Crisis Care: The Time for Action

SAMHSA GLS and Crisis Meetings
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Mike Hogan Ph.D
National Action Alliance—Crisis Task Force
Health Care Progress Measured by Death Rates
Houston, We Still Have a Problem
Why Crisis Care is Crucial

• Heart attack analogy...is brain care less urgent than heart care?

• Proven impact of crisis calls
  • For people entering crisis
  • For people still in crisis despite ED or inpatient experience

• Impact of crisis CARE (where it exists)
  – Getting what you need and prefer, when you need it
  – Instead of:
    • Being tied to a gurney and then discharged 48 hours later
    • Getting booked into a jail after police transport, processing
    • Going to the hospital for days, instead of getting support NOW for hours or overnight
    • Dying alone and desperate
  – Better health for the population, better care for individuals, reduced expenditures
Effective Crisis Care is AWOL in Most Communities... 
It is NOT...

- Relying on someone somewhere else to answer Lifeline calls
- “If you are in crisis, call 911 or go to the ED”
- “We have crisis services. Our clinicians are on-call”
- “Our crisis system is a:
  - Mobile team
  - Peer run respite center
  - Warm line
- “We have an inpatient bed registry”
- A problem solved by more beds. Or clinics. Or case managers
- Accomplished easily
- *But, now that we have calls for mental health reform, could we have something that works and is needed?*
Effective crisis care must be comprehensive. It must include core elements and practices:

- “Air Traffic Control capable coordination, using technology for real time care coordination while providing high touch support meeting NSPL standards, AND;
- Availability of Mobile Crisis Services, deployed centrally on a 24/7 basis, AND,
- Residential crisis stabilization programs, AND, and
- Conformance with essential crisis care principles and practices.
Current U.S. Approach to Crisis Care (The “Core Service in Community Care”)

- There is none
- Funding of crisis systems:
  - Federal support of NSPL coupled with inadequate state/local investments result in inadequate call center coverage
  - In states: an afterthought, except where there is focused leadership

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

- This is no way to run a system of national urgency. And given healthcare trends it could get worse (or better?)
Suicide Prevention Opportunities: Crisis Care

Expand Comprehensive Crisis Care
Via Budget/Funding/Regulation/
MCO Collaboration
• National/State standards for:
  • Tech enabled crisis
    coordination AND crisis call
    center under one roof
    • Manage access to inpt, outpatient
  • Manage/Deploy key
    Crisis Resources:
    • Mobile crisis
    • Crisis respite
  • Embed core principles
• Funding:
  • Need for Federal leadership
  • Direct, or via MCO’s
Suicide Prevention Opportunities: Crisis Care

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Apply Suicide Safe Care/ZS Standards to Crisis Operations

- For call center component: NSPL standards
- For clinical crisis components:
Care Components Embedded in a Pathway

Ask?
Collaborative Safety Plan?
Reduce Lethal Means?
Treat Suicidality?
Engagement and Support?

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
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Apply Suicide Safe Care/ZS Standards to Crisis Operations
• For call center component: NSPL standards
• For clinical crisis components:
  • Embed/standardize care pathway
    • Use of standardized tool for suicidality screening/assessment with clinical judgement
  • Stanley/Brown safety plan with means restriction
• Crisis center as core of transition supportive contacts
• Lead clinics etc. on suicide care
Crisis Now Recommendations

1. National and state level recognition that effective crisis care must be comprehensive;
2. Crisis call services should participate in and meet NSPL standards, and crisis systems should adopt and implement Zero Suicide across all program elements.
3. State and national authorities should apply standards of comprehensive crisis coordination and commit to achieving these capabilities within 5 years.
4. State and National authorities should work to ensure that mobile crisis teams are available to each part of every state.
5. Residential crisis stabilization alternatives to hospitalization should be made available in every state.
6. National and state authorities (and where relevant, accrediting organizations and payers such as health plans) commit to addressing core principles and practices in existing and to-be-developed comprehensive crisis systems.
7. Crisis calls should always be answered by a NSPL-qualified and participating center, in the caller’s area. This means that additional federal support for crisis call centers is alternatives.
8. All major health payers should recognize and reimburse crisis services provided to their members by comprehensive crisis systems. An analogy for this is payment for EMT by health providers. This step is necessary in order to have adequate capacity for crisis care and for efficiency. In order to achieve this step, leadership will be needed from CMS (Medicare/Medicaid), the Department of Labor, and state Insurance Commissioners.
Thank You
Download the report at http://crisisnow.com