Community Crisis Center

An Urban Model

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"Helping People Move from Crisis to Hope"

Common Ground
helping people move from crisis to hope

COMMUNITY MENTAL HEALTH
CMH OAKLAND COUNTY
AUTHORITY

Session Objectives

1. SAMHSA Mental Health Crisis Practice Guidelines
2. Community Crisis Center “service lines”
3. Crisis services alignment with AFP/Health Care Reform
4. Common Ground’s Urban Crisis Model
5. Critical Role of Certified Peer Support Specialists
6. Redirection of existing funding

Why do Crises have a Profound Impact on People with Serious Mental Health or Emotional Problems?

People with SMI, SED, SU often lead lives characterized by recurrent, significant crises:

- Lack of resources to essential services
- Poverty
- Unstable housing
- Coexisting substance use
- Health problems
- Discrimination
- Victimization

SAMHSA

- 1/3-1/2 of homeless people have a severe psychiatric disorder
- Approximately 7% of all police contacts in urban settings involve a person believed to have a mental illness
- 6% of all hospital emergency department visits reflect mental health emergencies
- Due to lack of available alternatives, 79% of hospital EDs report having to “board” psychiatric patients who are in crisis and in need of inpatient care, sometimes for eight hours or longer.
- 1 in 10 discharged from a state hospital will be readmitted within 30 days; more than 1 in 5 will be readmitted within 180 days
- About 90% of adult state hospitals report histories of trauma
- About ¾ of youth in JJ system report mental health problems and 1 in 5 has as SED
- Mothers with SMI are more than 4 x as likely as other mothers to lose custody of their children
- People with SMI die, on average, 25 years earlier than the general population

“Too often, public systems respond as if a mental health crisis and danger to self or others were one and the same. In fact, danger to self or others derives from common legal language defining when involuntary psychiatric hospitalization may occur- at best, this is a blunt measure of an extreme emergency. A narrow focus on dangerousness is not a valid approach to addressing a mental health crisis. To identify crises accurately requires a much more nuanced understanding and a perspective that looks beyond whether an individual is dangerous or immediate psychiatric hospitalization is indicated.”

-SAMHSA

SAMHSA 10 Essential Values of Responding to Crisis

1. Avoiding Harm
2. Intervening in Person-Centered Ways
3. Shared Responsibility
4. Addressing Trauma
5. Establishing Feelings of Personal Safety
6. Based on Strengths
7. The Whole Person
8. The Person as Credible Source
9. Recovery, Resilience and Natural Supports
10. Prevention

SAMHSA Principles for Enacting the Essential Values

1. Access to supports and services is timely
2. Services are provided in the least restrictive manner
3. Peer support is available
4. Adequate time is spent with the individual in crisis
5. Plans are strength-based
6. Emergency interventions consider the context of the individual's overall plan of services
7. Crisis services are provided by individuals with appropriate training and demonstrate competence to evaluate and effectively intervene with the problems being presented
8. Individuals in a self-defined crisis are not turned away
9. Interveners have a comprehensive understanding of the crisis
10. Helping the individual to regain a sense of control is a priority
11. Services are congruent with the culture, gender, race, sexual orientation, age, health literacy and communication needs of the individual being served
12. Rights are respected
13. Services are trauma-informed
14. Recurring crises signal problems in assessment of care
15. Meaningful measures are taken to reduce the likelihood of future emergencies

Infrastructure

- Staff is appropriately trained and demonstrate competence
- Staff and leadership understands, accepts and promotes the concepts of recovery and resilience
- Staff has timely access to critical information
- Staff is afforded the flexibility and resources
- Staff is empowered to work in partnership with individuals served
- Organizational culture does not isolate its programs or staff from surrounding community
- Coordination and collaboration with outside entities
- Rigorous performance improvement programs

Does your system have the money to make it happen?

- Look closely at use of ED for crises
- EDs are not equipped to serve people in crisis- yet this costs $
- Inpatient costs are rising just about everywhere. Can you redirect $
- Managed Care Gatekeeping is antiquated and requires $
- Incarceration (jail) $
- Police spending hours on MH crises cost $
- Ambulance cost $

State of the Art Crisis Center

- 24/7 Crisis Intervention: walk-in, call, text, chat, police drop off
- Offers 24/7 alternatives to Emergency Department
- Triage & Assessment
- Health Care
- Crisis Services Array
  - Peer Support
  - Mobile Crisis to ED and for Follow-up
  - Crisis Respite (Adults & Youth)
  - Crisis Residential
  - Short-term prescribing
  - Tele-help (psychiatry, assessment, crisis intervention)
  - Basic needs
  - Resource navigation
  - Psychiatric Evaluation & short-term prescribing

Attributes of a State of the Art Crisis Center

- Trained/experienced staff in suicide prevention and crisis intervention across populations
- World class Customer Services
- No waiting for services
- Collaborative Documentation
- Person/Family Centered
- Integration with outpatient providers and community partners
- Trauma informed & Recovery Oriented
- Police, DHS, hospital, schools couldn’t live without
- Technologies
- Pinnacle of the CMH Network and community partners
- Co-occurring enhanced (detox, access to addiction services)

Why Have a Crisis Center?

- The effectiveness of crisis center is a no brainer
  - For the consumer/family, payers, hospital EDs, and law enforcement
  - Cost effectiveness studies prove the case
- The AFP requires an array of crisis services
- The mental health code requires a “preadmission screening unit”
- There is a moral imperative to funding crisis services

Why is Funding ED Alternatives for MH Crises a Moral Imperative?

- The psychiatric emergency is in and of itself traumatic
- Forcibly removed from one's home
- Taken into police custody
- Handcuffed and transported in the back of a police car
- Evaluation in the ED
- Transfer to a psychiatric hospital
- Civil commitment hearing
- High likelihood of physical restraint, seclusion, involuntary medication or other coercion may be used
- Intense feelings of disempowerment are definitional of mental health crises, yet as the person becomes the subject of a "disposition" at each juncture, that person may experience a diminishing sense of control

MENTAL HEALTH CODE (EXCERPT)
Act 258 of 1974

- **330.1409 Preadmission screening unit.** Sec. 409.
- (1) Each community mental health services program shall establish 1 or more preadmission screening units with 24-hour availability to provide assessment and screening services for individuals being considered for admission into hospitals or alternative treatment programs.
- (2) Each community mental health services program shall provide the address and telephone number of its preadmission screening unit or units to law enforcement agencies, the department, the court, and hospital emergency rooms.
- (3) A preadmission screening unit shall assess an individual being considered for admission into a hospital operated by the department or under contract with the community mental health services program. If the individual is clinically suitable for hospitalization, the preadmission screening unit shall authorize voluntary admission to the hospital.
- (5) If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit shall provide information regarding alternative services and the availability of those services, and make appropriate referrals.
- (6) A preadmission screening unit shall assess and examine, or refer to a hospital for examination, an individual who is brought to the unit by a peace officer or ordered by a court to be examined. If the individual meets the requirements for hospitalization, the preadmission screening unit shall designate the hospital to which the individual shall be admitted. The preadmission screening unit shall consult with the individual and, if the individual agrees, it shall consult with the individual's family member of choice, if available, as to the preferred hospital for admission of the individual.

AFP

- Clinical expertise that can be immediately accessed for MH or BH crises
- Team(s) available by phone and on-site observation and consultation
  - Have training/expertise with adults and children with SMI, SED, I/DD, and people with co-occurring disorders
- Residential or inpatient component until the crisis is stabilized
  - Emergency Admission
  - Intensive crisis stabilization or crisis residential

Common Ground Crisis Services at the Resource & Crisis Center

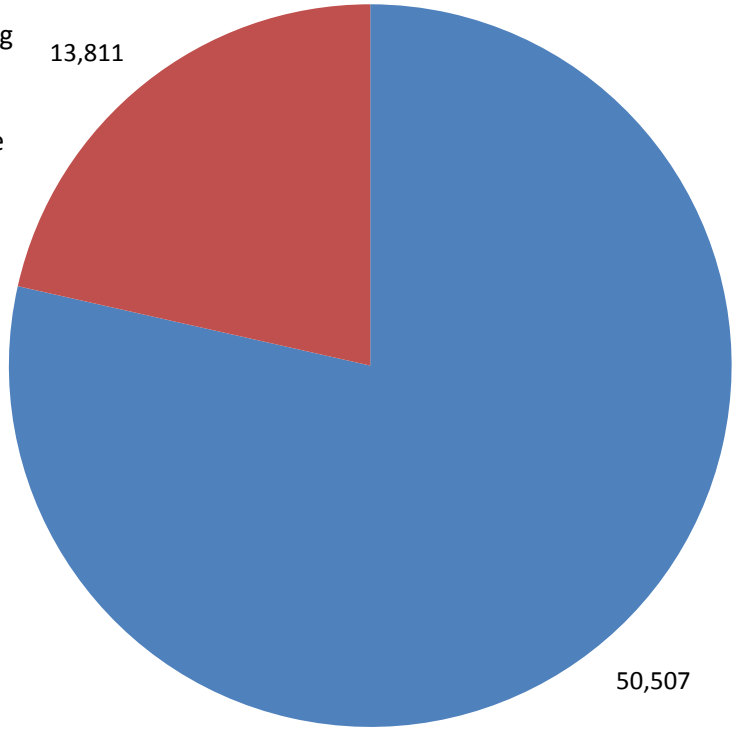
Common Ground provides ONLY crisis services funded by CMH, HUD, DHHS, DHS, Salvation Army, VOCA, DOE, United Way, fund raising, a variety of other small sources

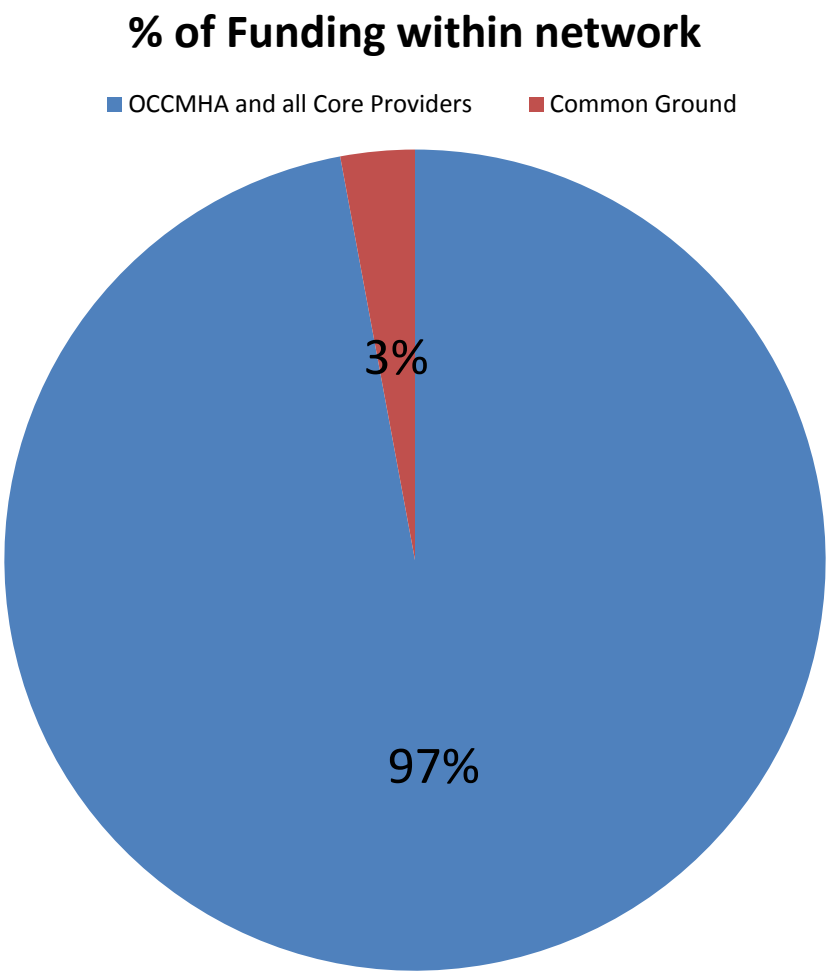
- Resource & Crisis Helpline- phone, chat, and text
- Victim Assistance- Any crime, jury, community, and agency debriefing
- Legal Services- Volunteer attorneys
- Access to CMH Network
- Liaisons at DHS, FQHC, Community Corrections, district & circuit courts, Adult Treatment Court, and hospitals (ATRs and AOT)
- Oakland & Genesee Crisis Intervention and Recovery Team (CIRT)- mobile crisis
- Oakland Assessment & Crisis Intervention Services (OACIS)- 24/7 secure setting
- Utilization Review
- Crisis Residential Program
- The Sanctuary- Six bed youth crisis home ages 10-17. Up to 3 week stay with intensive family involvement. Youth that have/at risk of runaway, and out of home respite
- Transitional living arrangements for homeless young adults
- Support Groups- Survivors of Suicide, Survivors of homicide, Love & Logic,
- SaYes Theatre Troupe
- Training- Mental Health First Aid, Individual Crisis Intervention & Peer Support Training, LivingWorks, suicideTALK, safeTALK, ASIST- Applied Suicide Intervention Skills Training, 80+ hours crisis intervention training for new staff, volunteers, and interns on the Resource & Crisis Helpline. All new staff have full day crisis intervention training.

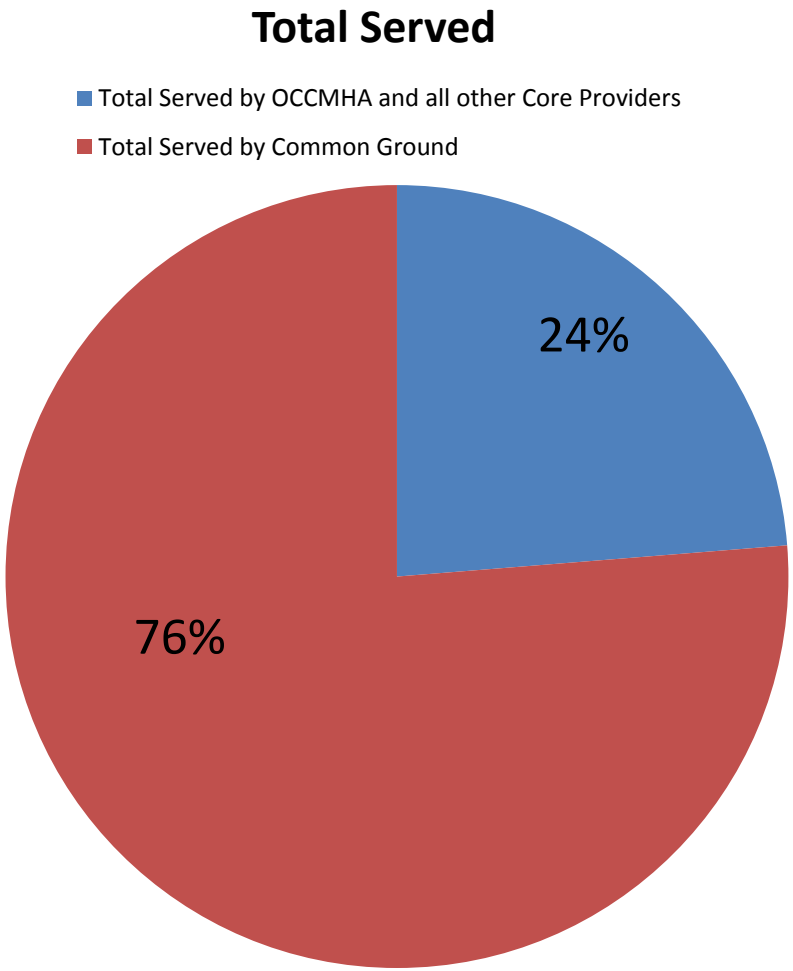
Total Served by Common Ground FY12-13

(64,318)

-Sanctuary
-Transitional Living
-Counseling
-Groups/classes
-Victim Assistance
-Legal
-GCIRT




% of Funding within network
OCCMHA and all Core Providers
Common Ground
3%
97%


Total Served
Total Served by OCCMHA and all other Core Providers
Total Served by Common Ground
24%
76%

We Love Volunteers and Interns!

- 226 volunteers
- Provided 16,644 volunteer hours
- Equal to 8 full time staff
- At a total value of $414,833

Resource & Crisis Center

Front Lobby

Front Lobby Partnership Room

Sorrenson Video Relay Service device- for deaf and hard-of-hearing individuals to communicate via phone. The camera part of the device sits on top of the wall-mounted monitor. The box part of the device sits on the desk behind the all-in-one PC.

Common Ground Resource & Crisis Center

Lobby Process Flow

1/28/14

Receptionist:

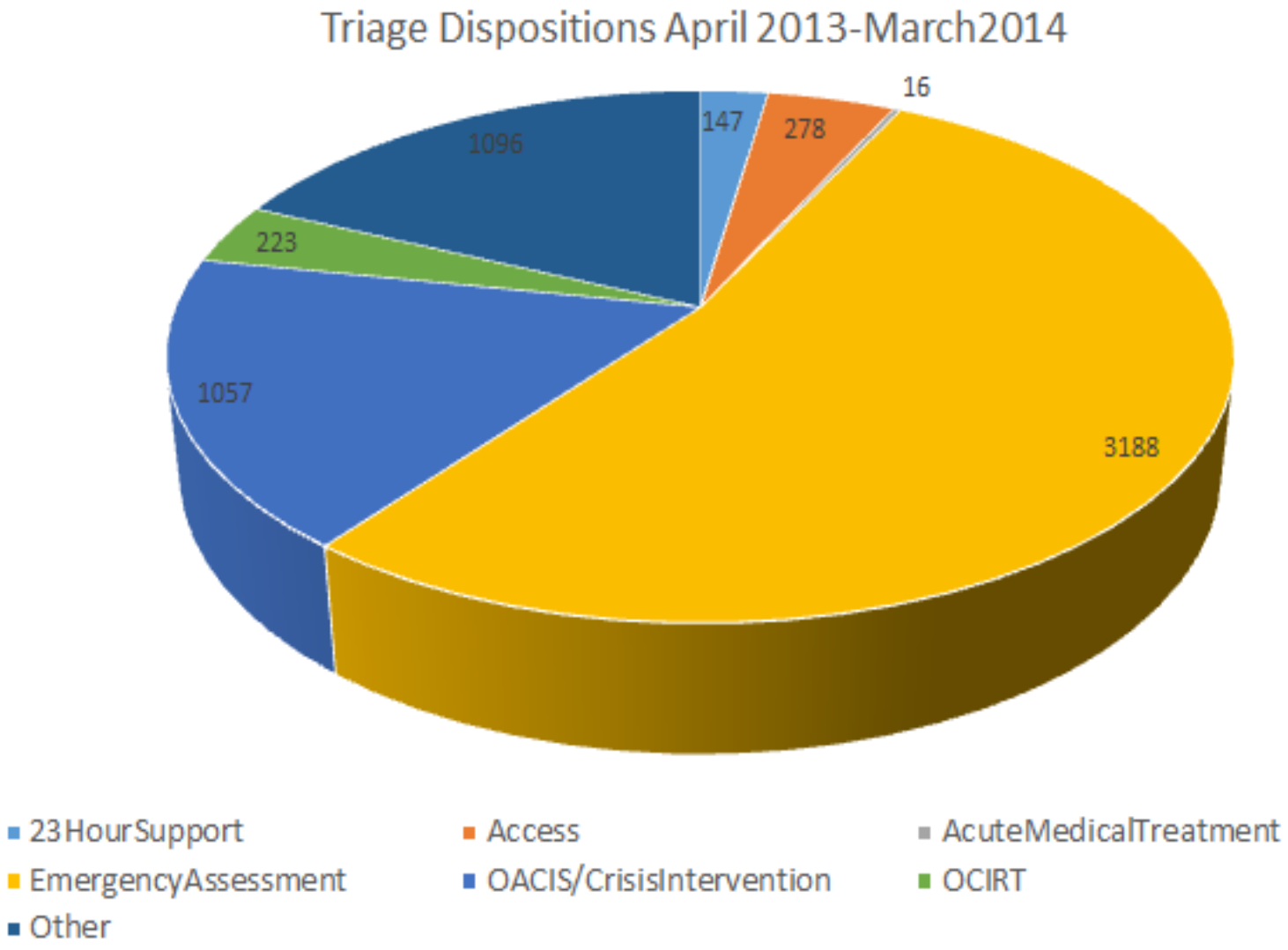
- Answers the calls for the building
- Welcomes people walking in for service
- Completes the Welcome Form in ODIN based on information from the Crisis Contact Form
- Copies Insurance and ID cards
- Prints Consent for Treatment from ODIN and obtains signature from consumer or defers to Triage Clinician if explanation is necessary
- Calls for a Recovery Coach if person needs more assistance who will use a Partnership Room for privacy.

Triage Clinician:

- The purpose of the Triage is to address the crisis through identifying the best service/next step that will meet the person/family's need
- If multiple people are waiting, reviews each Crisis Contact Form for priority
- Completes Triage Form in ODIN with Disposition
- Explains the Triage process and purpose
- Reviews the Crisis Contact Form with the consumer, listens to their story, and gently scopes the dialog to capture only enough information to complete the Triage
- Reviews Crisis Plan and PAD, if available, to inform the Triage
- Ensures all clipboard paperwork is completed and provides consumer/family with necessary copies of signed documents
- Contacts CMH provider to inform person is seeking services from the RCC and Disposition
- Warm transfers to the identified RCC team
- Contacts the program to meet the consumer and provides a warm transfer of the clipboard so that the information follows the consumer to minimize redundancies
- Triage Clinician can provide Access Screening if no one is waiting and Access is not available, or crisis intervention.

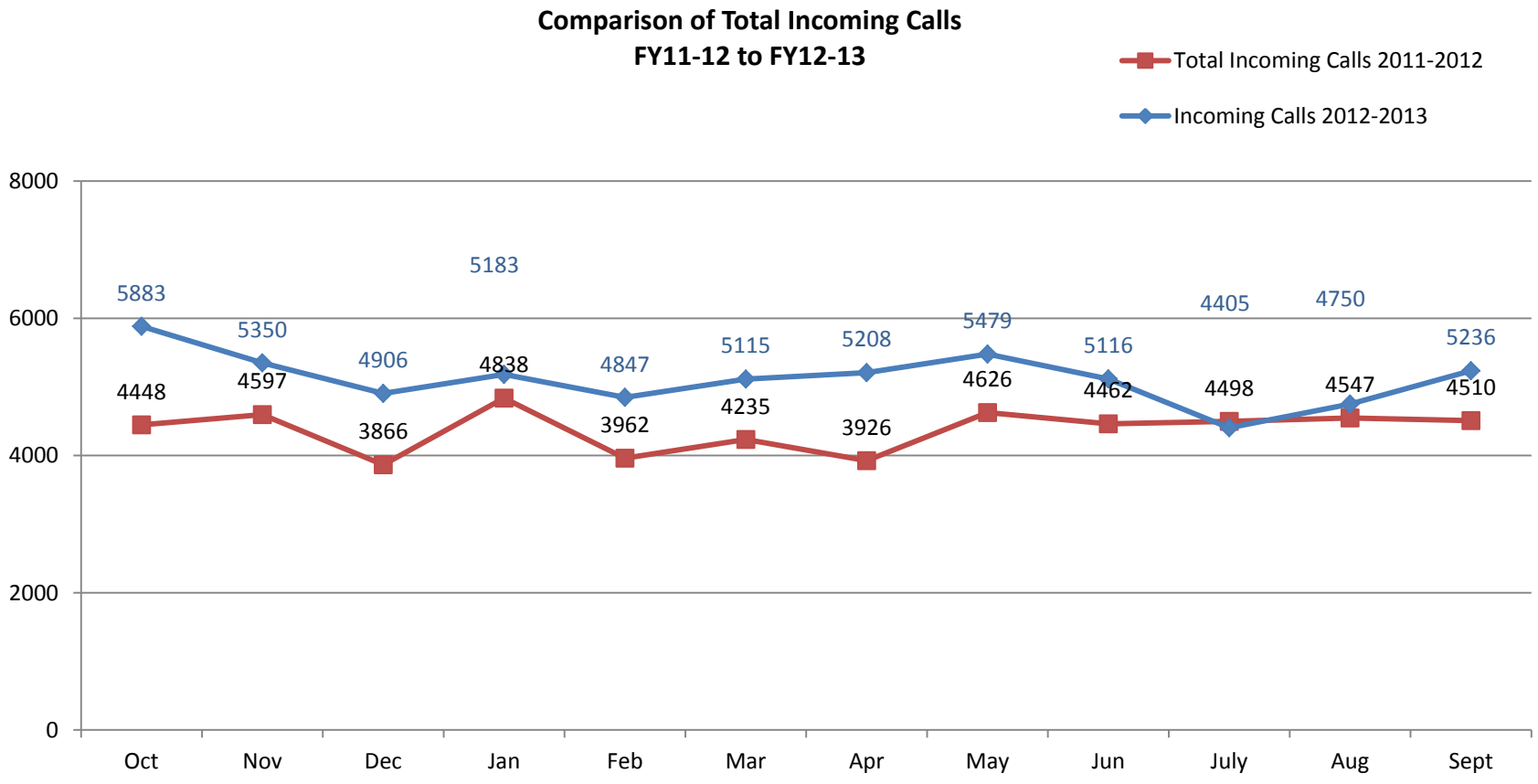
- Access
- EA
- MD
- RN
- VAP
- Crisis Intervention
  - Recovery Coach
  - OCIRT Intervention & F/u
  - OACIS (secure area) Crisis Intervention
- Other

The program that provides the last service will ensure record is secure for Health Information Team pick up; Complete Follow-up Plan Form and make copy for the consumer.


Triage Dispositions April 2013-March2014
147
278
16
1096
223
1057
3188
23 Hour Support
Access
Acute Medical Treatment
Emergency Assessment
OACIS/Crisis Intervention
OCIRT
Other

Call Center
Access and Resource & Crisis Helpline

Crisis & Resource Helpline



OACIS

Oakland Assessment & Crisis Intervention Service (OACIS)-

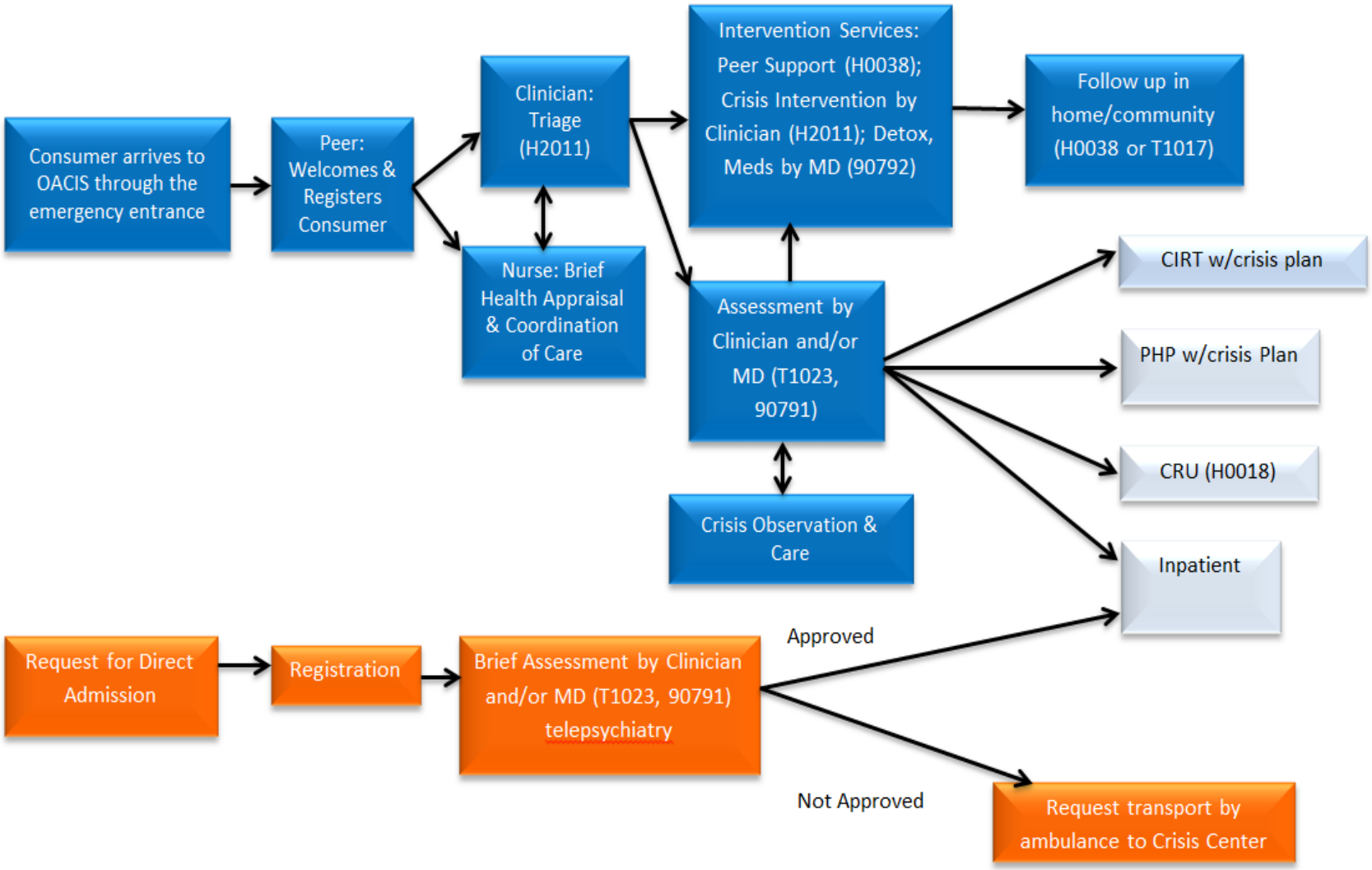
- Open 24/7
- Up to 24 hour support in a 24/7 secure environment
- Children's (OACIS) 2 beds w/family space
- Adult (OACIS) 8 beds w/large common area
- OCIRT on site for back-up and continuity
- Two bed nook for people with I/DD
- Weighted blankets
- Emergency entrance for ambulance and police
- Shower, laundry, snack, bus tickets, and some basic need products
- Sensory cart (music, drawing, tactile objects, etc.)
- Emergency Assessment for inpatient
- 24/7 RN for ED coordination, health services, medication administration
- Psychiatrist 16 hours per day for PEs, MRs, medications, certs/decerts
- "No Force First" environment
- Certified Peer Support Specialists as Recovery Coaches
- Licensed Master Clinicians
- 24/7 Access
- Back up for Crisis Line
- Interns

OACIS

RCC Emergency Entrance

Emergency Entrance Room

OACIS


Consumer arrives to OACIS through the emergency entrance
Peer: Welcomes & Registers Consumer
Clinician: Triage (H2011)
Nurse: Brief Health Appraisal & Coordination of Care
Intervention Services: Peer Support (H0038); Crisis Intervention by Clinician (H2011); Detox, Meds by MD (90792)
Follow up in home/community (H0038 or T1017)
Assessment by Clinician and/or MD (T1023, 90791)
Crisis Observation & Care
CIRT w/crisis plan
PHP w/crisis Plan
CRU (H0018)
Inpatient
Request for Direct Admission
Registration
Brief Assessment by Clinician and/or MD (T1023, 90791) telepsychiatry
Approved
Not Approved
Request transport by ambulance to Crisis Center

New Common Ground Nurses Process

Beginning of Shift:

1. Get report on each consumer in the building;
2. Talk to each consumer and review their medical status with them;
3. With last shift RN, count meds & co-sign log;
4. Review court orders for health care concerns in preparation for their arrival;
5. Review blue sheets from last shift for medical status and what it takes to come to OACIS

Phone Calls

Blue Sheets: Evaluate medical needs and what it takes to come to OACIS

OACIS Arrivals

Complete Brief Health Appraisal (BHA) with each person, for each visit. *

Complete Release of Information for Primary Care (PCP) indicated in the Medicaid look up in ODIN. If no Medicaid, and no PCP, write the following on the release, "No primary care physician at this time, referral provided to xxx (Burnstein/OIHN) low cost health care clinic."

Coordinate with Primary Care Physician or help connect to low cost clinic by mailing ROI and Transition Planning Form that provides referral to low cost clinic.

Complete RN Worksheet in ODIN by summarizing each BHA results. CODE= T1002

Complete RN Assessment in ODIN if:

1. People experiencing an exacerbation of symptoms ;
2. Unaddressed/untreated health care issues, or professional judgment of RN;
3. *If a BHA is not completed

CODE= T1001

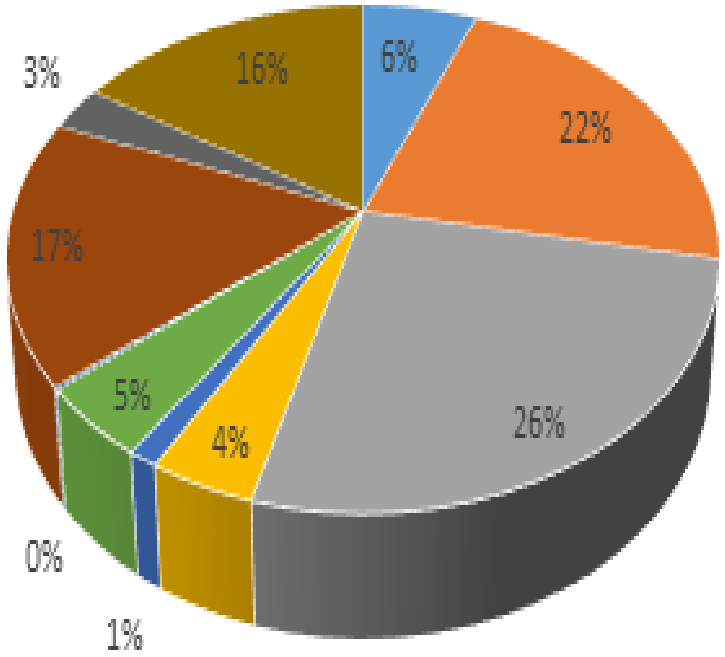
Document the following RN services in ODIN Progress Note:

1. Health Services/Ongoing RN care: CODE= T1002
2. Medication Admin w/MD in building: CODE= 96372
3. Medication Admin w/o MD in the building: CODE= 99211
4. Patient Ed: CODE= indiv S9445; group S9446
5. Med Training & Support ONLY: CODE= H0034

Complete Consent for Meds Form, explain med side effects, etc. CODE= H0034 If in an emergency or person declines to sign, write, John Doe "is unable to give consent at this time".

Med Room

Emergency Assessment Disposition

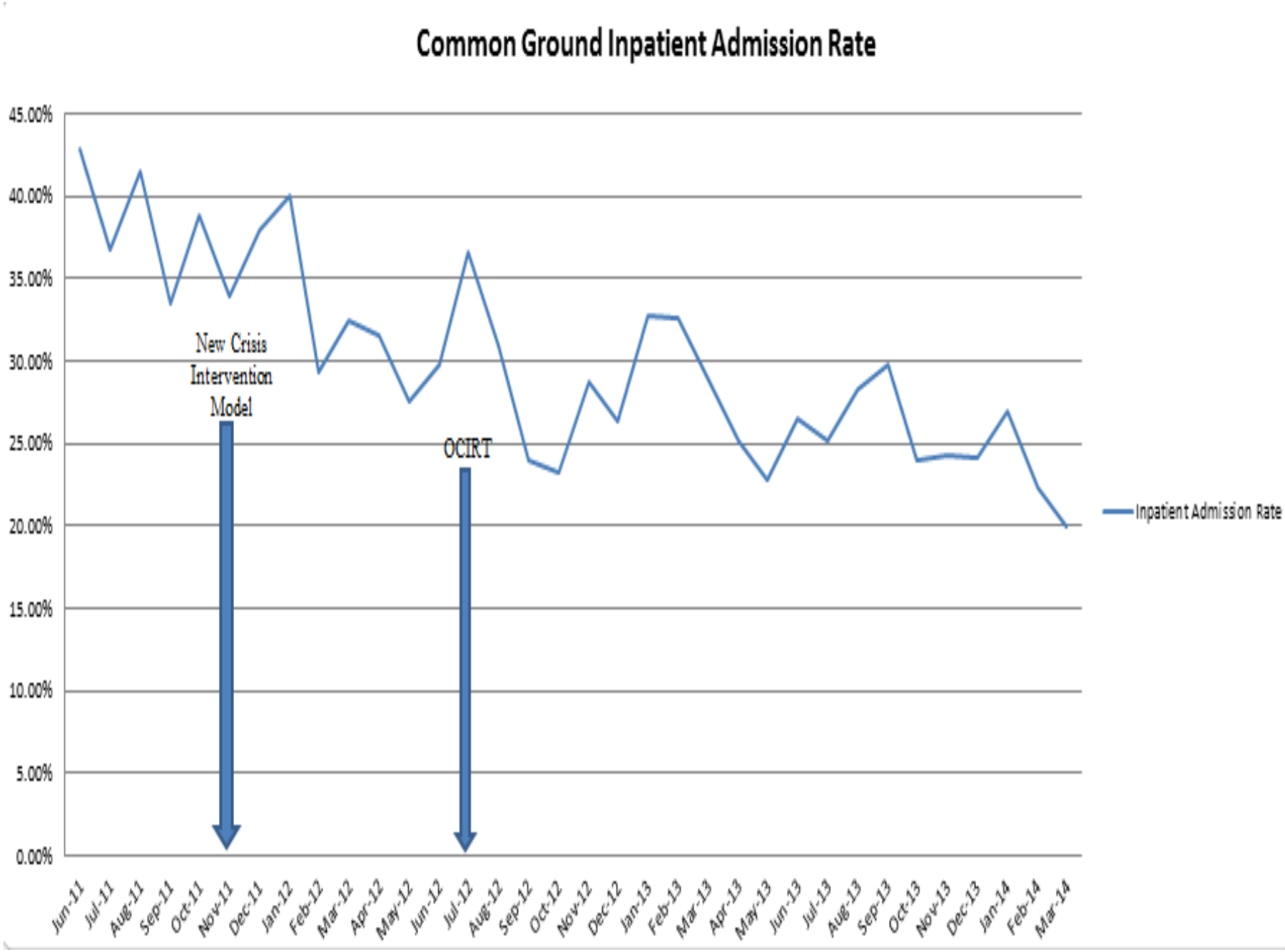


Crisis Center Data

April 13 – March 14

- Total presenting at the RCC = 6,505*
- Average per month = 500
- # by ambulance = 764
- # by police = 385
- All other = 4856
- 38% of people that arrived on a petition and/or clinical cert were hospitalized (62% were “decerted”)
- # of people that would have gone to the ED is there wasn’t a Crisis Center= 4,477

*Does not include VAP or Legal Clinic


Common Ground Inpatient Admission Rate
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
New Crisis Intervention Model
OCIRT
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
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May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Inpatient Admission Rate

Recovery Coaches

- Paul Lyons' Story: CPSS Recovery Coach
- Recovery Coach Role
- Day in the life of a Recovery Coach

Partnership Room

CRU Work Station

CRU Hallway

CRU Hallway

CRU Bedroom

CRU Art Room

CRU Exercise Room

CRU Great Room

CRU Great Room

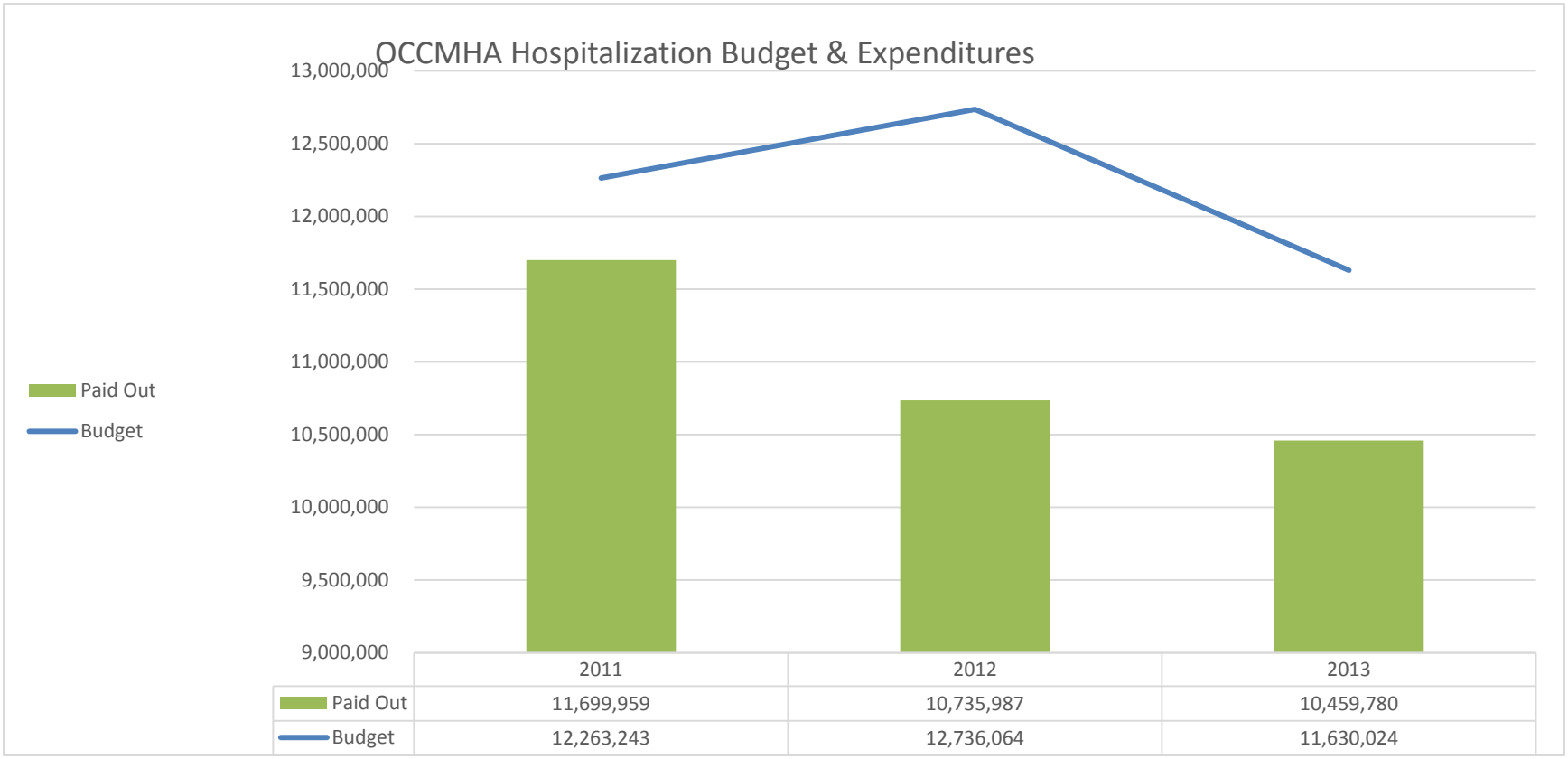
CRU Great Room

Staff Break Room

Conference Center

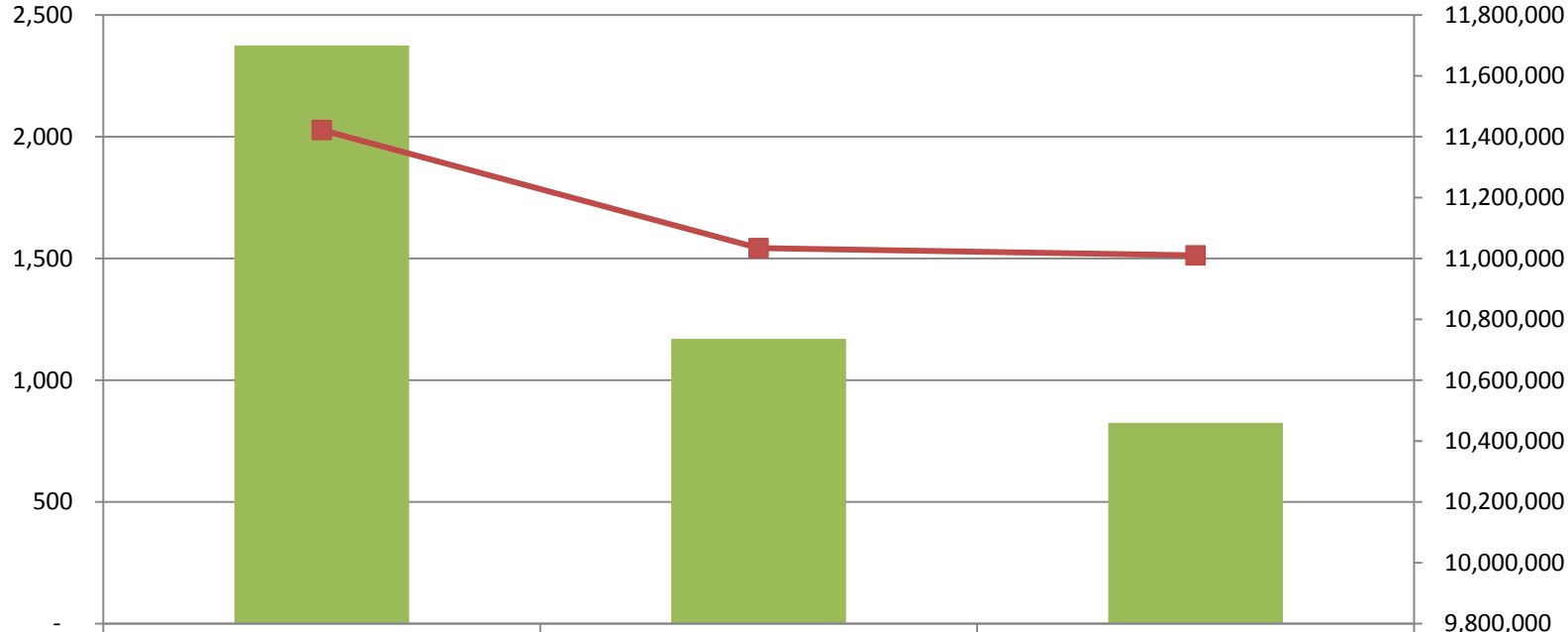
How was this beautiful building paid for?

- Inpatient Hospitalization Saving
- $109 per person served
- Jail diversion*
- Emergency Department alternative for Behavioral Health Care*
- Our positive outcomes occurred before we moved into the new building. Imagine what we can do now…



	2011	2012	2013
Paid Out	11,699,959	10,735,987	10,459,780
Budget	12,263,243	12,736,064	11,630,024

Hospital Funding



	2011	2012	2013
Paid Out	11,699,959	10,735,987	10,459,780
Consumers	2,028	1,543	1,513

Summary

Year	Paid Out	Budget	Difference	Consumers
2011	11,699,959	12,263,243	563,284	2,028
2012	10,735,987	12,736,064	2,000,077	1,543
2013	10,459,780	11,630,024	1,170,244	1,513

Welcome to Common Ground

Reception

OACIS

OACIS Room

Access

Resource & Crisis Helpline

Resource & Crisis Helpline

Staff Break Room

Next Steps

- This is our model, what is yours?
- What can your system do to enhance crisis services?

References/Resources

- *Practice Guidelines: Core Elements for Responding to Mental Health Crises* *www.samhsa.gov*
- www.commongroundhelps.org
- *Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services,* Lori Ashcraft, Ph.D. & William Anthony, Ph.D.
- *The development and implementation of no force first as a best practice*, Lori Ashcraft, Recovery Innovations, Michelle Bloss, Recovery Innovations, and William Anthony, Boston University
- *Peer Services in a Crisis Setting: The Living Room*, Lori Ashcraft, Ph.D., Executive Director META Services Recovery Education Center

Contact Information

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Thank you!