Community Crisis Response

Rapid Improvement Event 3: Putting It All Together

Report Out: June 11, 2021

AIM:

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

https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

Priority Improvement Areas

Community Crisis Hub

Mobile 24/7 Response

Collaborative Response

Alternate Destinations

Lived Experience

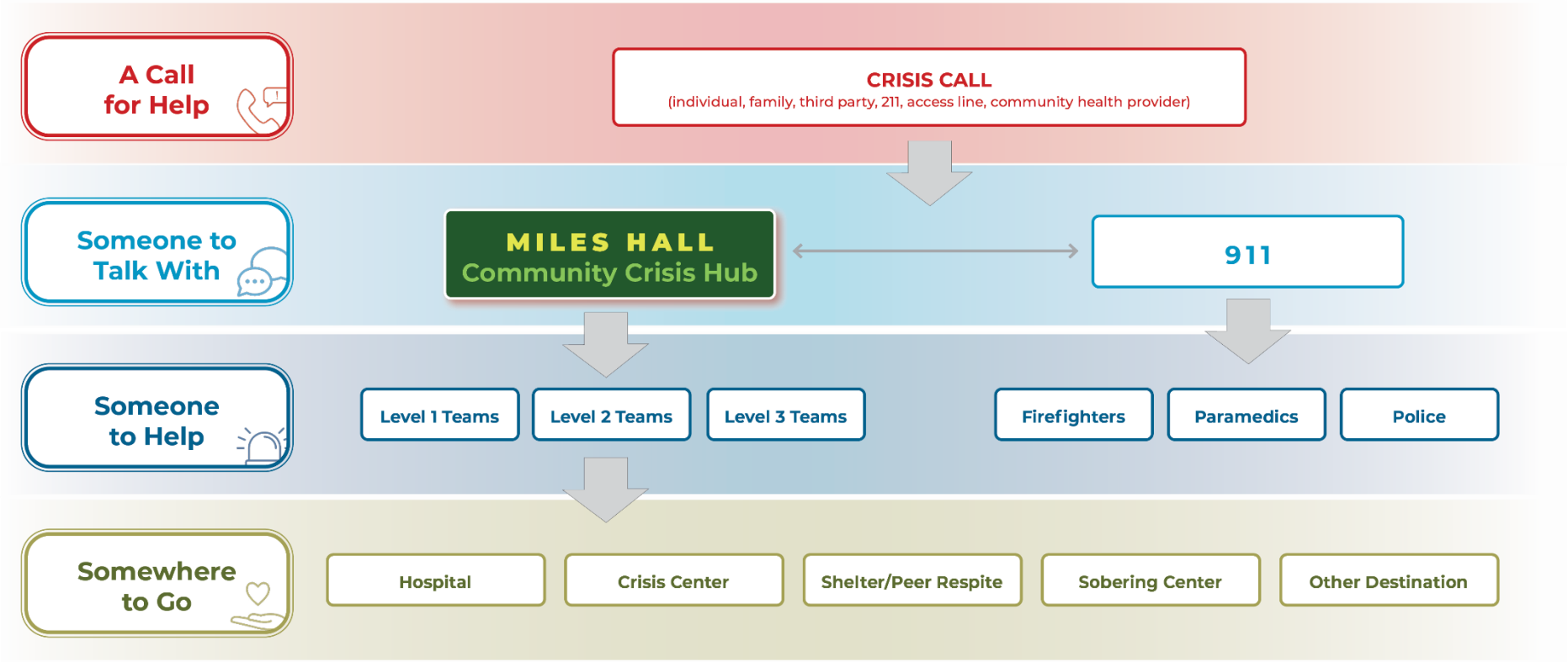
"The way the system is set up, its just failing. The criminalization, not having enough resources to make sure he was kept safe…just so many things that failed us."

- Taun

CONTRA COSTA

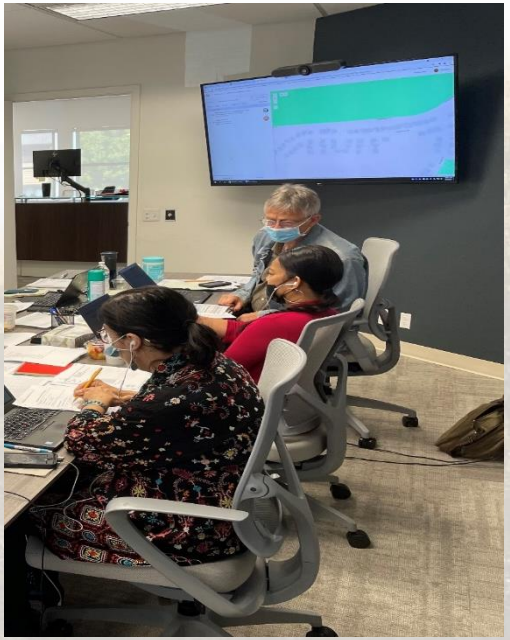
Community Crisis Response Model

anyone, any time, any place



Community Crisis HUB

MILES HALL
Community Crisis Hub

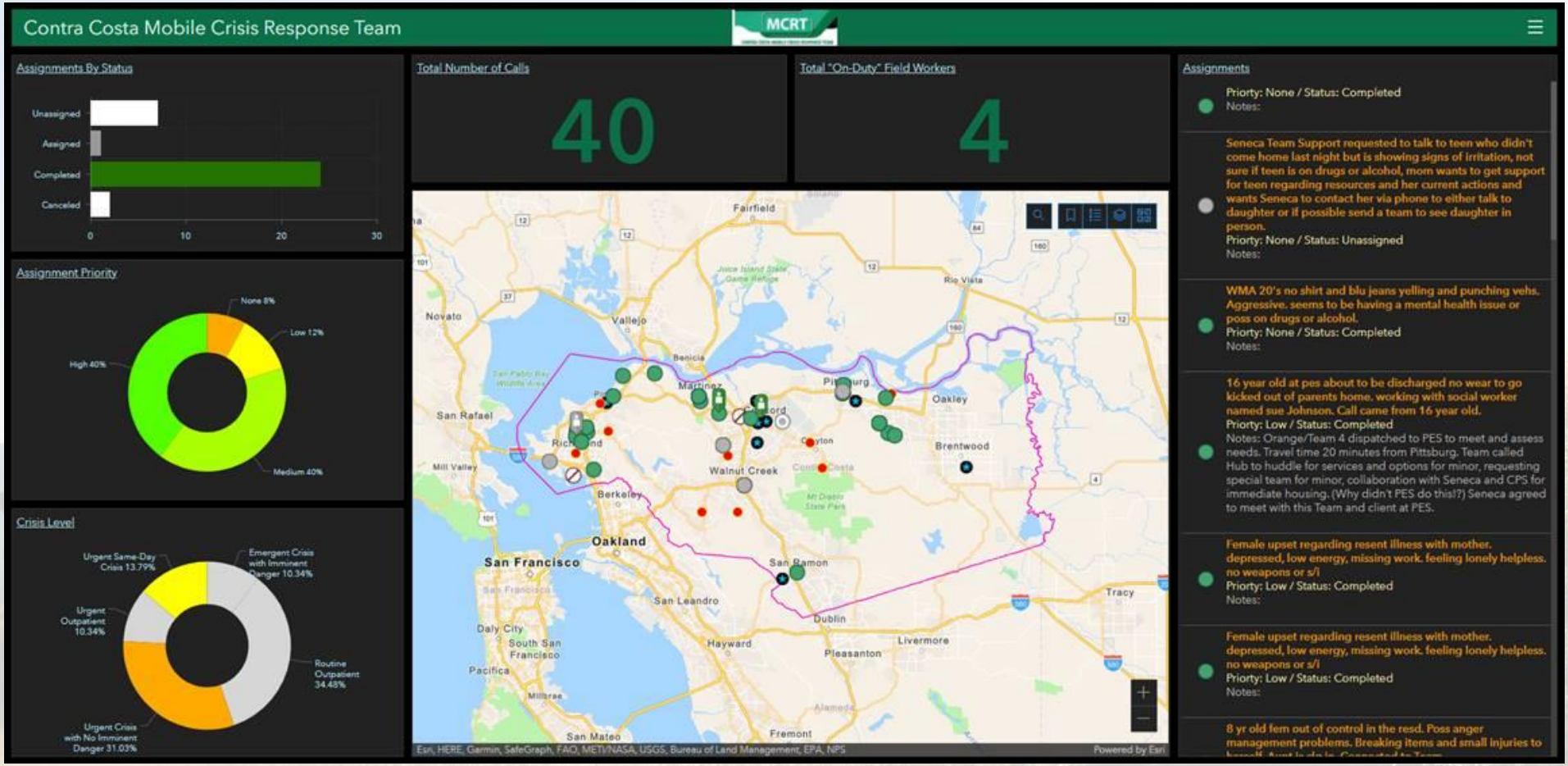


Test of Change

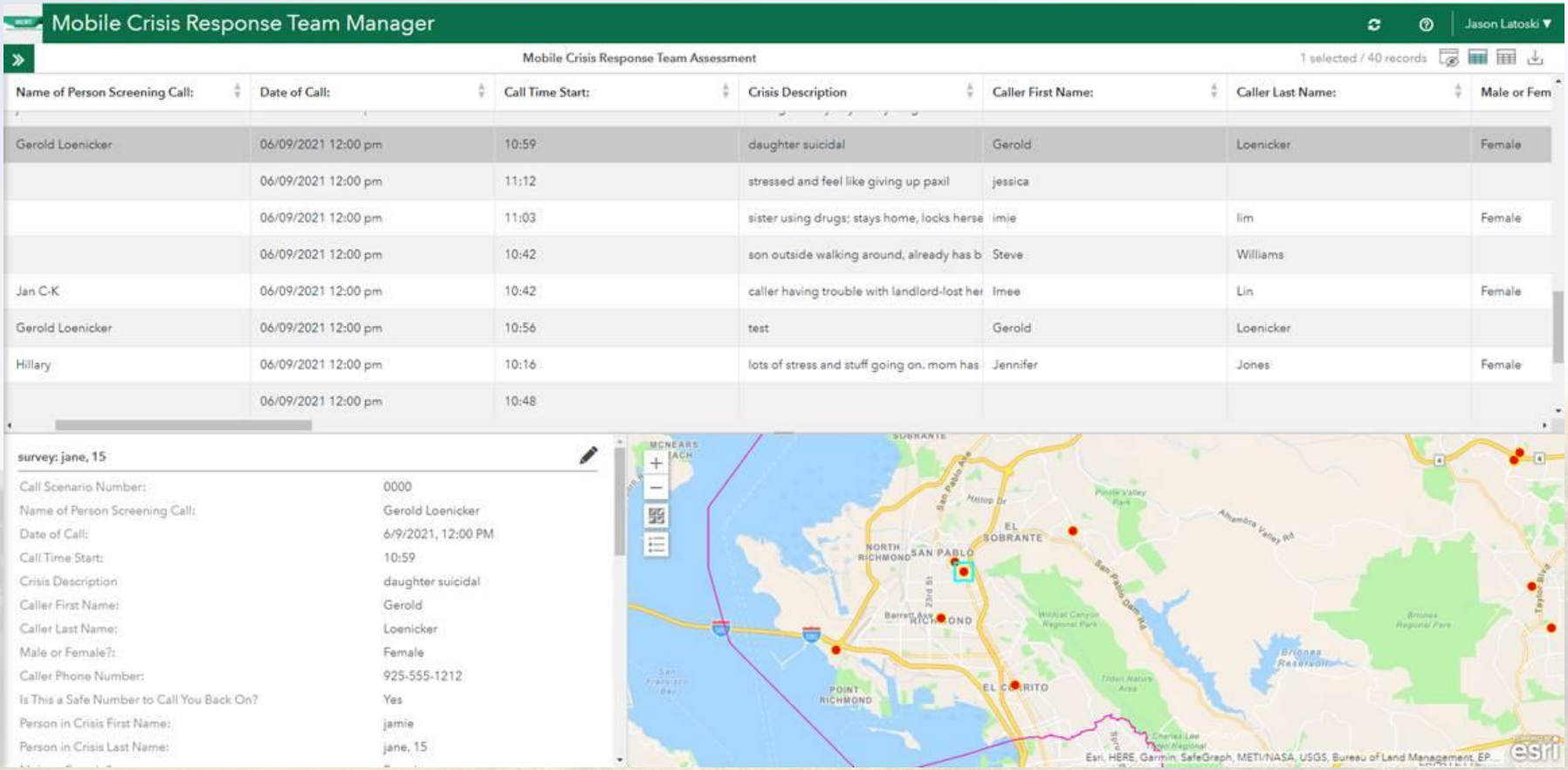
Learned 3 new software systems:

- **InContact (Phone system)**
- **Workforce-ARCGis**
  - Staff tracked by GPS
  - Dispatched mobile response teams
- **Survey 123**
  - Completed a triage form
  - Triage form shared with field teams
  - Field team able to communicate with HUB

Simulated Mobile Crisis Operational Dashboard



Manager Tool



Test of Change: Simulation Calls

- **Processed 46 calls**
- **6 Call Takers staggered throughout the day**
- **Average of 4 people taking calls**
- **The calls were dispatched to the appropriate field team composition**

"A couple of questions were repeated could cause frustration during a crisis"

"I think that the crisis call might be better with suggesting a tip on how to reduce anxiety in the moment as well as having help come as soon as possible"

"I also like the fact that I was given the option to talk in person with a crisis staff person or to continue on the phone"

Thank you to all the volunteers and staff who called

What We Learned

- **HUB Staffing:** Number of call takers are flexible to account for variability in call volume
- **Software:** Coordinating 3 systems & responding to caller – challenging
- **Technology:**
  - Multiple screens
  - Good phones with headsets and microphones
  - Internet

"Less hold time would be great."

Miles Hall Community Crisis Hub: Preparing for Launch

- **Office Space**
  - Computer/multiple screens/large monitors/phones
- **Technology**
  - Continue testing and designing the appropriate system
- **Continued Collaboration**
  - Law Enforcement Dispatch Teams to continue learning
  - Develop workflows between the systems
- **Staff**
  - To continue testing and refining
  - Clinicians/people with lived experience/IT support
  - Training

"I really look forward to having a more streamlined process to better help in crisis, as well as the consistency."

"I'm looking forward to what this process is going to result in for our crisis response systems. "

Crisis Triage & Assessment

Lived Experience Perspective

"Send in the right people with the training and experience to know who they are dealing with.

My husband (who was bipolar) charmed social services and his psychiatrist into thinking that I had the problem, not him."

Triage Team: What We Did

- **Developed a Triage Protocol tool**
- **Purpose of tool**
  - Give direction to call taker on what intervention to choose
  - Standardize triage to ensure consistency of outcomes
- **Goals of tool**
  - Comprehensive
  - Accurate
  - Balance standardization and flexibility
  - Ease of use

Triage Team: Triage Protocol

- One of five crisis levels determined by the triage tool
- Response team configuration is determined by the nature of the crisis

Emergent Crisis with Imminent Danger — 911 / CR

1. 911 Health Symptoms including difficulty breathing, severe chest pain, excessive bleeding, trauma to neck or eye, severe physical trauma
2. Serious Substance Use Withdrawal symptoms including seizures, vomiting/diarrhea (esp. if for more than 24 hours), shaky hands, inability to hold down fluids or solid foods, psychosis related to substance use
3. Serious self-harm or self-injurious behavior requiring medical attention
4. Serious harm to others in progress (including violence, assault), or Imminent/high risk of harm to others (threats of violence esp. with possession of a weapon; HI with plan/intent/means/history of aggression; High-risk behavior associated with acute psychotic crisis including command hallucinations to harm self/others, perceptual/thought disturbance or impaired impulse control; Driving while intoxicated)
5. Suicide attempt in progress, or imminent risk of suicide; Acute SI with plan/intent and means (violent/dangerous), and/or history of attempts of suicidal behavior
6. Suicide attempt in progress, or imminent risk of suicide; Acute SI with plan/intent and means (and/or history of attempts of suicidal behavior)

INTERVENTION: Call 911 immediately for all situations. Have the caller call directly if they have capacity so their location can be traced; if not, identify the client's location as best as possible and call on their behalf. If the case of (6), discretion to direct caller to ER/PES (WHICH?) depending on the emergency and if family/caregiver/support person is able to safely/voluntarily take the client.

Urgent Crisis but no Imminent Danger (Client refusing help or has limited capacity to access/accept help) — 911 / COLLABORATIVE RESPONSE

1. Violence/threats of violence and possession of weapon, or non-imminent risk of harm to others (HI with plan/intent, and/or means, and/or history of aggression)
2. High suicide risk -- With recent suicide attempt or behavior not requiring medical attention; SI with plan but no intent or means; SI with no plan but with recent intent and/or history of attempts, and/or acute stressors
3. Risk of harm to others (HI without plan/intent or means, with or without history of HI/ aggression)
4. Acute risk factors or vague/poor consumer reporting requiring face-to-face assessment of risk of harm to self or others, with history of suicidal behavior or aggression
5. Rapidly increasing symptoms of psychosis or severe mood disorder, or known SPMI history requiring intervention to prevent or contain relapse/hospitalization
6. High-risk behavior associated with perceptual/thought disturbance or impaired impulse control
7. Acute risk factors (WHAT KIND?) requiring immediate response due to limitations in telephone screening (e.g., disconnected call, unable to reach client); This is really ambiguous! Should law enforcement go first to check out the situation? Ask Paolo)

INTERVENTION: Call 911 immediately for (1). Request CR team for all other situations.

Urgent Same-Day Crisis (Client voluntarily seeking help or has capacity to accept/access help) — CR

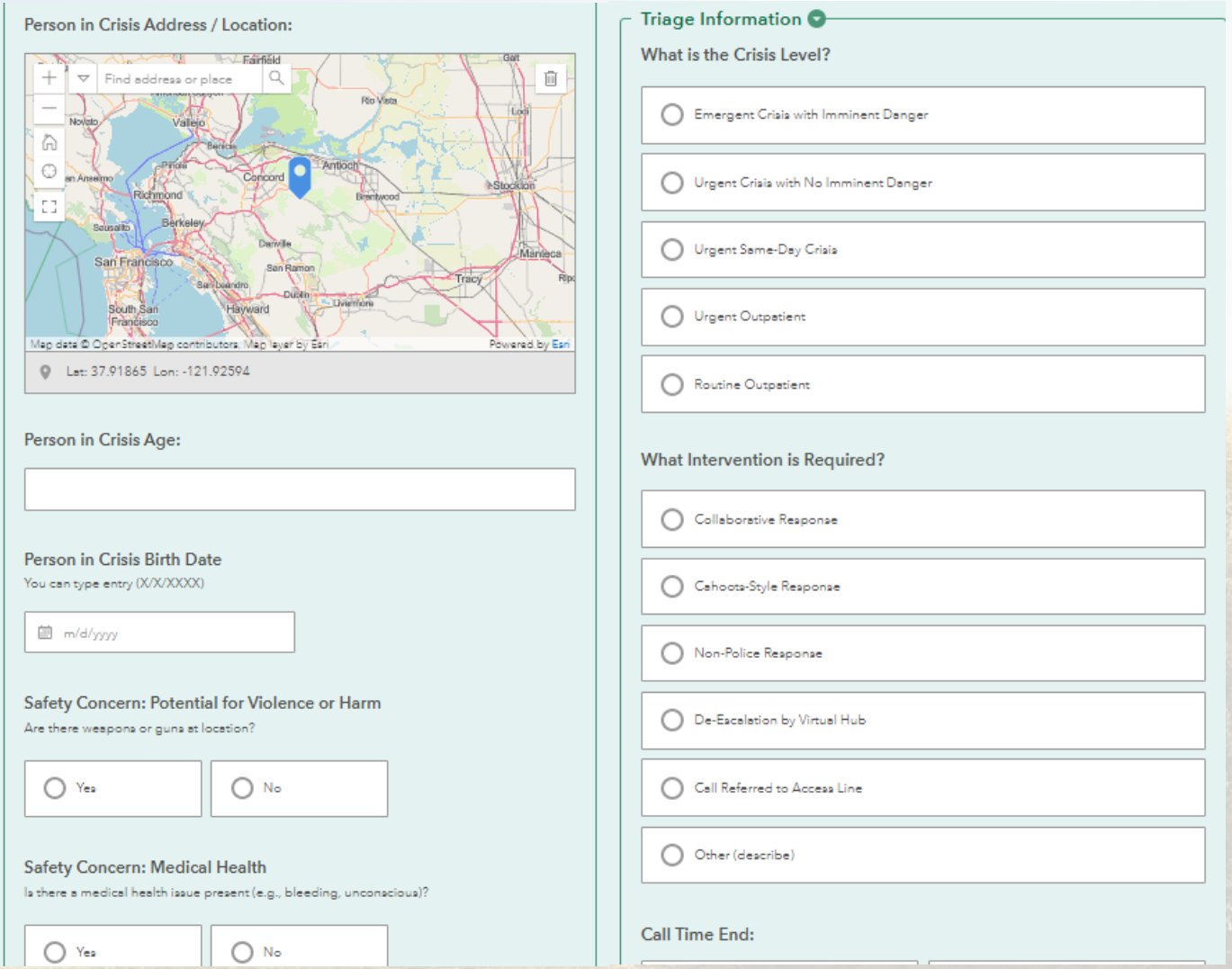
1. Risk of harm to others -- HI without plan/intent or means, with or without history of HI/ aggression
2. High suicide risk (recent suicide attempt or behavior not requiring medical attention; SI with plan but no intent or means; SI with no plan but with recent intent, and/or history of attempts, and/or acute stressors)
3. Acute risk factors or vague/poor consumer reporting requiring face-to-face assessment of risk of harm to self or others, with history of suicidal

Triage Team: What We Did

- Designed the call data entry template
- **Purpose:** Enable call information to be entered into the virtual hub system for everyone to see
- **Goal:**
  - Ensure survey captures the right information
  - Ensure survey matches the workflow of the call takers and field responders

Crisis Call Information Gathering

- 20 Background Questions
- 5 Crisis Levels
- 5 Response Types (subject to change)



Triage Team: What We Learned

- Triage Protocol needs to be more decisive while still permitting flexibility for judgement calls
- Need a children-specific Triage Protocol

Triage Team: Preparing for Launch

- **Refine and continue testing the Adult Triage Protocol** for accuracy, comprehensiveness, ease of use, and decisiveness vs. flexibility
- **Develop and test Children's Triage Protocol**
- **Extend data entry template** for depth and comprehensiveness to cover the entire end-to-end process (beyond taking calls only)

COLLABORATIVE RESPONSE TEAM

Lived Experience Perspective

Collaborative Response Team

Testing Team Composition utilizing Triage Tool

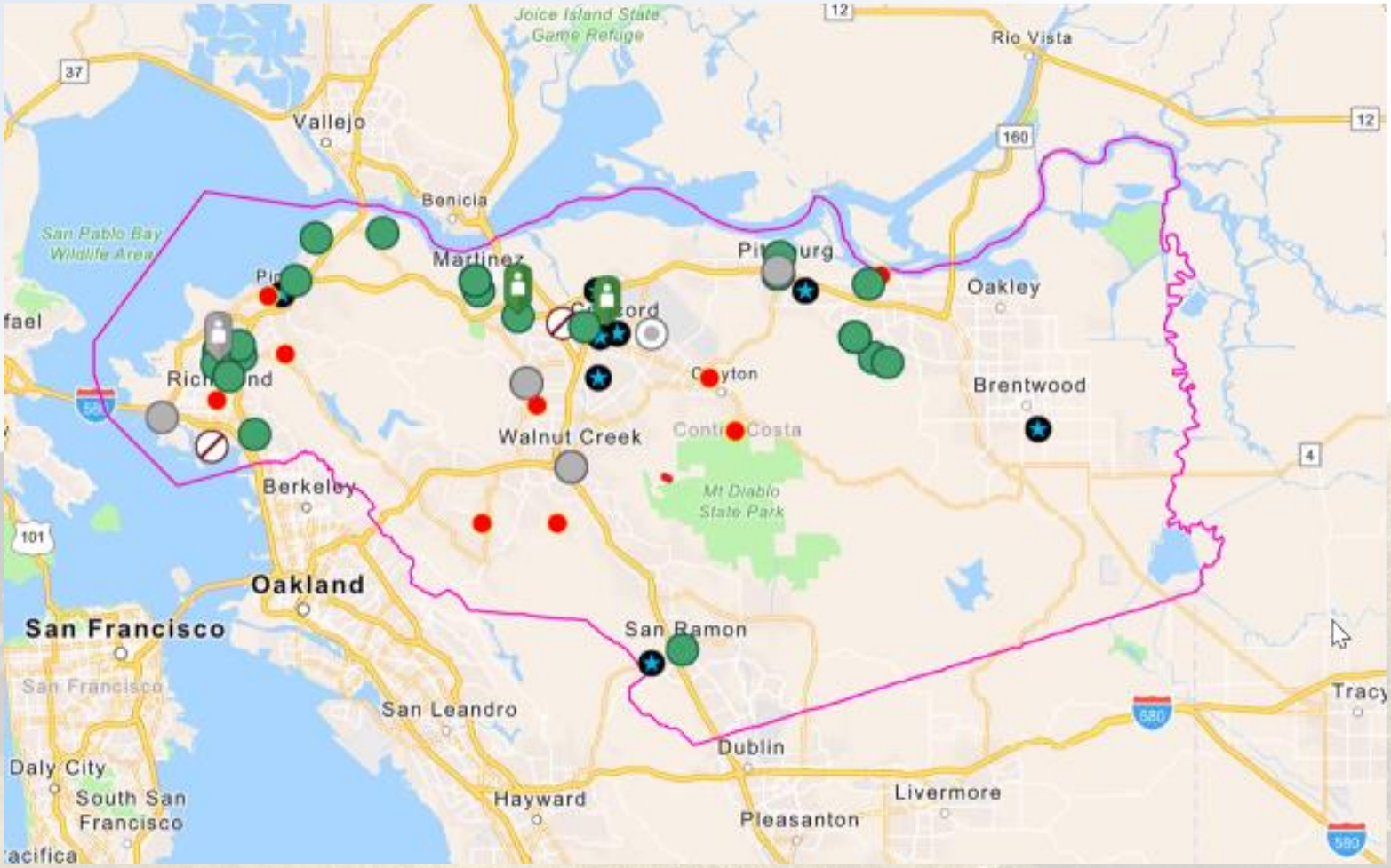
- **Level 1**: Peer Support Worker, EMT
- **Level 2**: Clinician, Peer Support Worker, (+ - EMT)
- **Level 3**: Law Enforcement, Clinician, Peer Support Worker, (+ - EMT)

Collaborative Response Team

Regionalized responses to decrease response time

- Teams in 3 regions: Central, West, East
- Response times dramatically decreased with regionalized approach

Regionalized Response



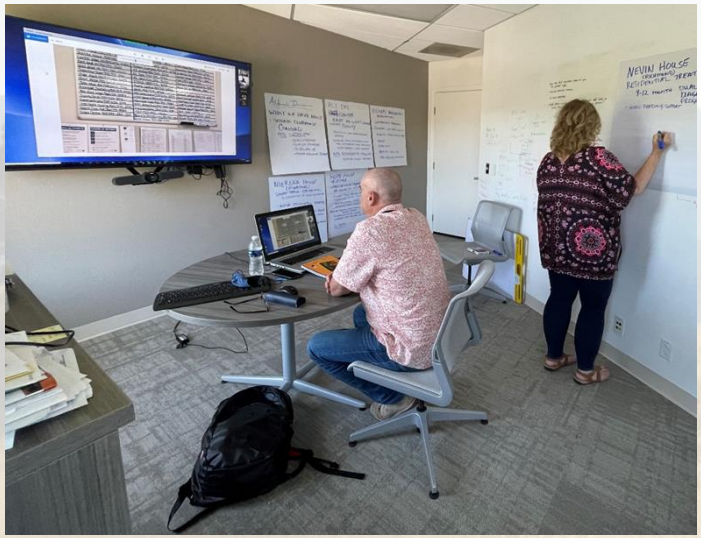
Lessons Learned

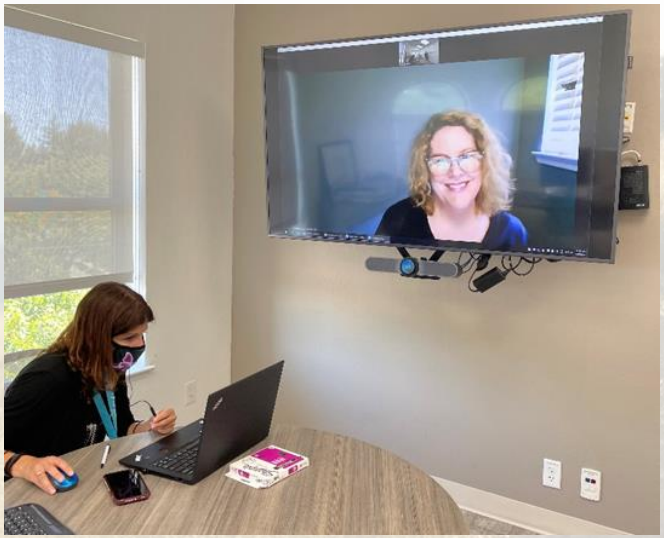
- Cross training for response team staff to effectively manage responses with youth
- Continual refinement of team composition
- Need enhanced communication chain from field team back to HUB
- Warm handoff between HUB and field team worked well

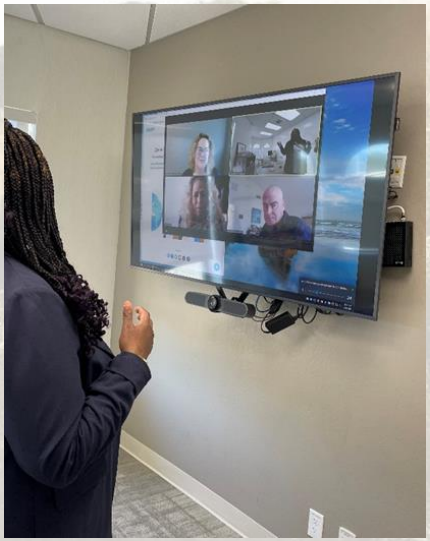
Collaborative Response Team: Preparing for Launch

- Preparing for July 2021 Pilot
  - Develop a pilot team
  - Phones and effective technology platforms
  - Access to important client information (ex: medical history, previous services, care team members, etc.)
  - Regional vehicles for team to transport

ALTERNATE DESTINATIONS







Lived Experience Perspective

"…Bring HUMANITY back into the conversation!"

Alternate Destinations Team

- **Problem Statement:** Psychiatric Emergency Services is the only 24/7 facility

- **Goal:** To provide safe, alternative facilities

What We Learned

- Analyzed data from Psychiatric Emergency Services data and Mobile Crisis Response data
- Identified facilities that would be the appropriate destination to psychiatric emergency services
- Can substantially reduce Psychiatric Emergency Service visits
- Strongly recommend a dedicated Rapid Improvement Event for a deeper dive to explore alternative facilities

Alternate Destination #1: Peer-Operated Respite

- **What is a Peer-Respite?**
- Mobile Crisis Response Team data
- Santa Cruz's Second Story data

Alternate Destination #2: Crisis Intervention Services

- What is a Crisis Intervention Service
- Psychiatric Emergency Service data

Alternate Destination #3: Sobering Center

- What is a Sobering Center?
- Psychiatric Emergency Service data

Data Measures

Lived Experience Perspective

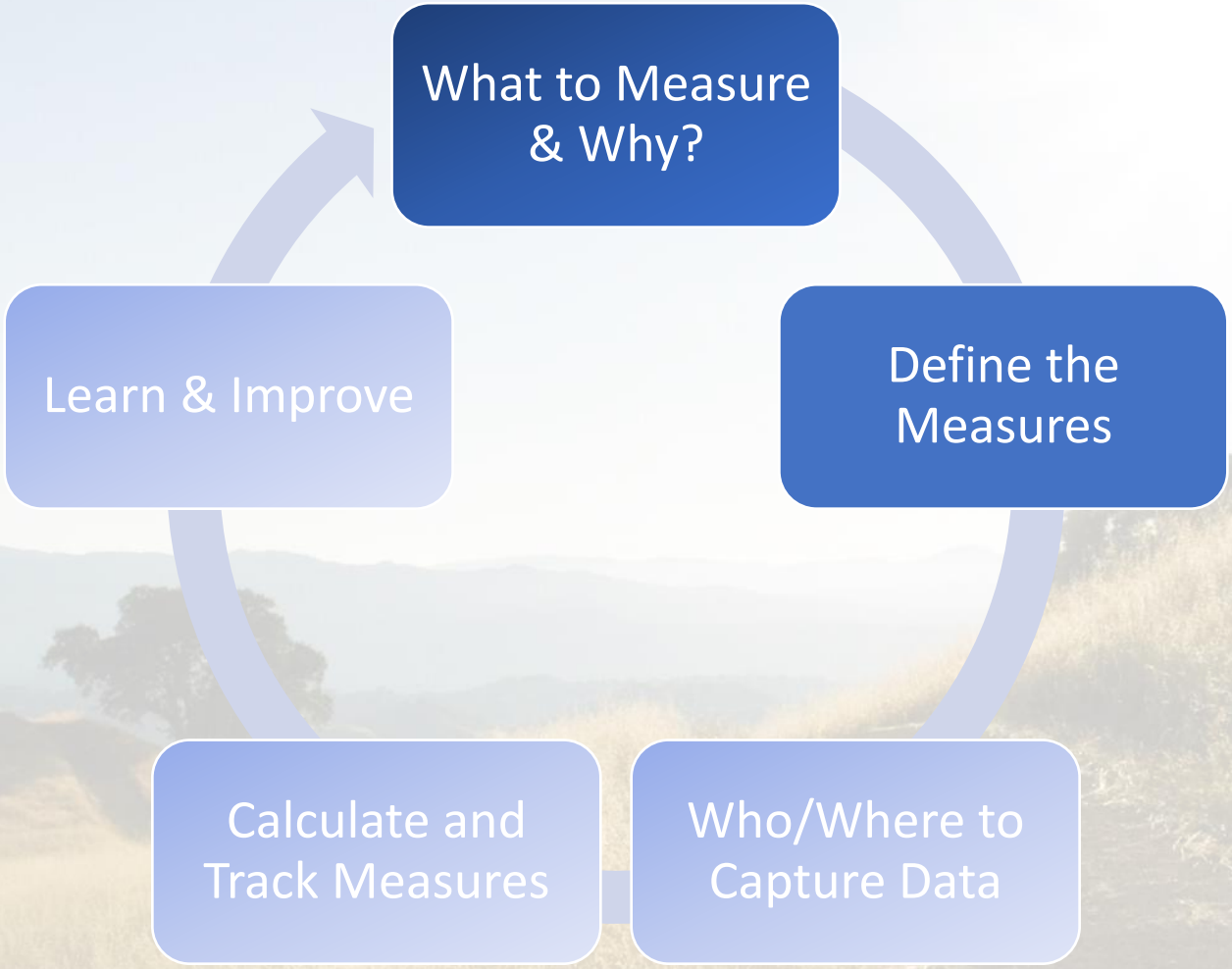
"The Rainbow Community Center gave me hope."

- Jay

More Done

Less Done

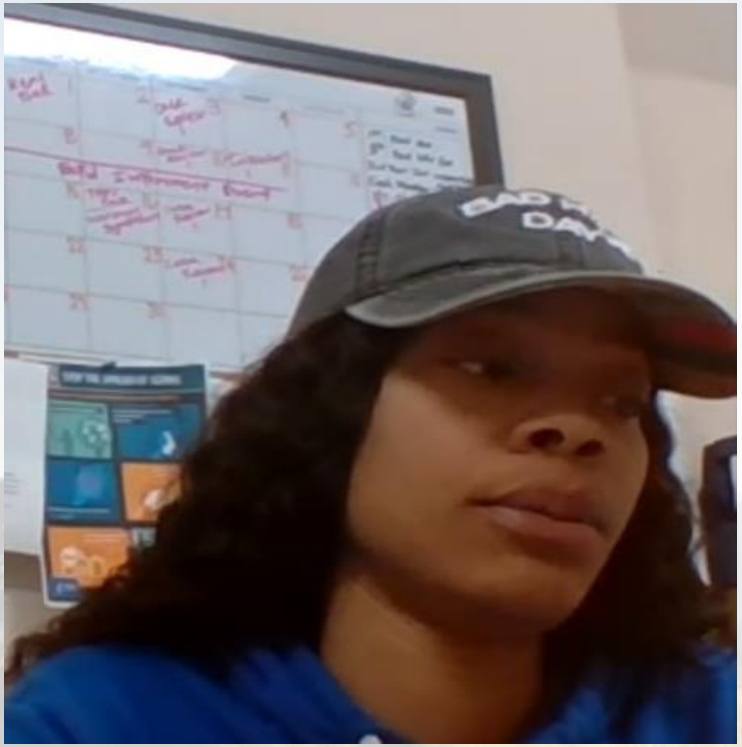
Data Journey



Next Steps

- Develop detailed testing and launch plan (facilities, staffing, equipment, technology, vehicles, etc.)
- Identify existing resources to leverage
- Test and launch pilot by July 15, 2021
- Develop agreements for pilot sites countywide
  - West
  - East
  - Central
  - South

Lived Experience Perspective



“Don’t be afraid to say you need help. Always put yourself first, especially with mental health.”

- Angelica

Reflections & Thank You

Sponsors & Leadership

People who were interviewed

- Including those with lived experience and family members

Speakers

- Taun Hall
- Jay Razzell
- Angelica Brownlee
- Jo Bruno

Sponsors

- **Public Managers Association Subgroup**
  - Valerie Barone, Concord
  - Niroop Srivatsa, Lafayette
  - Garrett Evans, Pittsburg
  - Matt Rodriguez, San Pablo
  - Joe Gorton, San Ramon
  - Dan Buckshi, Walnut Creek
- **Contra Costa County, Health Services**
  - Anna Roth, Health Director

Leadership Advisory Group

- Suzanne Tavano
- Lavonna Martin
- Jill Ray
- Mark Goodwin
- Matt Kaufmann
- Colleen Awad
- Marie Scannell
- Chief Craig Stevens
- Barbara Serwin
- Laura Griffin
- Natalie Dimidjian
- Jessica Donohue
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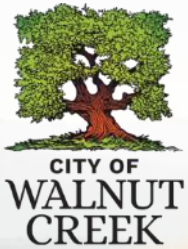
Thank you to our Sponsors, City Partners and Funders



Thank You to the Team