



## Crisis Solutions Initiative

### White Paper on Mental Health Crisis Solutions

#### Introduction

Our current system of providing care for people in crisis related to their mental illness or addiction disorder is not working. We have come to rely too much on local hospital emergency departments (EDs) along with law enforcement to provide interventions at very late stages of a crisis episode.

The current mental health crisis system is a reactionary one and lacks the alternative resources needed to help individuals and their families access help during crisis episodes. The result is high levels of ED usage, extended wait times in an ED, repeated visits to the ED, increased incidence of mental illness in jails and prisons and higher costs.

#### Crisis System in Crisis

North Carolina experiences high levels of emergency department admissions for patients with mental health and substance abuse issues. In 2012, there were 17,000 additional visits to EDs related to behavioral health issues than in 2010. These ED admissions are among the highest cost options available.

Once admitted to an ED, wait times to receive the appropriate care can be lengthy. Extended lengths of stays in EDs for patients needing mental health and substance abuse inpatient care range from multiple hours to several

*For example, “Justin” is a 21 year old young man enrolled in his third year at a university. Justin had some problems with depression which impacted his school performance, self esteem, and friendships when he was in the 9th grade. He was hospitalized briefly and took some medicine for a couple of years. But for the past few years he has been free of symptoms. He works hard in school, has a few close friends, and although he drinks beer once in awhile is not known as a party guy. Recently, he has begun missing morning classes. He is letting his hygiene decline, not eating properly, and begins drinking earlier every day. He tells his roommate that “life is just not worth living”. He refuses to seek help at the student counseling service. His roommate is concerned and despite Justin’s objections calls his parents. They arrive in the early evening to find him intoxicated and he tells them he is worthless and wants to die. They need to take him somewhere for an assessment.*

*In many North Carolina communities, the only place for Justin and his parents to go is a local hospital emergency department. Unfortunately, if Justin needs inpatient hospitalization he might wait at the emergency department for hours, perhaps even days, waiting for a bed to become available to begin treatment for depression. The available bed will most likely be a number of hours away and Justin’s transportation to that facility will be in the back of a sheriff’s car. Connecting to services after the hospital stay will be made difficult since the hospital is not near the outpatient care offered in Justin’s school or home community.*

*If Justin’s symptoms had been more public, he may well have come to the attention of police—perhaps in the form of behavior that could get him charged with a misdemeanor—public intoxication, or walking in traffic or trespassing for instance. So Justin, like many others with mental illness, might end up in a jail instead of in any treatment setting.*

days. These extended lengths of stays are known as psychiatric boarding. According to the January 1, 2014 recommended standard from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), psychiatric boarding is not to exceed 4 hours. In NC, psychiatric boarding averages over 3 days as individuals wait for care in a state-operated facility.

A 2010 report stated that emergency departments are not a therapeutic environment for treating mental health symptoms that may include: paranoia, out of control thoughts, emotions, and personal nightmares. The report also estimated that over \$7 million is spent boarding people with psychiatric distress in EDs.

Repeated visits to the emergency department are another example of flaws in the mental health crisis system. In FY 2012, the repeat rate for a person seeking help in an ED with a primary diagnosis of mental health or substance abuse was 27 percent. The repeat rate within 30 days was 13 percent. This shows that individuals are not receiving the correct treatment, medications or planning to avoid a future crisis once they are released from the ED and often must return.

Often a person in crisis comes into contact with a law enforcement officer and may end up in jail instead of a hospital. Current estimates based upon national studies indicate that about 17 percent of the jail population has a serious mental illness compared to a rate of about 5 percent among those not incarcerated. In addition, 72 percent of the jail population with serious mental illness has a co-occurring substance use disorder. This is a significant population.

Jails are not mental health institutions and are not properly equipped to handle this population, yet people with mental illness are arrested more frequently and spend longer time in jail than the average citizen. A recent study conducted by researchers at RTI International, NC State University and the University of South Florida showed that outpatient treatment, including medication and outpatient services, may reduce the likelihood of arrest among adults with serious mental illness. Overall, costs were lower for those who were not arrested, even when they used more outpatient services. Individuals who were arrested received less treatment and each cost the government approximately \$95,000 during the 7-year study period. Individuals who were not arrested received more treatment and each cost the government approximately \$68,000 during the same period.

## Goals of the Crisis Solutions Initiative

The first focus of this initiative will be to reduce the number of visits to emergency departments along with the length of stay in EDs when a visit to one is unavoidable. This will provide better care, save money and reduce the burden on law enforcement and hospitals.

As work proceeds, the initiative will work towards identifying and implementing the best known strategies for crisis care. In addition to alternatives to emergency departments for crisis response, the system will benefit when we strengthen the supports that help people with earlier interventions or with strategies to help prevent crisis altogether.

## Expand Existing Solutions

We know there are multiple ways to address this problem. We will need solutions on multiple levels and in many areas of expertise. There are several evidence-based best practices that are already working in parts of the state that can be expanded and built upon.

- ***Walk-In Crisis Centers and Short-Term Residential Treatment Options***

Walk-in crisis centers are great alternatives to emergency departments in most crisis cases. They allow a person in crisis to be assessed and treated quickly by clinically appropriate staff. Crisis Centers serve as an alternative to jail or the emergency department where individuals in distress might wait for days until they get the correct treatment. They have shown to decrease the utilization of an emergency department for mental health and substance abuse crises in communities where they are located.

Walk-In Crisis Centers also offer the advantage of being more directly connected with community based alternatives for inpatient care. Due to complex regulations, ED's often have little choice but to refer to a psychiatric inpatient facility. Walk-In Crisis Centers, however, can access short term residential beds to assist a person who needs only a few days of crisis intervention for stabilization of mental health or detox needs. These Crisis Recovery Centers and Non-Hospital Detox Centers are closer to home and their ongoing support systems for most people.

- ***Youth Mental Health First Aid***

Youth Mental Health First Aid is an exciting new tool that, similar to CPR certification, is an evidence-based program that trains adults to be attentive to mental health issues in young people and intervene before the problem escalates. This will include training about unique risk factors, warning signs of mental health problems in adolescents and how to help youth who are experiencing a mental health crisis or substance abuse challenges.

- ***EMS Pilot Programs***

Walk-in crisis centers have successfully partnered with EMS paramedics developing opportunities to divert individuals in crisis to alternative locations for care. A Wake County pilot program included advanced mental health training for EMS paramedics. As a result, 258 individuals were able to avoid a trip to an emergency department and get care directly at a mental health or substance abuse treatment facility in 2012. This resulted in conservative estimated savings of 2163 bed hour resources in the ED, enough time to evaluate 721 chest pain patients.

- ***Person-Centered Crisis Prevention Plans***

Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's or family's needs. The standardized crisis plan, which is a component of the Person-Centered Plan, was implemented in April of 2006. Since then, we have realized that crisis plans must take a more comprehensive approach with an emphasis on promotion, prevention, and recovery strategies in order to decrease the number of individuals utilizing emergency departments.

- ***Telepsychiatry***

In August 2013, Governor Pat McCrory announced a statewide telepsychiatry program that builds on existing networks to improve access and quality of mental health services in North Carolina emergency departments. The start date for this program is January 1, 2014, and the Department of Health and Human Services has already met its goal of signing up 60 hospitals across the state to join the telepsychiatry network.

- ***Crisis Intervention Teams***

Crisis Intervention Teams (CIT) are a police-based, pre-booking jail diversion approach that provides law enforcement (including school resource officers) and other first responders the training and tools needed to understand mental health and substance abuse crises and symptoms, as well as helping them make decisions that get youth needed services in lieu of incarceration. CIT is spreading across the state through the Local Management Entities-Managed Care Organizations (LME-MCOs) through which North Carolina's mental health system is administered locally, in partnership with various local entities including local law enforcement, community colleges, county commissioners, advocacy organizations and similar groups. To effectively expand CIT, DHHS will continue to educate police chiefs, sheriffs, LME-MCOs and other local entities as to the benefits of CIT and how various sites are identifying resources for the training and materials, as well as provide technical assistance regarding best practices for implementing CIT programs.

- ***Care Coordination***

Care Coordination is one of the foundations for behavioral health care in North Carolina. We will engage our LME/MCO partners to assure that care coordination is an integral part of our crisis solution. Effective care coordination can help individuals navigate our complex system and link to the most appropriate community services.

## **Other solutions**

One of the first steps toward these goals is a reduction in paperwork. The Secretary has identified overlap in the requirements and regulations related to mental health facilities and providers that impact the ability of these providers to perform their job. She has instructed the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Health Service Regulation to review the existing regulations and reduce duplication wherever possible. The goal is to streamline processes that will make the job of caring for North Carolina citizens easier by reducing duplicative paperwork.

With constant change in the mental health system for at least the past ten years, many people do not know where to go or what to do in a crisis. One fix would be to create an easy-to-use online resource to assist consumers, families, parents, schools, neighbors and friends, with helpful information on who to call and how to seek services related to a substance abuse or mental health crisis or treatment.

More complicated but essential work will be done to identify the best use of public funding to support services that are working and to phase out some which are not. This will involve careful evaluation and negotiation within local communities.

## Mental Health Crisis Solutions Coalition

One key to the success of these efforts will revolve around understanding the entire crisis continuum and the development of partnerships. A Mental Health Crisis Solutions Coalition will be established that can address the serious inefficiencies that exist in crisis services. This solution oriented group will be tasked with examining the intersections of systems where people have a tendency to get stuck.

The responsibility for crisis intervention and treatment extends beyond the Division of MHDDAS. Hospitals, EMS and other health care providers, schools, law enforcement, magistrates, the faith community, and family and consumer organizations all have valuable roles to play to help people with mental illness and substance use disorders stay out of crisis and to help them return to recovery after a crisis. Representatives from these and other systems will be asked to participate in the Mental Health Crisis Solutions Coalition. The group will be encouraged to:

- Recommend and establish partnerships
- Make recommendations related to data sharing across systems
- Evaluate research on evidence based practices
- Provide technical assistance to LME/MCOs behavioral health providers, law enforcement and other criminal justice officials, and other interested community partners
- Develop education and marketing about alternatives to the use of emergency departments
- Recommend legislative, policy and funding changes
- Strategizing on the use of varied funding sources to support innovative community level programs.
- Finding the right balance of funding and other resources to promote the development of a comprehensive array of both crisis and non-crisis services and supports.



## Measuring results:

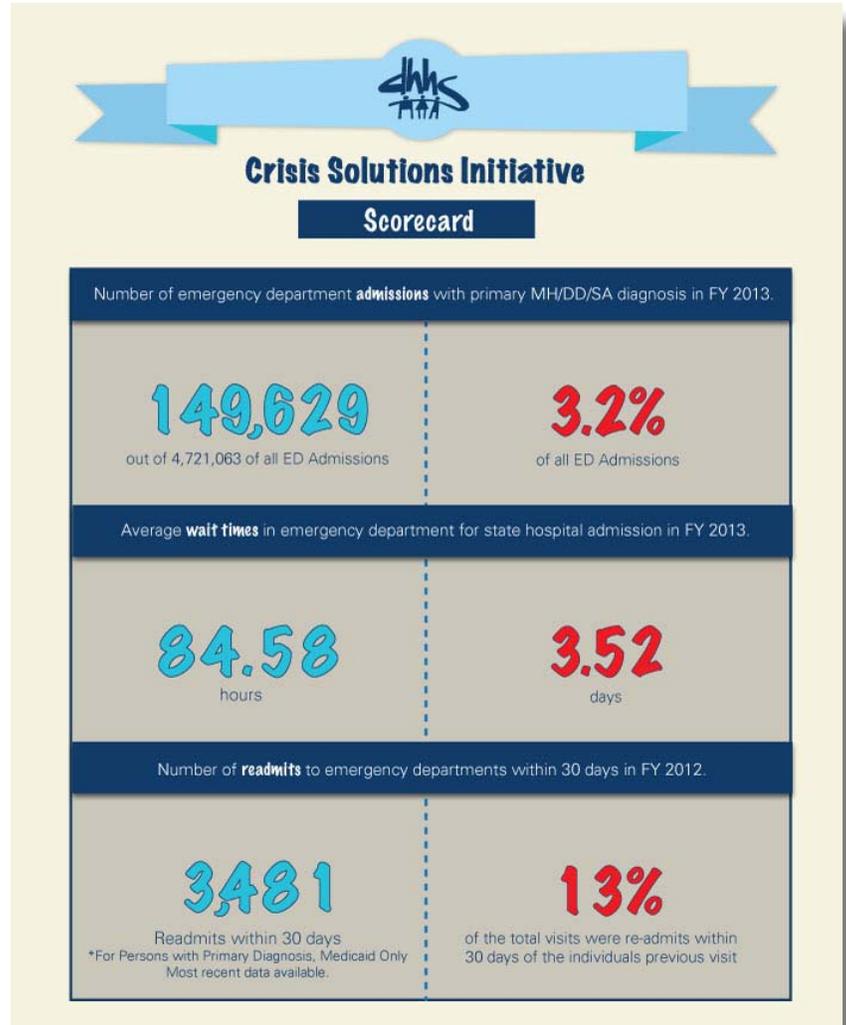
It is extremely important that the goals we set are attainable and are measurable. An annual scorecard will track the progress of these initiatives by measuring three key indicators.

- The percentage of emergency department visits for primary diagnoses related to mental health or substance abuse issues,
- Wait times in EDs for inpatient care (psychiatric and substance abuse) placement,
- Numbers of people with mental health crises, who have been admitted to EDs that are readmitted to an ED within 30 days.

## What does success look like?

We know that the current system does not work as it should. We know some things that will address the problem and alleviate the stress on the state's hospitals and law enforcement officers. We should start the process to utilize the best practices that we know while we continue to search for additional solutions. This initiative will do both.

Success will be based on the continuous improvement model. We must continue to reduce the numbers of individuals that utilize EDs by giving them alternatives. At the same time, we must continue to reduce the wait times in emergency departments and the repeat visits by attacking the problem on multiple fronts. The solutions will be many and some have not been thought of yet, but we can do some things now like person centered planning and telepsychiatry. The Crisis Solutions Coalition will continue to search for new best practices. ●



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