CRISIS SYSTEM OF CARE STRATEGIC DEVELOPMENT PLAN SKAMANIA COUNTY ADDENDUM

June 2017

Specific Recommendations & Next Steps for Skamania County

Building effective Crisis Systems of Care is a continuous process of adding depth and breadth and applying new knowledge. There are many ways to start and the work is never complete. An effective crisis system requires continuous evolution, as the communities and components themselves constantly change. Several themes emerged during a recent community engagement process. We concur with Skamania County behavioral health leadership that untapped opportunities exist, particularly in areas of crisis prevention and early intervention in the Crisis Systems of Care (CSOC) Framework below. When intervention comes early (pre-involuntary process initiation, pre-hospital transport, pre-arrest, when symptoms first emerge) there is less risk, lower cost and greater flexibility in methods of response

With these caveats in mind, we recommend the following priority areas for initial focus. We have chosen these because we believe progress is achievable in a relatively short timeframe, improvements have potential for paying significant dividends, and they will have a positive impact on care experience. The ordering does not reflect their relative importance.

Crisis Systems of Care (CSOC) Framework

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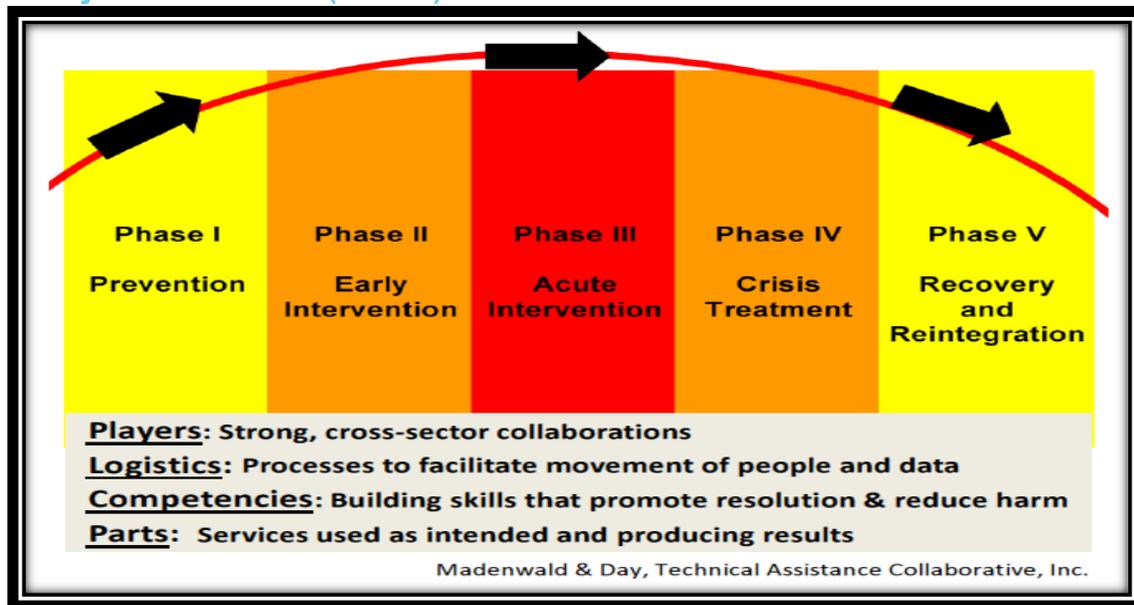
1. DEVELOP A CRISIS SYSTEMS OF CARE COLLABORATIVE SPECIFIC TO SKAMANIA COUNTY

Experience has shown that with little investment — other than time — communities can dramatically improve Crisis Systems of Care by focusing on player partnerships, logistics, and competencies. We recommend the formation of cross-sector and Skamania County-specific crisis system collaborative to focus on identifying opportunities and to tackle challenges unique to Skamania's population and rural geography. As the regional BH-ASO, Beacon sees our role as the organizer: the entity

responsible to ensure work is completed between meetings to make forward progress and ensure people feel invested in the forum and that their time is well spent.

Opportunity exists to maximize Skamania County's potential by mapping a Crisis System of Care specific to the county, cultivating resources, aligning partners within the county, and home-growing new resources. In other rural or frontier communities this has included developing local peer specialists, using the talents and any downtime of local emergency medical technicians (EMTs) in different ways, and educating a diverse representation of residents in skills like Mental Health First Aid (MHFA).

Efforts underway to bring a Federally Qualified Health Center (FQHC) to the county are a positive advancement to expand access to care. Finding more alternatives to Sheriff department-based evaluations should be high on the agenda.

It is essential to have participation of people with lived experience on the collaborative. The following activities are examples of focus areas for the collaborative:

1. Decide critical data for the community to track to assess crisis system performance and review the data routinely, such as real-time data sharing, cost analysis and target populations.
2. Track data and strategize how to reduce the use of involuntary interventions in crisis episodes.
3. Track data and strategize how to increase the use of peer or parent peer specialist involvement in crisis episodes.
4. Track data and strategize how to reduce Sheriff-department involved crisis detentions and out of area placements.
5. Develop written protocols that describe roles and expectations in interactions between the players in the crisis system.
6. Develop a communications strategy to share written protocols with key community partners so they understand the crisis continuum of care and opportunities for upstream interventions.

2. DEVELOP NONTRADITIONAL CRISIS SERVICE PATHWAYS

The large county geography coupled with low density population means it can take significant time for traditional crisis responders (mobile crisis team or law enforcement) to arrive on-scene. To decrease the wait time and to give additional tools to others in the community who may first encounter a person in crisis, we recommend exploring nontraditional pathways to deliver initial crisis support, such as recruiting volunteers to be mental health first aid crisis responders through Emergency Medical Technician (EMT) personnel, Park Rangers, Volunteer Fire Departments, Meals on Wheels volunteers, pharmacies, Skamania County Council on Domestic Violence and Sexual Assault, school counselors and administrators, peer and family support specialists, etc.

Beacon is committed to supporting regular access to a master trainer in mental health first aid and crisis intervention core curricula in Skamania County. We can develop an annual curriculum of training opportunities and explore providing a stipend to participants upon completion to encourage enrollment. MHFA can be effectively offered to the general public with an interest in expanding their knowledge of mental illness and ways they can support those in crisis, as well.

Training curriculums:

- **Mental Health First Aid**[1] is an 8-hour training that teaches skills to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Mental Health First Aid takes the fear and hesitation out of starting conversations about mental health and substance use problems by improving understanding and providing an action plan that teaches people to safely and responsibly identify and address a potential mental illness or substance use disorder. Just as CPR helps in assisting an individual having a heart attack, Mental Health First Aid helps to assist someone experiencing a mental health or substance use-related crisis. Topics covered include risk factors, warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Mental Health First Aid teaches about recovery and resiliency – the belief that individuals experiencing these challenges can and do get better, and use their strengths to stay well. Course types include one for adults (age 18 and up), one for youth (age 12-18), and one for law enforcement.

- **The Crisis Intervention Team (CIT) program**[2] is a community partnership between law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families and other advocates. It is an innovative first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness related behaviors. It promotes officer safety and the safety of the individual in crisis. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. A national CIT training curriculum model was developed through a partnership between NAMI, the University of Memphis CIT Center, CIT International and the International Association of Chiefs of Police. The curriculum provides an outline for local programs to follow and programs often innovate within these guidelines to meet local needs. The 40-hour intensive training includes verbal de-escalation skills, scenario based training on responding to crises, personal interaction with people who have experienced and recovered from mental health crisis and with family members and learning from mental health professionals and experienced officers.

- **Southwest Washington NAMI Chapter**. The local NAMI chapter currently receives funding to complete six Family to Family trainings per year. There is an expectation that at least one of these is offered in Skamania County.

3. COLLABORATION WITH SHERRIFF'S OFFICE & CRIMINAL JUSTICE SYSTEMS

The Sherriff's office is highly engaged with the local community and often on the front-lines of mental health crisis response. We recommend the following approaches to make incremental improvements in supporting their ability to be an effective partner in crisis response:

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[1] Learn more at https://www.mentalhealthfirstaid.org

[2] https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT

a) Share with the Sherriff's deputies pocket-size cards with crisis hotline number.
b) Encourage Sherriff's deputies to call the crisis line to get a counselor on the phone if they are responding alone to a crisis situation. The counselor can help de-escalate the situation and create an effective safety plan.
c) Pilot a procedure when deputies are called for a behavioral health related response to utilize the crisis line and/or utilize an iPad to connect with a crisis clinician for supportive interventions. If this pilot is successful, we could contemplate rolling this out to other professionals, such as EMT and/or park rangers.
d) Support the purchase of naloxone so that trained deputies have the lifesaving drug available.
e) Support the local mental health department in providing jail-based intervention services.
f) Start a pre-adjudication behavioral health court to help divert individuals into treatment instead of incarceration.

4. DEVELOP A CRISIS SYSTEM OUTCOME TRACKING DASHBOARD

Stakeholders invested in developing the crisis system need to be able to view process and outcome performance data. This data is important to inform areas for investment of time and resources and to demonstrate the value of those investments across sectors. The appendix includes a draft dashboard of crisis system measures to track and review with crisis system collaborators. It is broken down into what data is already easily available to track and data that may be useful but will require more effort to consolidate and track.

The goal will be to make the data publicly available on the Beacon website. Key questions we seek input on from stakeholders are: 1) Are these the right data elements to track i.e. is anything missing or shouldn't be included? 2) What is the right frequency for updating it? 3) How can the data be used strategically to improve system performance?

Longer-term goals would be to develop a dashboard with real-time data along with real-time bed and treatment capacity trackers for the region.

5. DEVELOPING RESPITE CARE OPTIONS & EXPANDING TRANSPORT OPTIONS

An important tool in preventing crisis situations is to have crisis stabilization alternatives to acute inpatient admissions that are recovery-focused and welcoming for individuals experiencing crisis and can also be supportive in giving caregivers a needed break. This need for respite can pertain to people caring for individuals with a mental illness, a developmental disability or dementia.

Respite care may be provided by home health care agencies, adult family homes, boarding homes, adult day health or adult day care programs, nursing facilities, or family, friends, and volunteers.[3] Detailed procedures would need to be developed and logistics coordinated but there is opportunity to leverage these existing community resources to support individuals living with mental illness and

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[3] https://www.dshs.wa.gov/altsa/home-and-community-services/respite-care

also strengthen them for families confronting other challenging situations. A successful model of leveraging respite programs for mental illness can be found in the Colorado Respite Coalition.[4]

Transportation can be a barrier to accessing respite or other services. The system is currently designed to only allow EMS transport to hospital settings, however, Washington State has updated law that allows EMS ambulances to transport to non-hospital settings. We recommend that Skamania County change local policies and procedure rules to allow the local EMS district to transport residents to a non-hospital setting.

Figure 2: Stepped care model for treatment of suicidal behavior disorder
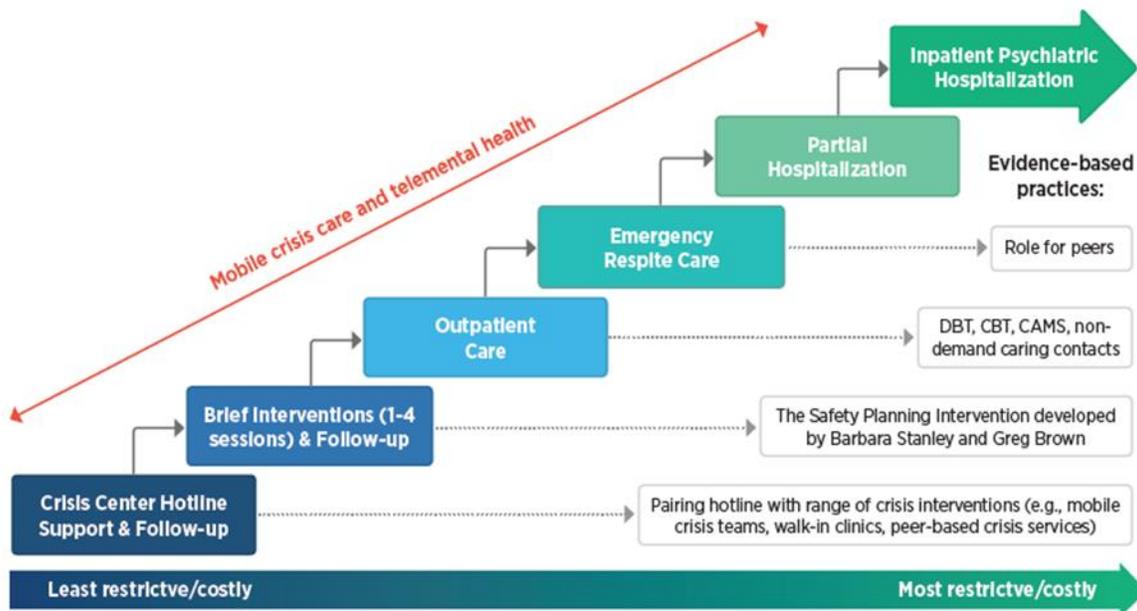
Source: Adapted from the Zero Suicide website, http://zerosuicide.sprc.org/toolkit/treat/providing-least-restrictive-care

6. CARE EXPERIENCE ANALYTICS

There are many ways to enhance a crisis system of care and it is important to keep focus on the human, service-user aspect of this. Deep dives into "care experience" are critical in keeping CSOC's on track. Based on local conversations here are two considerations for cross-sector review and strategy development:

a. **Course of care analysis**: Although the volume of crisis episodes is relatively low in Skamania County (April 2016-December 2016: 73 crisis calls, 37 face to face crisis responses, 30 involuntary detention assessments and 1 involuntary detention; January 2017-May 2017: 26 crisis calls, 8 face to face crisis responses, 8 involuntary detention assessments and 0 involuntary detentions), the per episode length of time can be substantial particularly when hospitalization is required. Analysis of timelines and throughput factors by sector (i.e. decisions/protocols/how a person moves through

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[4] http://www.coloradorespitecoalition.org/index.php

course of care/contact) of 5 to 8 of these events could yield improvements that would bring faster relief to the person in crisis and streamline resources for the various sectors.

b. **Top Ten user intervention**: Considering emergency department visits, crisis line calls, 911 calls, jail admissions that are mental-health related, crisis episodes, identify the top 5 to 10 Skamania County residents that come to the attention of one or more of these systems. Engage each individual in problem solving and development of person-specific strategies for future response. What helps? What doesn't help? If it were to go perfectly next time, what would the community's response look like? In addition to any involved systems, consider engagement of a peer specialist in those conversations.