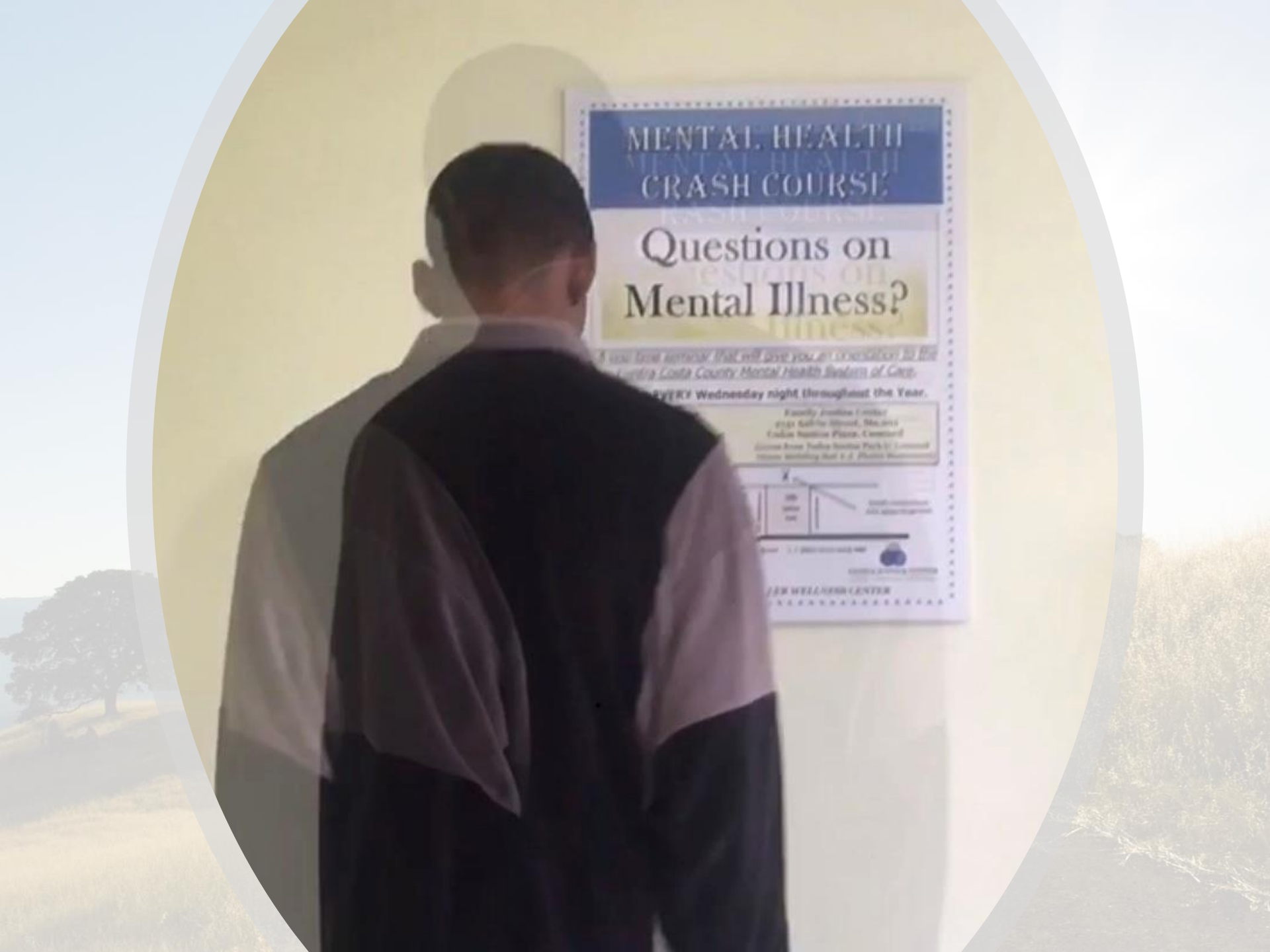
Community Crisis Response

Rapid Improvement Event I

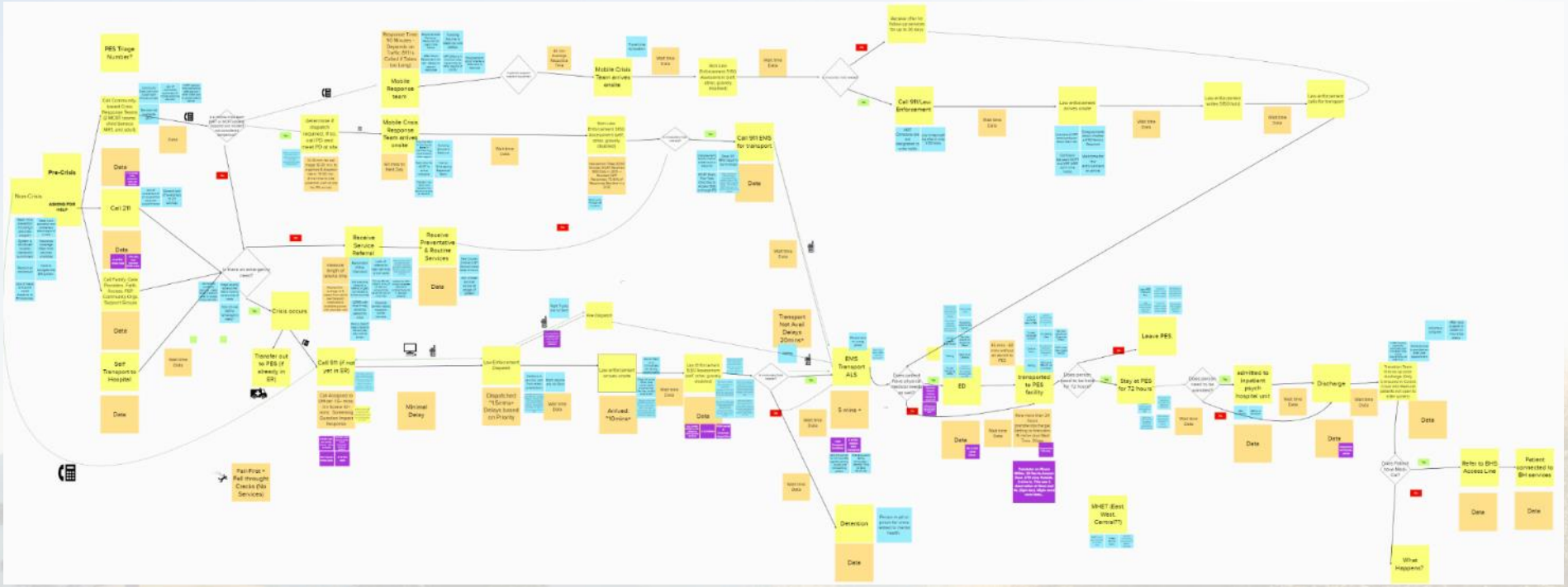
Report Out: April 2, 2021


MENTAL HEALTH
CRASH COURSE
Questions on
Mental Illness?
Wednesday night throughout the Year.

AIM:

Anyone in Contra Costa County can access timely and appropriate behavioral health crisis services anywhere, anytime.

The Current State:
Value Stream Map, November 2020



Blue = Waste	Yellow = Process Step	Orange = Data Cycle and wait times	Purple = Specific Data Points

Waste Identified

Priority Improvement Areas

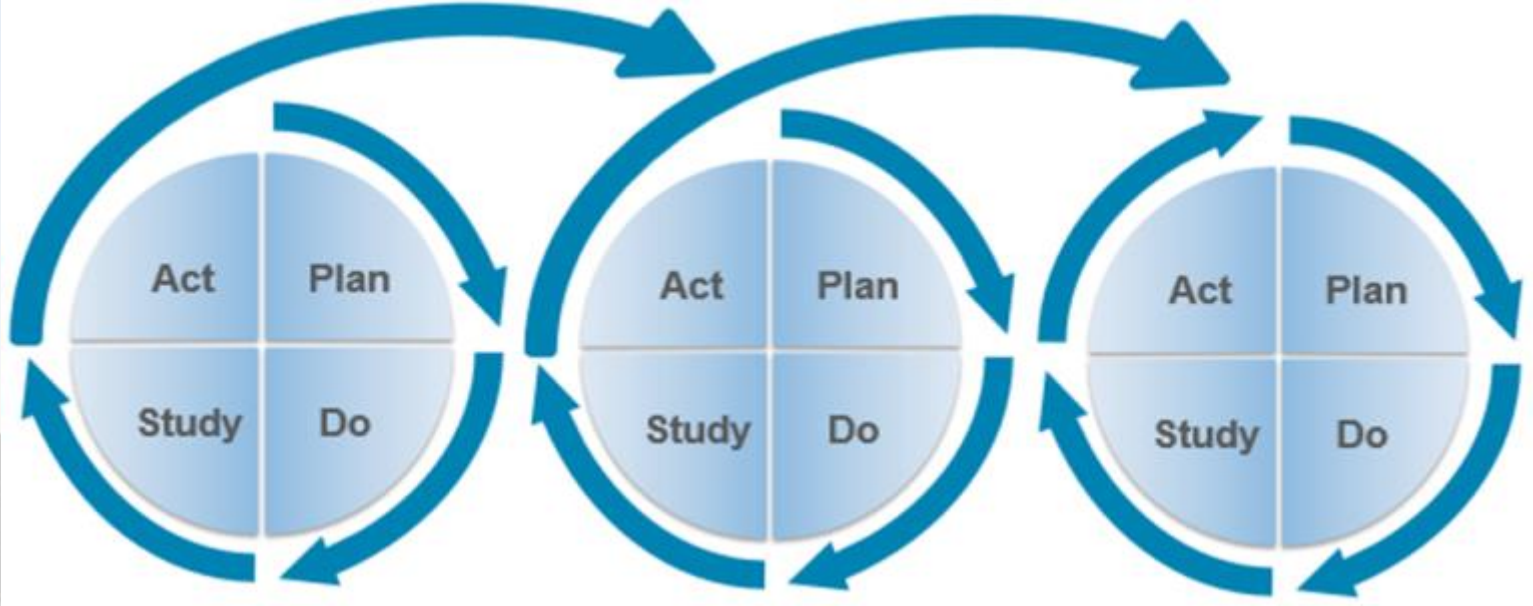
Single Phone Number

Mobile 24/7 Response

Non-Police Mobile Crisis Team

Alternate Destinations

The PDSA Cycle
"Small Tests of Change"



A project may require multiple PDSA cycles in order to achieve the project's overall goal.

Guest Speakers and Teams

GUEST SPEAKERS

- Stephanie Lewis
- Latasha Bouzek
- Marshall Bennett
- Tracy Borghesani
- Sgt. Matthew Cain
- Paolo Gargantiel
- Katy White
- Tom Tamura
- Juno Hedrick
- Ariana Singh-Adams

TEAMS

- Single Phone Number Mobile 24/7 Crisis Response Team
- Crisis Triage & Assessment Team
- Non-Police Mobile Crisis Team

Single Phone Number/Mobile 24-7

Single Phone Number/Mobile 24-7 Team

- **Problem Statement:** There are 19+ telephone numbers for the public to access crisis mental health support. The uncoordinated multiple entry points limit access by creating barriers for an appropriate and timely response.
- **Goals:** By January of 2022 75% of individuals who call a single phone number for a mental health crisis will have 24/7 access to services and a mobile response within 45 minutes.

Community Perspective

"I would like a direct line for a dispatcher. So that a mobile response could be contacted directly. Also, more mobile response so that they're not flying from San Pablo to Discovery Bay." – Healthcare Worker

TEST OF CHANGE: Who would you call during a mental health crisis?

- **Problem**: The community does not know who to call FIRST for a mental health crisis other than 911.
- **Test of Change**: We asked residents who they would call during a mental health crisis.
- **Results:** Of the 34 people asked - 12% would call family member; 33% don't know who to call; 18% would call their doctor; 3% would call the suicide hotline; 9% would call 211; 25% would call 911.
    - Approximately 75% were not aware of the available community resources.
    - Community outreach is needed to market who to call besides 911.

Community Perspective

"911, because it is the only number I know." - Medical Assistant

"I don't know any of those numbers, I would probably suffer in silence." - Banker

"I don't know who to call, not 911, because it's not life or death." - Executive Assistant

TESTS OF CHANGE: What is the current system?

- **Problem:** Uncoordinated entry points for crisis support
- **Test of Change**: Interviewed two existing call centers and two mobile response teams
- **Results:** A centralized hub is more effective for a mobile crisis response

"I would like the county to let people know that help exists and they can call other numbers besides the suicide hotline or 911" – Teenage Student

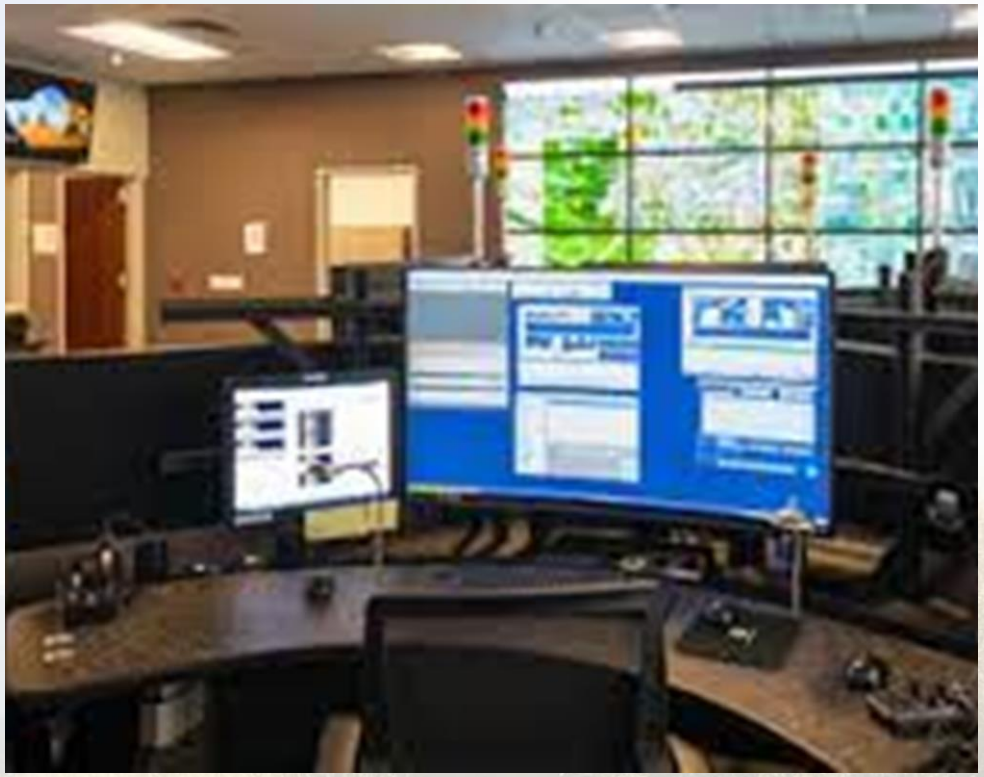
Centralized Crisis Call Services

"I would like a direct phone number to a crisis response team"- Caregiver

- Ensure call services offer real-time access to a live person every moment of every day for individuals in crisis.
- Follow "Best Practices" according to SAMHSA guidelines.
- The incorporation of advanced technologies is essential to operating a centralized crisis call center hub.

The Hub

All calls are routed to a call center where they are triaged and dispatched to Mobile Crisis Teams in the field.



CALL CENTER TECHNOLOGY"HUB"

Advanced Call Center Software (Motorola-Vesta)

- Caller ID and text functioning
- GPS
- Real time client updates sent directly to a mobile data terminal inside crisis team vehicles

Computer Aided Dispatch

- Dispatch calls directly to Crisis Team for immediate response
- Real time Crisis Team status and location for safety monitoring
- Optimizes response from the time of call to post crisis follow up

Crisis Triage & Assessment

Crisis Triage & Assessment Team

Problem Statement: Mental crisis calls (regardless the source) are not consistently responded to with a mental health crisis team.

Who responds to mental health crisis calls? Too often, it is just the police.

Goals: Develop two triage tools [911 diversion & mobile team assessment] and a decision tree that can provide *the most appropriate level of care* in a *timely fashion* to anyone, anywhere, & anytime.

Lived Experience Perspectives

"In February 2021, the Martinez Police brought my son who was threatening another with a knife into Psychiatric Emergency. **Law Enforcement must spend as many hours training how to save the life of a person whose mental state is impaired as they do apprehending a person robbing a bank."**

Family Perspectives

"Our son's first involuntary hold was a suicide by cop-type event. He was 16. I have had to call the police over 50 times in the past 19 years in order to get him medical care. He was 5150d every time, which is not easy. That usually meant that we were living on the edge, in fear of what he would do to himself or someone else. We knew that if we called too soon he wouldn't be taken into the hospital. So we waited and, when the time was right, my husband would stand watch while I snuck into the backroom and dialed 911 and said, "Please hurry."

We have had to watch our son walk out of our front door in handcuffs to the waiting ambulance too many times. It is the same door that I carried him through as a baby. This illness and system were not included in the dreams for our newborn son and our family. But now that they are our reality, I have committed to partnering with anyone to fix what I call the system of luck and heroics. **All of us in this room are part of that system and we need to join our voices and start shattering silence about the chaos of care."**

Mental Health – the 4th arm

Law enforcement

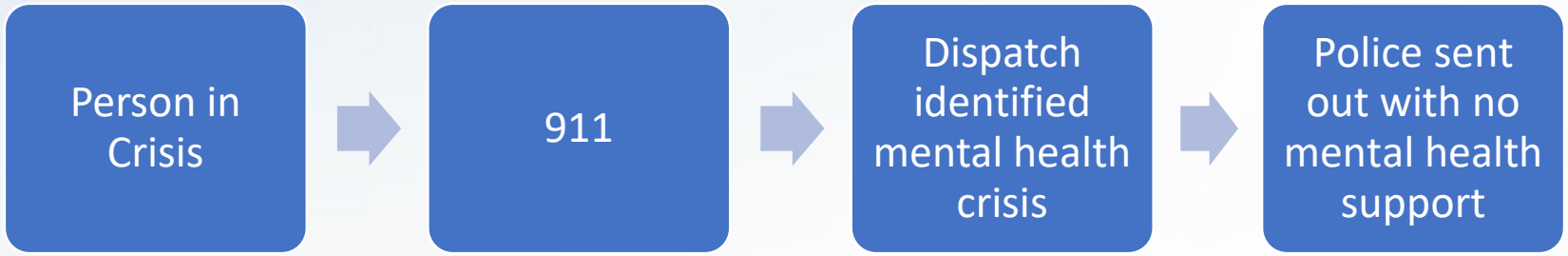
Medical

Fire

Mental Health

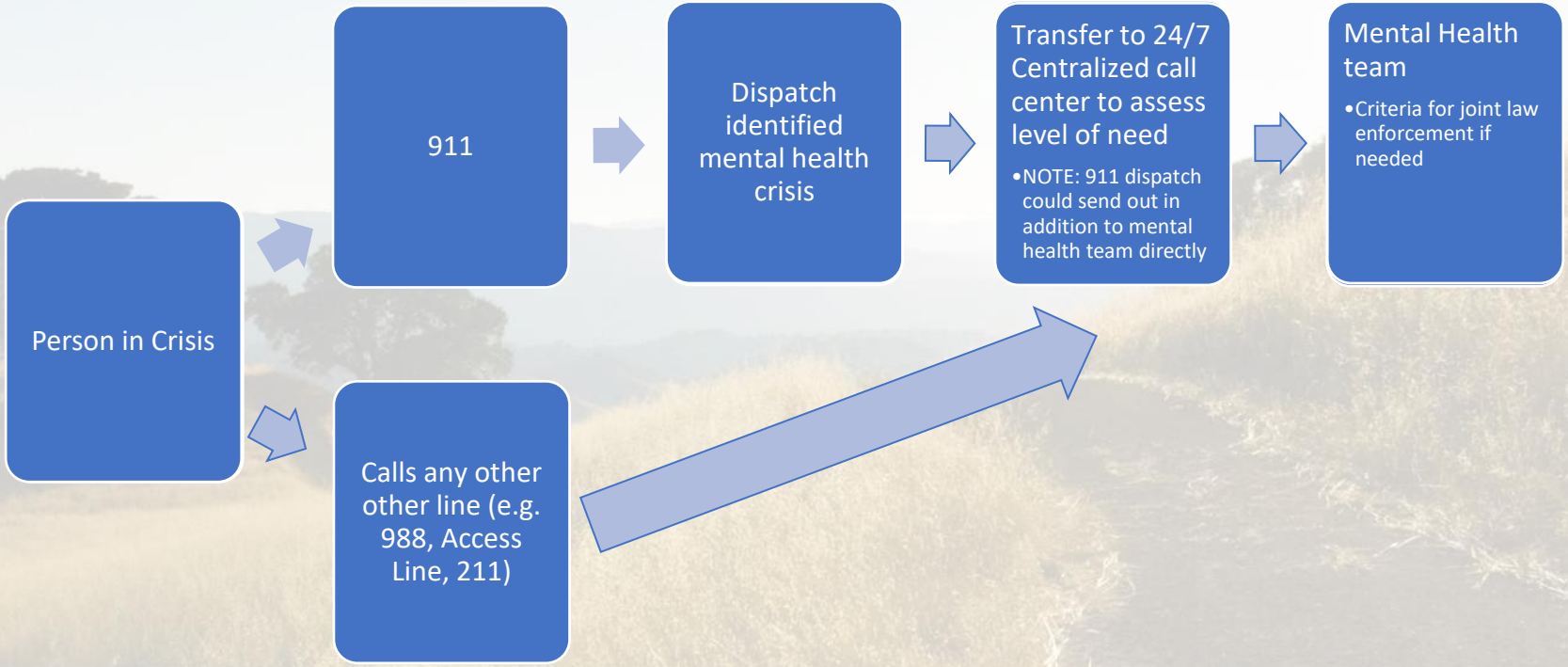
Current State of 911 mental health crisis calls

Worst Case Scenario



Best Case Scenario

Ideal State


Person in Crisis
911
Calls any other other line (e.g. 988, Access Line, 211)
Dispatch identified mental health crisis
Transfer to 24/7 Centralized call center to assess level of need
•NOTE: 911 dispatch could send out in addition to mental health team directly
Mental Health team
•Criteria for joint law enforcement if needed

911 Triage Tool

911/Dispatch

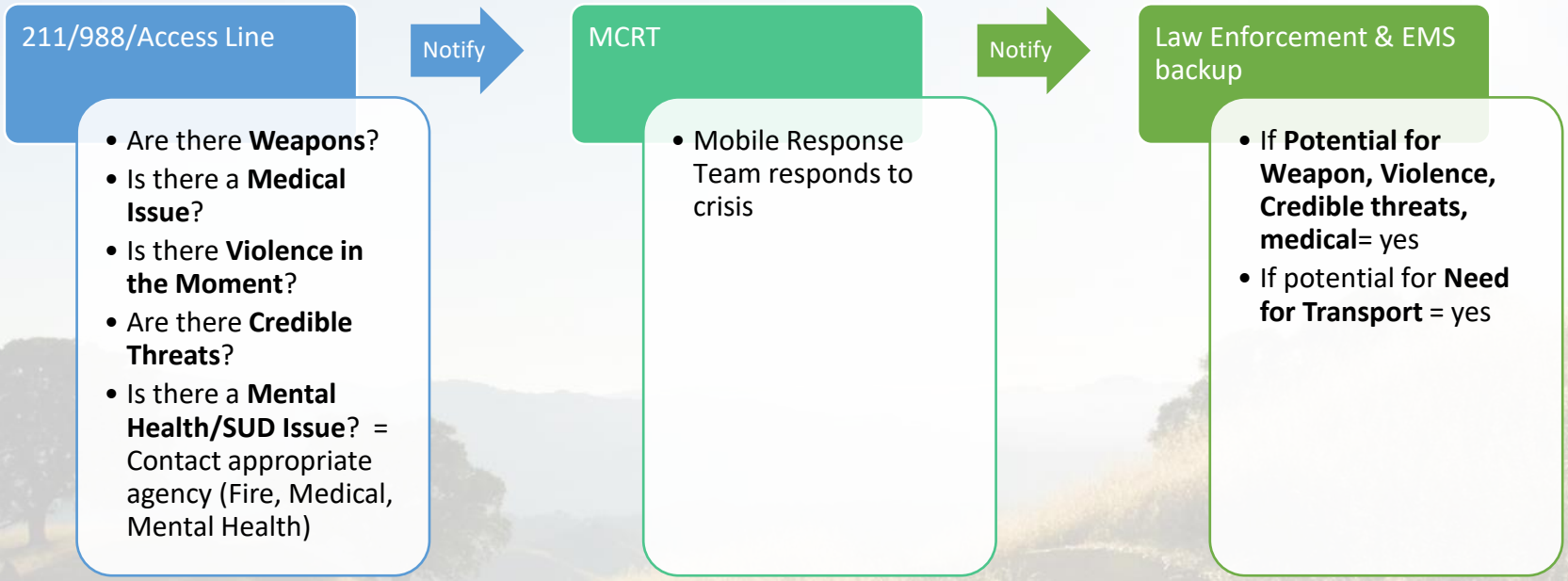
- Is there a **Mental Health/SUD Issue**?
- Are there **Weapons**?
- Is there a **Medical Issue**?
- Is there **Violence in the Moment**?
- Are there **Credible Threats**?

Notify

MCRT

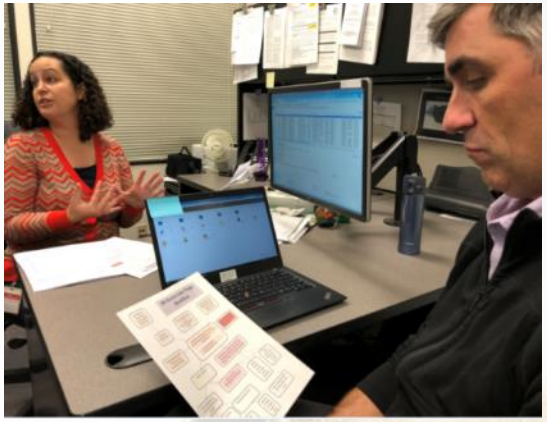
- If MH/SUD → always send out MH team
- If weapons, medical, violence, credible threats → LE and EMS will go out with MH team available

Call to 211/Access Line/988



911 Diversion Test:

- **Problem:** Employ 911 triage with police dispatch to understand if mental health was identified



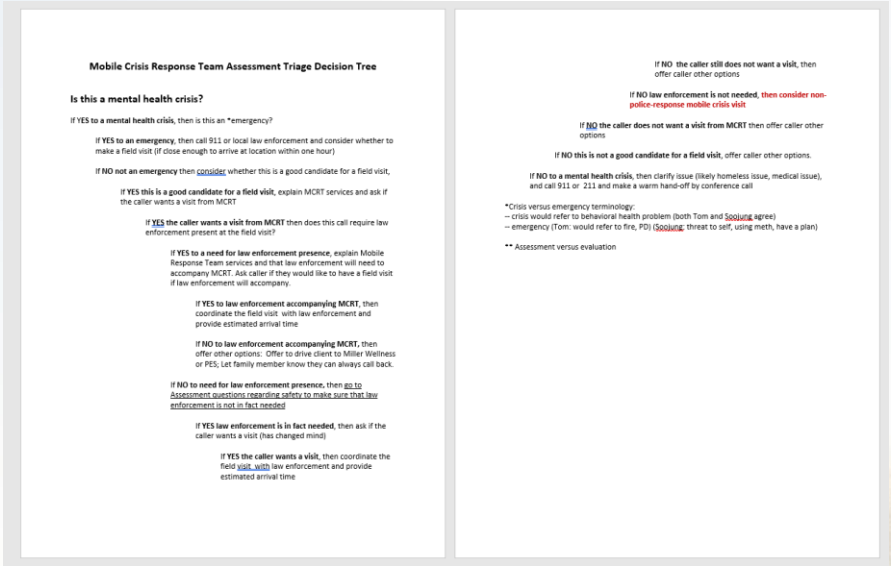
- **Test of Change:** Applied mental health crisis scenarios with Concord Sgt to see if he would deploy MRCT or MRT.

- **Results:** In a little over half of scenarios a mental health crisis team would NOT have been deployed in conjunction with law enforcement.

Goals of MCRT/MRT Assessment

- Goals:
  - A triage decision tree that is
    - inclusive of the majority of crisis and non-crisis scenarios
    - includes non-police-response option whenever appropriate
    - efficient
    - allows for various levels care (mobile crisis, crisis line support, referral to other resources)
  - A script that is
    - Efficient, comprehensive, as brief as possible, compassionate, respectful, and culturally sensitive

Triage Decision Tree Test:



Mobile Crisis Response Team Assessment Triage Decision Tree

Is this a mental health crisis?

If **YES to a mental health crisis**, then is this an *emergency?

If **YES to an emergency**, then call 911 or local law enforcement and consider whether to make a field visit (if close enough to arrive at location within one hour)

If **NO not an emergency** then consider whether this is a good candidate for a field visit,

If **YES this is a good candidate for a field visit**, explain MCRT services and ask if the caller wants a visit from MCRT

If **YES the caller wants a visit from MCRT** then does this call require law enforcement present at the field visit?

If **YES to a need for law enforcement presence**, explain Mobile Response Team services and that law enforcement will need to accompany MCRT. Ask caller if they would like to have a field visit if law enforcement will accompany.

If **YES to law enforcement accompanying MCRT**, then coordinate the field visit with law enforcement and provide estimated arrival time

If **NO to law enforcement accompanying MCRT**, then offer other options: Offer to drive client to Miller Wellness or PES; Let family member know they can always call back.

If **NO to need for law enforcement presence**, then go to Assessment questions regarding safety to make sure that law enforcement is not in fact needed

If **YES law enforcement is in fact needed**, then ask if the caller wants a visit (has changed mind)

If **YES the caller wants a visit**, then coordinate the field visit with law enforcement and provide estimated arrival time

If **NO the caller still does not want a visit**, then offer caller other options

If **NO law enforcement is not needed**, **then consider non-police-response mobile crisis visit**

If **NO the caller does not want a visit from MCRT** then offer caller other options

If **NO this is not a good candidate for a field visit**, offer caller other options.

If **NO to a mental health crisis**, then clarify issue (likely homeless issue, medical issue), and call 911 or 211 and make a warm hand-off by conference call

*Crisis versus emergency terminology:
-- crisis would refer to behavioral health problem (both Tom and Soojung agree)
-- emergency (Tom: would refer to fire, PD) (Soojung: threat to self, using meth, have a plan)

** Assessment versus evaluation

Problem: The current decision tree is not inclusive of all potential crisis scenarios

Test of Change: We tested the current decision tree and ask for feedback on how we can include the critical elements that would make it more inclusive.

Results: Revise the decision tree to make it more inclusive of all crisis scenarios

Non-Police Mobile Crisis Team

Non-Police Team

Problem Statement: It's hard to get a consistent quality non-police response to a Mental Health Crisis in Contra Costa

> *"You need to have a crisis at certain times of day, have certain insurance, know who to call, what to ask for, and be patient…."*
> Non-Police Team

Goal: When "Mental Health Crisis" Rapid Responses are requested; we will provide the "least restrictive" response and start providing services within 45 minutes of the call, during expanded business hours for now, and attempt follow-up on 100% of the interactions by 12/31/2021.

Perspectives

“I thought 911 was the only option”
–San Ramon family

“One **common issue** that comes up with **city/county driven non-police response** projects is that they can end up either **replicating punitive structures** (like mandating care or forcing treatment) or getting stuck in a place where the **police leverage their power** to make sure they’re still somehow connected into responses” – Alameda County Community Crisis Group

Reduce Police Involvement with Adult Mobile Crisis Response Team

Problem: Police presence can escalate/traumatize customers. Delays time to respond.

Test of Change: Change from a Police Co-Response Model to MH First when safe

Results: Called dispatch in advance but not able to evaluate results based on calls today. Using MH First Model has been tested and can work

"I had a fear of calling 911, with my son being an African American and restrained in the past. However, here with Concord Police and MCRT, we had a positive experience and we will call again."

Use of Technology

Problem: Response times can be too long. Hard to share resources and securely connect with Customers.

Test of Change: Asked customers if they had interest in virtual connections. This will also improve wait times.

Results: Want to test tech next time but idea was received favorably

"In the future I would be open to virtual interactions"

Behavioral Health Operations Center

Problem: Supporting the Crisis in the field can be hard. Having access to the right systems, resources, radios, transports, etc.

Test of Change: Thought exercise based on SAMHSA (Substance Abuse and Mental Health Services Administration) guidelines

Results: Having someone who could pull in additional resources, see placement availability, transports, etc. would be really helpful

Overall Recommendations

- Empower law enforcement dispatch with a standardized, clear county wide protocol to utilize the mental health crisis response team
- Offer a clear alternative to 911 for mental health and substance use crises
- Review a subset of all law enforcement dispatch calls to determine what percentage could deploy the mental health crisis team
- Establish a coordinated review process that includes, law enforcement, behavioral health, emergency medical services, families for how we are doing, identify and explore possible improvements
- Establish collaborative/crossover training program for mental health, law enforcement, emergency medical services – all call takers and crisis responders

Overall Recommendations Part 2

- **Develop a 24/7/365 Centralized Crisis Call Hub**
  - Call answered by a live person
  - Based on the Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Meets the National Suicide Prevention Lifeline Operational Guidelines
  - Offers air traffic control (ATC) quality coordination of crisis care in real-time
  - Explore virtual options for hub
  - Using existing crisis call data to determine staffing needs
- **Develop 4 Regional Crisis Teams to be deployed by the centralized hub**
  - Located in South, East, West, and Central regions of the County
  - Culturally and linguistically responsive to the needs of the community
  - Receive real-time support from the centralized call hub for ongoing care following a crisis (accessing needed resources, warm handoffs etc.)
  - Using existing mobile response team data to determine staffing needs

Overall Recommendations Part 3

- Continue testing with MCRT and local police
- Create flexible response teams
- Develop a centralized Hub
- Explore systems/technology to support this work
- Incorporate customer feedback and other quality measures for continuous improvement

Data and Measures

How will we know we are successful

Program Success

The coordinated response should be able to reduce the number of mental health detention bookings, police interventions for mental health, reduced involuntary holds, psychiatric emergencies, and link people into ongoing behavioral health care.

This program will save lives.

Data Needs

To successfully monitor this project we will need data from a variety of different sources:

- Call Center log details
- Dispatch system history
- Client demographics
- Triage and Assessment tool responses
- Mobile response team travel details
- Crisis encounter details and outcomes
- Encounter follow-up and referrals

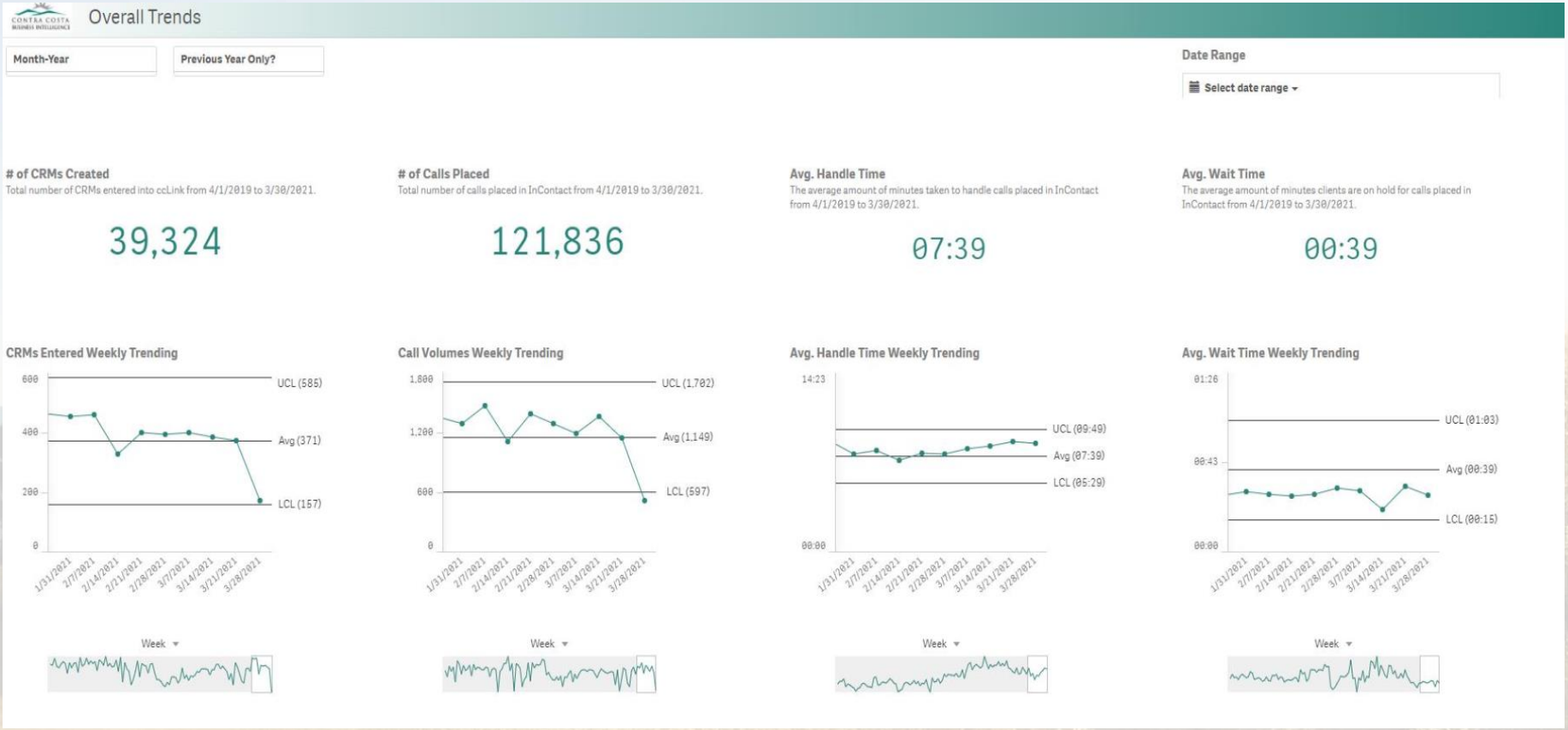
Data between the sources will need to be:

- Flag mental health at all points across the continuum
- Standardized across sources (data governance)
- Centrally located
- Accessible to the right people at the right time
- Tackle privacy and data sharing laws
- Universal training and education
- Funding to accomplish this

Brainstorming Measures

Team	Updated Priority Aim	Process Measure Examples	Balancing Measure Examples
Single Phone Number & 24/7 Mobile Response	By Q2 of 2022, 75% of individuals who call the crisis hub for a mental health crisis will have 24/7 access to services and a mobile response within 45 minutes.	Call Volumes Abandonment Rates Wait Times Handle Times Caller Demographic Analysis Dispatch Stats Education Survey Responses By Q2 of 2022, 85% of county survey responders know about 211 and other mobile response services Predictive modeling for call volumes, client vulnerability, etc.	Handle times for clients calling behavioral health hotlines and 911 Call volumes for non-health services mental health hotlines
Triage & Assessment Tools	80% of 911 calls that had mental health identified received a mental health intervention 100% of calls to the hub received services that were appropriate to that call	Type of incoming calls (harm to self, harm to others, etc) Type of intervention received (in person, telephonic, referral, AMA). With/without LE Calls coming in by location & geography Time of call from start to finish (min/med/max) Time of call to service rendered (min/med/max)	Ability for central call center to respond to non-mental health calls (e.g. substance use, developmental disabilities, memory care) that may come in
Non-Police Response	Provide the “least restrictive" response and start providing services within 45 minutes of the call with attempted follow-up on 100% of the interactions by 12/31/2021	Reduced interactions with Law Enforcement, Improved Response Times, Increased Connections to Care, Improved Customer Satisfaction. Review of "Near Misses"...tracking rare events.	No Suicides

Dashboards to track progress



Reflections & Thank You

Thank You

People who were interviewed

- Including those with lived experience and family members

On-call Specialists

- Stephanie Lewis
- Latasha Bouzek
- Marshall Bennett
- Tracy Borghesani
- Sgt. Matthew Cain
- Paolo Gargantiel
- Katy White
- Tom Tamura
- Juno Hedrick
- Ariana Singh-Adams
- Laura Blumenthal, Care Innovations
- Ella Schwartz, California Health Foundation

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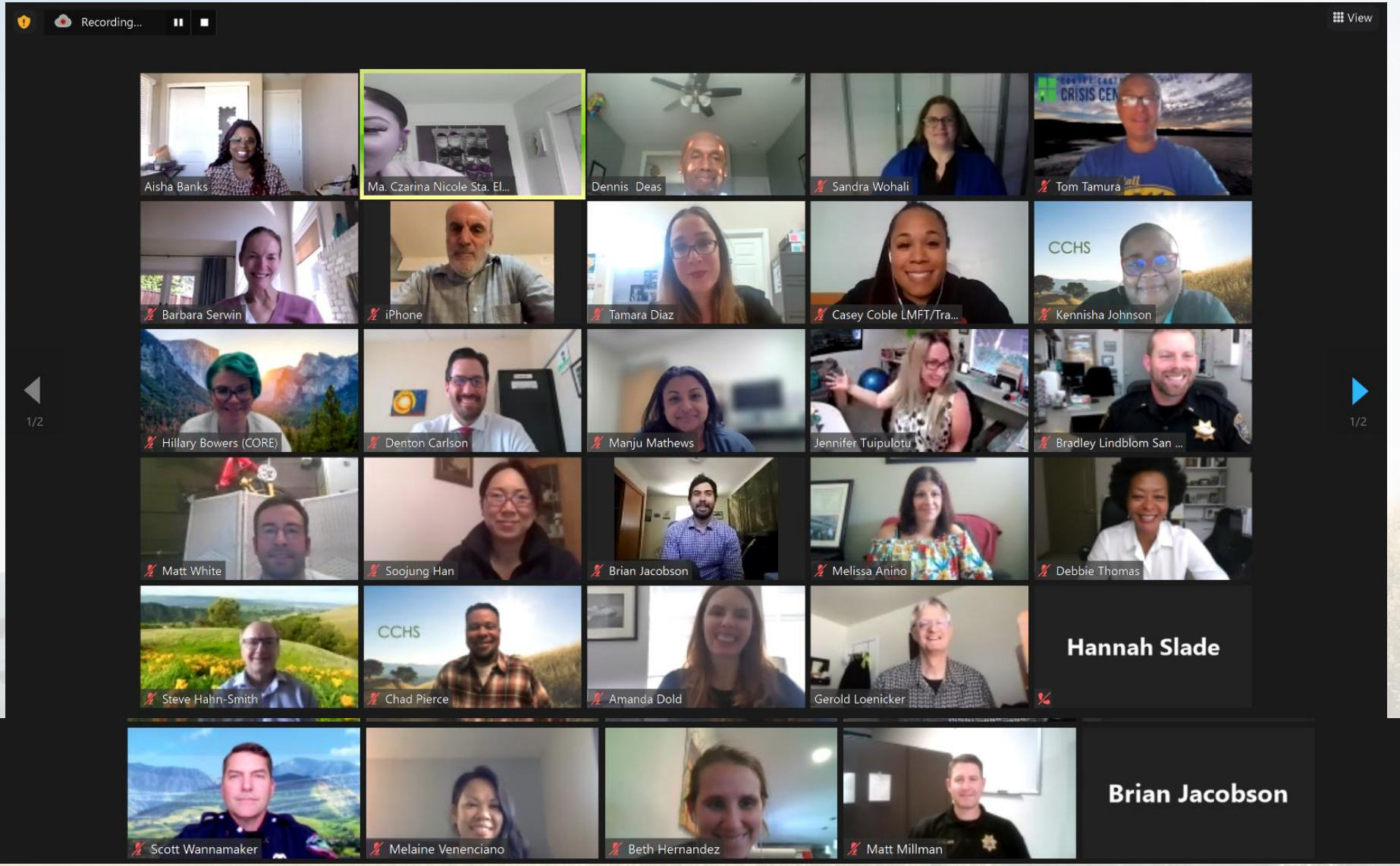
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