and local law enforcement to provide crisis and assessment services to anyone living in Delaware County.

In the two-and-a-half years since its inception in July 2013, the program has received more than 3,200 calls—2,600 involving the crisis team. The team not only connects individuals to community providers for high-level care, it also offers mental health education to school districts and crisis trainings for staff within the county.

In the two-and-a-half years since its inception in July 2013, the program has received more than 3,200 calls—2,600 involving the crisis team.

So far, 213 police officers have attended a rigorous four-and-a-half-day crisis intervention training. The police and DCCCT have established a close working relationship where police officers notify DCCCT if they require the mental health services provided by the mobile crisis program and, in turn, DCCCT contacts the police for assistance when weapons are involved or in the case of a domestic dispute.

DCCCT does not play the role of the experts who arrive and fix everything. They are partners sup-

porting a system that is already in place.

DCCCT is one more resource for the community that provides services to people who may be experiencing the worst part of their lives.

Building Community for Seniors in Crisis

Karin E. Taifour

Crisis Case Manager II – Geriatric Regional Assessment Team, Evergreen Health



They're supposed to be the golden years. But for many seniors, aging brings mental health and substance use issues, abuse, neglect and financial exploitation. Too many have nowhere to turn, but in King County, Seattle and the surrounding area, seniors aren't alone. Together, a unique combination of programs respond to seniors in crisis.

The Geriatric Regional Assessment Team (GRAT) is a county-funded program based at Evergreen Health, a community public district hospital, that serves anyone age 60 and over who is in crisis because of mental health issues, alcohol or other substance use. GRAT clinicians perform a comprehensive assessment—including cognitive, mental health and/or chemical dependency evaluations—and provide linkage to community resources. The team includes masters-level geriatric mental health specialists, a psychiatric nurse, a chemical dependency specialist and a consulting psychiatrist. Clients with mobility or transportation issues can receive home visits at no charge.

Cases often involve multiple parties, including families, guardians, hospitals, doctors, inpatient and outpatient mental health providers, residential care facilities, home health services and law enforcement—even criminal prosecutors. Referrals from anyone in the community are responded to within three days and first responders can request a next-day visit.

The Geriatric Regional Assessment Team sees more than 500 seniors each year in King County, connecting them with resources to support their safety, independence and well-being.

GRAT coordinates with Evergreen's other behavioral health programs, including our in-home mental health services, which provide Medicaid-funded counseling and case management to clients who are unable to access community-based services. The Family Caregiver Support Program, with federal and state funding, provides connection with respite care and other resources, including free in-community caregiver counseling.

Connection and coordination with multiple agencies benefits our community and our seniors. To ensure our services identify an array of older adults in our community who may be in crisis, GRAT coordinates with a number of area services, including:

- The Seattle Police Department, which receives part of their Crisis Intervention Team training from GRAT, participates in a mobile crisis team to respond 24/7 to situations and coordinates with a specialized elder abuse detective unit.
- The Crisis Solutions Center, a resource for first responders to help individuals in crisis avoid jail or hospitalization.
- County designated mental health professionals, who handle involuntary commitment.
- Senior Services, a nonprofit service provider.
- Aging and Disability Services case managers, some focusing on elder abuse and exploitation cases.
- Adult Protective Services, which is starting a self-neglect focused pilot project.

GRAT sees more than 500 seniors each year in King County, connecting them with resources to support their safety, independence and well-being.

A Helping Hand — for Ms. J. —

After she fell in the street, Ms. J.'s neighbors expressed concern about her need for more support to her visiting son, but they felt he was not responsive. Ms. J. explained that her son did not want her to spend her money because it would cut into his inheritance. A neighbor called Senior Services to seek help and Ms. J. was referred to GRAT and Adult Protective Services.

A GRAT clinician and an Adult Protective Services investigator visited Ms. J., who is legally blind and has limited mobility, impaired functioning, chronic pain due to a history of multiple surgeries and a sprained ankle from her recent fall. She was tearful throughout the visit, reporting a long history of depression, anxiety and panic attacks. Cognitive testing showed she had significant impairment. Adult Protective Services started an investigation of the son as trustee of Ms. J.'s inheritance.

GRAT coordinated with her doctor for labs to rule out any medical conditions contributing to cognitive and mood issues. Ms. J. was referred to the home health program for ongoing counseling and case management support and to an Aging and Disability Services case manager who assisted with the application process for Medicaid-funded in-home care or residential placement. Ms. J.'s daughter, who was providing support to her mother, was referred to the Family Caregiver Support Program.

Today, Ms. J. has hope for the future. Instead of spending the holidays alone, she was surrounded by the warmth of her family. During weekly meetings with her counselor, they focus on coping skills and stress management as well as transportation options and resources to help with her low vision. She now has help at home and is considering moving to an assisted living facility.



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Charity Begins at HOME

TAKING IT TO THE STREETS IN PORTLAND, MAINE

Joseph McNally | HOME Team Manager, Milestone Foundation

Bob Fowler | Executive Director, Milestone Foundation

The familiar adage, “Let’s hear it for the home team,” speaks to the work of the Milestone Foundation of Portland and Old Orchard Beach, Maine. We support people with chronic health, mental health and substance use issues who are also homeless so they can attain stability, dignity, recovery and an enhanced quality of life.

It’s what we all want and so we meet them “where they are” with our Homeless Outreach and Mobile Engagement, or HOME Team. It addresses a previously unmet community need—not only for those we serve, but for our entire city—those who live and do business here.

In conjunction with the city of Portland and the Portland Downtown District, which partially funds the HOME Team, we’ve reduced costs for serving this vulnerable population by providing a sensible and proven alternative to emergency departments and jails.

Instead of recycling repeat clients back into the system, our interventions engage

them with mainstream services such as appropriate treatment, housing assistance, primary care and even the Department of Veterans Affairs, when appropriate. We maintain relationships with approximately 400 clients each year.

As a result of the HOME Team’s outreach, transports by the Portland Police Department and the city’s Fire and Rescue Emergency Medical Services have fallen by nearly 91 percent since 2009. Although we receive calls to intervene from law enforcement, merchants and citizens, we believe in preemptive outreach—not waiting for a crisis to occur. We walk the streets and visit campsites and “hangout” spots where we engage people experiencing homelessness.

Approximately 8,200 encounters occur each year, resulting in approximately 2,500 transports to area shelters, to detox or to local hospitals. It’s generally accepted that a third of these clients require up to 33 percent of resources as “frequent fliers,” and we know we’ll encounter our most vulnerable clients multiple times in a day.

The HOME Team delivers services regardless of ability to pay. Many of those we encounter would not otherwise receive services because they have difficulty navigating traditional social services systems. Since Maine elected not to expand Medicaid in 2014, many vulnerable people either lost health care coverage or are ineligible to receive it, limiting their access to case management and other services.

As a result, we’re “around” where and when other services aren’t and we help fill in the gaps. We collaborate with emergency services, downtown merchants and social services providers so we can provide comprehensive, humane and compassionate care. The goal is to leverage all our community’s resources on behalf of those who would otherwise fall through the cracks, and we do that with state and federal funding, funds from the city and the downtown district and grant funding. We know that outcomes are not “one size fits all,” but are based upon each individual. What works for one client doesn’t work for another, and that remains top of mind as we help them achieve recovery, harm reduction and secure housing.



In the areas of substance use and homelessness, we also know there's no quick fix. Our "total" success stories don't happen every day, but when they do, they remind us we are doing something that really matters. For example, in conjunction with our partners at Mercy Hospital, we recently assisted an elderly male with severe physical disabilities who was homeless since 1983. We relocated him into stable housing and supported him to maintain his housing. He's been sober and housed for nearly a year after many prior attempts to achieve sobriety. He serves as an inspiration to other clients—not to mention the Milestone staff—with his success.

This kind of heart-warming achievement makes us wide-eyed with joy. And we're opening the eyes of local merchants and citizens who now see our clients in a different light. That often means they'll interact with them differently—in a more respectful and positive manner. Perhaps these new accomplishments and attitudes remind us all that "there but for the grace of God go I."

For us at the Milestone Foundation, HOME is where the heart is. We've committed to being out there for the long haul—for as long as it takes.



As a result of the HOME Team's outreach, transports by the Portland Police Department and the city's Fire and Rescue Emergency Medical Services have fallen by nearly 91 percent since 2009.

In Maine, a Team Approach to Juveniles in Crisis

Ron Young

Director of Emergency Services, Maine Behavioral Healthcare

Jonathan J. Shapiro

Sargent, Maine State Police

Maine police were getting more calls responding to kids in mental health crisis or displaying out-of-control behavior—too many. Troop A of the Maine State Police worked with Maine Behavioral Healthcare’s crisis response team to address the problem and develop a program before it hit crisis stage—“An Improved Police Response to Juveniles in Crisis.” Within the first year, juvenile crisis calls to police dropped 40 percent, from 48 to 29 calls.

The reporting form captures critical information for tracking and accountability. In addition, parents of juveniles in crisis use the form as a tool to convey concerns and record problem behavior to mental health professionals. With parental consent, they use the information to inform the school system and help prepare an appropriate response to the child’s needs.

The result is a program that recognizes juveniles at risk at the earliest possible stage, captures relevant and useful information, secures an appropriate referral network and tracks results for mutual

providing significant resources when the child at risk is first identified, instead of waiting for a history of crisis or delinquent behavior.

The result is a program that recognizes juveniles at risk at the earliest possible stage, captures relevant and useful information, secures an appropriate referral network and tracks results for mutual accountability.

accountability. The results of the program were decisive—86 percent of the families reported that only one response was needed to receive the appropriate resources.

Data collected over a five-year period, including 186 calls involving juveniles in crisis, confirmed that the 10-year-old demographic is a tipping point for criminal justice system involvement and signifies a possible correlation

Conservative estimates indicate that more than 30 percent of the youth in Maine’s juvenile corrections would be better served in a mental health environment. Trends highlight that after receiving these services, the vast majority of families and juveniles do not call again for police intervention, a clear indication of how critical it is to link families to appropriate services at initial involvement.

The cost of incarcerating our youth is astronomical. The cost of incarcerating our youth due to mental illness is inexcusable.

The concept is simple: After police respond to a call involving a juvenile, the officer completes a police juvenile reporting form and sends it to the Maine Behavioral Healthcare crisis team. A clinician then calls the family to arrange an assessment, provide resources and services and provide later follow-up to ensure the family has engaged in referred services.

between juvenile brain development and behavioral problems. Too often, juveniles with challenging behavior are at higher risk of entering the justice system because the issues are not identified quickly enough and they don’t receive adequate services in a timely manner. Research on juveniles in Orange County, Calif., found results similar to Maine’s, showing the importance of



Holly Tumiel, MBH Mobile Crisis Response; Sgt. Jonathan Shapiro, Maine State Police, and Cherylan Camire, MBH Mobile Crisis Response.

Making a Difference for Youth in Central Ohio

Jessica J. Burchard

Chief Community Relations Officer,
Behavioral Healthcare Partners of Central Ohio, Inc.

Too often families in crisis are

overwhelmed by systems, rules and stigma—the fear of being judged by friends, other family members and the community. Some fear that Children's Services will take away their child, so they wait until the crisis escalates. By departing from the traditional office model, the Kids' Mobile Crisis Team meets families and youth where they are and when they need help.

Since 2014, the Kids' Mobile Crisis Team has provided families with support and comprehensive mental health services to help mitigate the risk presented by young people eight to 24 years old.

The partnership between Behavioral Healthcare Partners of Central Ohio, Inc., and Mental Health and Recovery of Licking and Knox counties brings together crisis intervention specialists, therapists, case managers and other staff members who pair up to visit teens and young adults in schools, jails, hospital emergency rooms and other places to connect them with mental health services.

Because the team is mobile and goes out into the community where the crises are, the team reaches young people who are in need of treatment services but might not receive them until a much larger and potentially more life-threatening crisis takes place.

Program data shows that more than 70 percent of youth served by the Kids' Mobile Crisis Team had no previous treatment services, over 85 percent were able to stabilize with services in the community and over 70 percent were still receiving services 90 days later. The majority—more than 50 percent of all clients—were between 13 and 17 years old, with the remaining half evenly divided between eight to 12 and 18 to 24 years old.



The Kids' Mobile Crisis Team draws from best practices borrowed from other states. The program receives funding through a Strong Families/Safe Communities grant in conjunction with support from the State of Ohio and the Ohio Department of Mental Health and Addiction Services.

The mobile treatment team works to reduce the number of hospitalizations among young people who are at risk of harm and/or aggression toward themselves or others. In Licking and Knox counties, the treatment team works with the Village Network, Board of Developmental Disabilities and Pathways of Central Ohio (2-1-1 Crisis Hotline) among others to provide a continuum of services to help clients reduce rates of recidivism.

The Kids' Mobile Crisis Team is initially contacted through the community crisis hotline. The flow begins with a 2-1-1 call that is triaged and sent to a helpline. Appropriate calls go to Behavioral Healthcare Partners crisis staff who again triages and responds in person with a secondary staff person, who may be a therapist or case manager.

The Kids' Mobile Crisis Team has made a tremendous difference by identifying and serving youth who are in need, but have no previous treatment history to avert a crisis before it becomes one.

Program data shows that more than 70 percent of youth served by the Kids' Mobile Crisis Team had no previous treatment services, over 85 percent were able to stabilize with services in the community and over 70 percent were still receiving in services 90 days later.

When Family Comes First

Mona Townes

Mobile Crisis Director,
Integrated Family Services, PLLC

Family is the tie that binds. That's how Integrated Family Services, PLLC, sees it. Our logo says it all: "A puzzle, with each piece representing family members 'fitting together' as a unit."



When a person experiences a mental health crisis, part of the mobile crisis team's assessment includes propping up any "natural support"—people like family or friends—who can be a positive and helpful part of crisis planning and recovery.

As part of the North Carolina Crisis Solutions Initiative, Integrated Family Services provides emergency assessments and immediate intervention for family, individual and community crisis situations. A key focus is mobile crisis management.

In almost half of the mental health crisis calls, a person in crisis has family members. Sometimes, when the team arrives at a home, they find the entire family in crisis. Typically, the key individual is assessed in the car or somewhere offsite and family members are often advised to "go somewhere else to cool off."

Obviously, an adult can consent to treatment, but a minor must have parental consent. The team won't try to intervene inside the home if parents don't agree. However, if a child is at risk of harming themselves or others—as with threatened suicide—the rules of involuntary commitment apply. Whatever the age, every effort is made to receive consent for treatment.

When a person experiences a mental health crisis, part of the mobile crisis team's assessment includes propping up any "natural support"—people like family or friends—who can be a positive and helpful part of crisis planning and recovery.

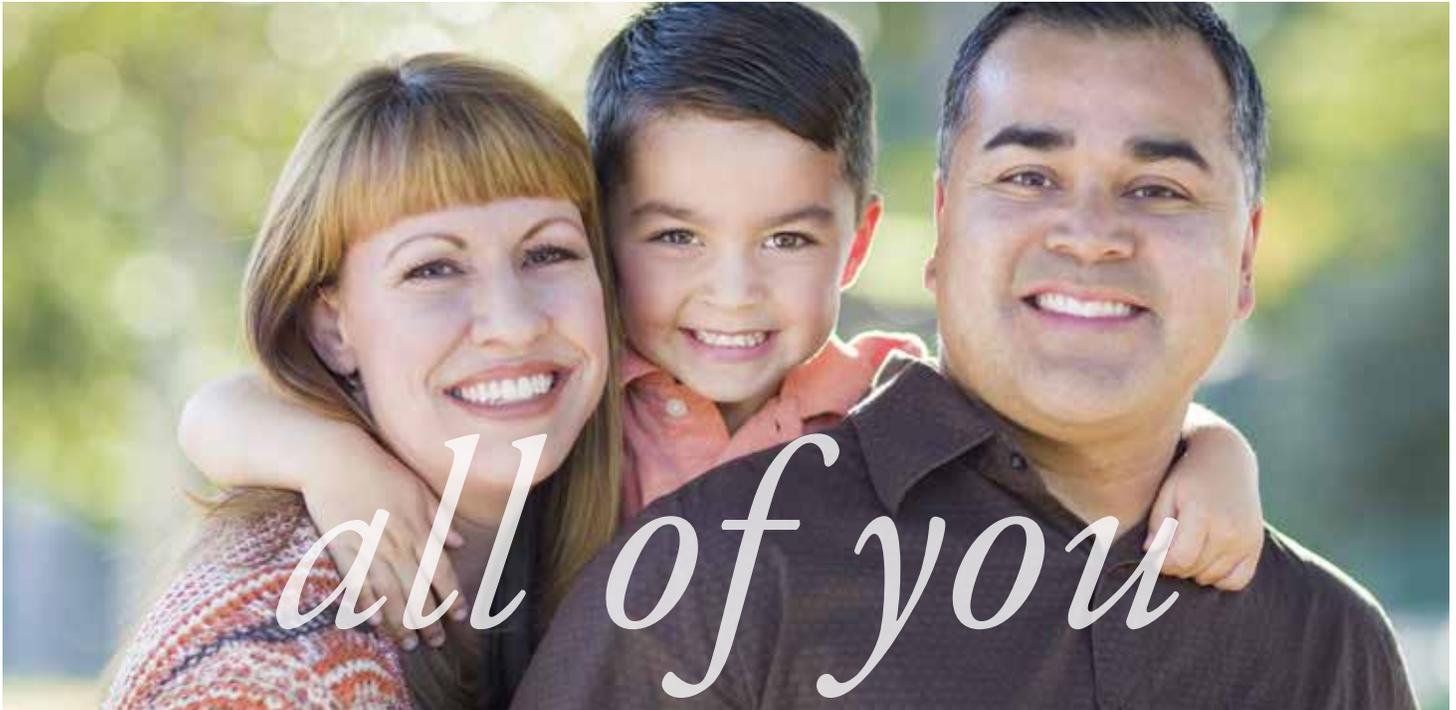
More often than not, families are helpful and an important part of the team effort. While it isn't a state requirement, families are included in crisis planning whenever appropriate.

When a child is in crisis in a school setting, it is essential to follow protocol. A parent or the child's legal guardian is first contacted to give permission for the agency to intervene. With memorandum of understanding and other agreements in place, the team works with system personnel to develop a plan. Then team members may meet the family and school administrators before including the child. If transportation to the meeting is a barrier for the parent, the team arranges transportation.

Following the acute phase of any encounter, the team equips families with the necessary tools in the event the crisis reoccurs and will even help suicide-proof the home. For non-crisis events, when a child causes dissension in the family or community, intensive in-home counseling and planning is available to anyone living in that home.

The goal is to deliver the appropriate level of crisis care and equip family members to provide support to prevent a crisis from happening again. Stronger families mean stronger, healthier communities. Integrated Family Services is here to put those puzzle pieces together and make sure they stay in place.

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WHAT PEOPLE THINK



WHAT WE DO

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