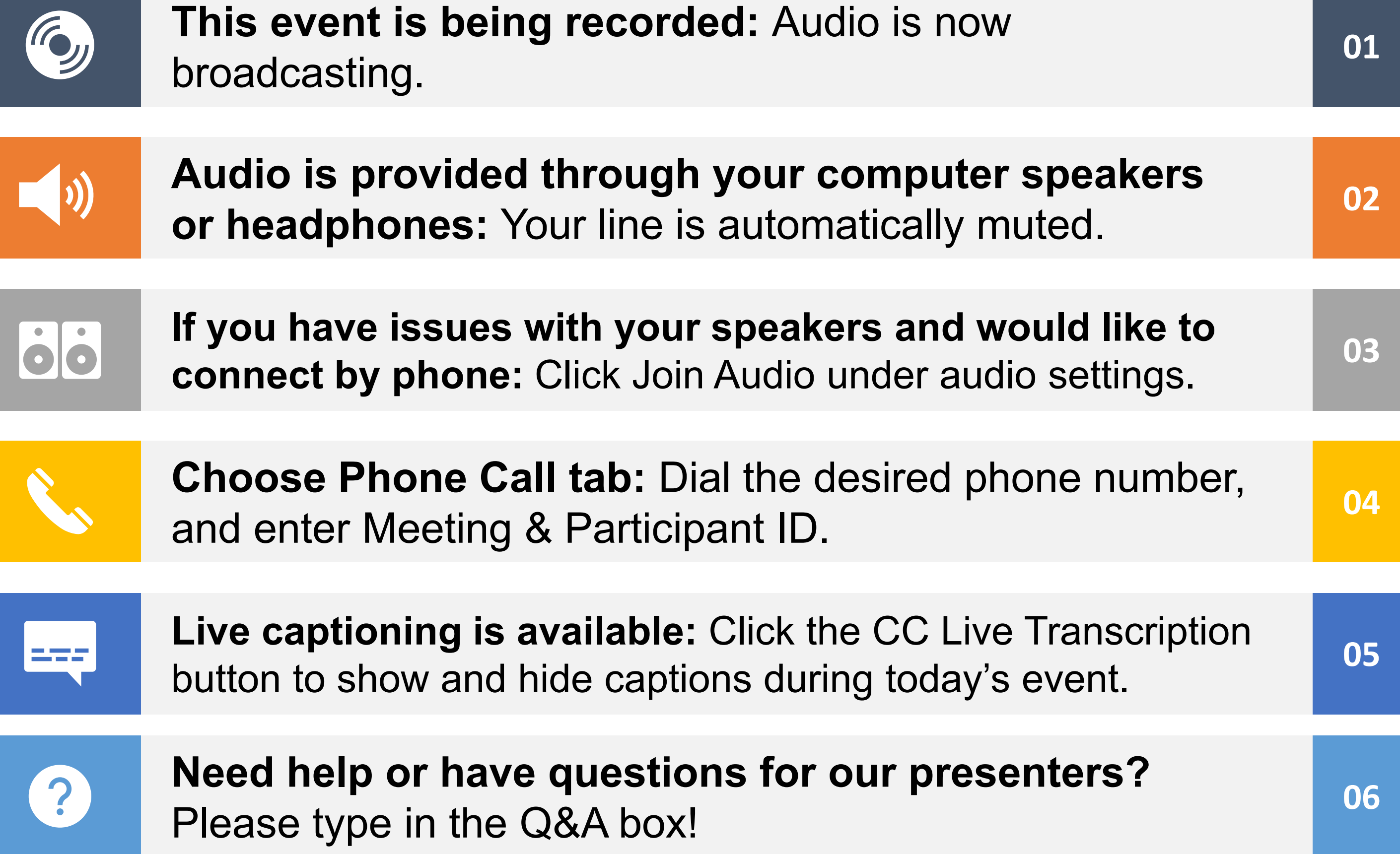
Transforming the Crisis Care Experience in California

Facilitator: Kappy Madenwald

May 2023

Housekeeping



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Center for Applied Research Solutions (CARS)

CARS is a California-based nonprofit that provides training, consultation, and coaching to enrich the behavioral and public health field by promoting evidence-based practice and workforce development.

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Kappy is Licensed Independent Social Worker in the State of Ohio and an independent consultant who works with federal, state, and local governments, community treatment providers, and managed-care entities in building person-centered, competency-rich behavioral health crisis service systems. She offers unique expertise in the evaluation, development, implementation and/or operation of community-based crisis systems of care. Previously Clinical Director of Clinical Director of ADAMH Board of Franklin County, and the Director of Clinical Services at Netcare Corporation, Kappy has direct practice experience in mobile and site-based program design, service delivery, and team competency development; and cross-sector crisis systems collaboration. Over the past 20 years, Kappy has provided consultation, training and/or team-specific coaching in 20 states, and Ontario, Canada, working with scores of communities and agencies to transform practice.

Transforming the Crisis Care Experience in California

- Crisis systems of care are undergoing change across the country with the intention of delivering improved, less-restrictive services delivered by well-trained teams that are working as part of an organized system
- I have had the chance to work with many states, communities, and agencies that have or that are transforming their crisis system of care
- I have learned a lot about the competencies and attributes that that are present in the most effective crisis systems

Transforming the Crisis Care Experience in California

- My hope today is that this seminar and conversation stimulates creative thinking and furthers collective vision for a crisis treatment standard of care in California as you consider:
  - The needs and assets of your local communities
  - Current habits of practice in those communities
  - Opportunities for innovation

Transforming the Crisis Care Experience in California

- Some of what I share today may feel provocative
- May unearth deeply held beliefs
- Candor is useful in sorting it out
- In training or coaching sessions the importance of psychological safety cannot be underestimated

Transforming the Crisis Care Experience in California

- Psychological safety is a key ingredient in innovation
- It makes it comfortable to explore areas where we aren't doing as well—when care experience is not measuring up to our vision
- It allows us to take informed risks, propose and trial new approaches, and consider radical innovations that disrupt the status quo but lead to greater success
- This is a parallel process to our work with individuals and families

What happens to us when we feel psychologically UNSAFE?

What is California doing?

- Introducing a new community-based mobile crisis intervention service to individuals in California regardless of insurance coverage
- Expanding the array of crisis services in California
- Adding a Medicaid treatment benefit for children and adults
- Providing an alternative FIRST response in lieu of more restrictive first options such as calling law enforcement, co-response teams, or emergency department services

What is California doing?

- Developing a service that is focused on delivering relieving, stabilizing interventions that sufficiently resolve the crisis
- Emphasizing personal choice
- In doing so, California is creating a <u>safer</u> crisis care experience

A safer crisis care experience includes

- Offering responses that are:
  - Early
  - Voluntary
  - Local
  - Community-based

A safer crisis care experience includes

- Using approaches that are collaborative and resolution-focused.
- Resulting in diminished use of:
  - Law enforcement
  - 5150/5585 evaluations
  - Inpatient hospitalization

Safer crisis care experience

Significant shift in practice for much of the state

- Providing crisis care in the community, including in homes
- Engaging individuals not known to the team
- Responding to acute situations
- Maximizing use of voluntary interventions
- Minimizing use of less-restrictive solutions

Safer crisis care experience

- Important that this work is also experienced as safe for the teams in the field

Safer crisis care experience for everyone

How do teams achieve this?

- Use of technology and logistical efficiencies
- Seamless interface between mobile teams and call center team
- Continuous consideration of safety for everyone, including psychological safety
- Diversifying the team

Safer crisis care experience for everyone

How do teams achieve this?

- Use of approaches that promote rapid establishment of trust, calm crises, and maximize choice
- Engaging other systems and stakeholders to improve upstream of the crisis and downstream of the crisis practices
- Adopting a “learning community” mentality

Multidisciplinary teams in California

- Introduction of other disciplines into a Mobile Crisis Service is a way to diversify the response
  - Peer Support Specialists who bring lived experience and an essential set of competencies to this work
  - Community Health Workers who are trusted leaders that bring knowledge of specific regions, neighborhoods, and cultures
  - EMTs, Paramedics and Community paramedics who bring the ability to consider medical comorbidities that may factor into the existent crisis.

Multidisciplinary teams in California

- If co-response with Peers, CHWs and/or Paramedics is new for you or your team, it can feel disruptive at first
- And that disruption is a GOOD THING!!

California’s new Mobile Crisis Service is not a “screening” model

- Historic models of mobile crisis have often been narrowly focused
- Less often is this the FIRST response to the crisis (i.e. if the service is delivered in the ED)
- The key deliverable is determining eligibility for inpatient hospitalization or other level of care

California’s new Mobile Crisis Service is not a “screening” model

» Because these are the key deliverables, the content of the intervention is often geared around:

- What a receiving facility will want to know to make an admission decision
- What an insurance company will want to know to make a service authorization decision

California’s new Mobile Crisis Service is not a “screening” model

- Sometimes, the nature of this kind of service influences the decision of call center staff in terms of who is eligible for the service (i.e. limiting mobile response to situations where the need for higher level of care is likely)

5150/5585 evaluator vs. crisis stabilizer

Think about these dichotomous roles…

- These services have opposing intentions—for some that have been providing crisis response, the muscle memory may lean towards the 5150/5585 Evaluator function
- What needs to be unpacked here?
- How do the intentions/subsequent approaches differ?

5150/5585 evaluator vs. crisis stabilizer

- Consider how to delineate these functions
  - in team practice?
  - in the eyes of other system players?
  - in the eyes of crisis service users?

Crisis systems of care in California

- The new mobile crisis response service is markedly different from a 5150/5585 evaluation
- For some individuals/teams it will introduce a very different approach to care.
- And, of course, it will be new to many individuals who are experiencing a crisis that have been through the 5150/5585 process

Crisis systems of care in California

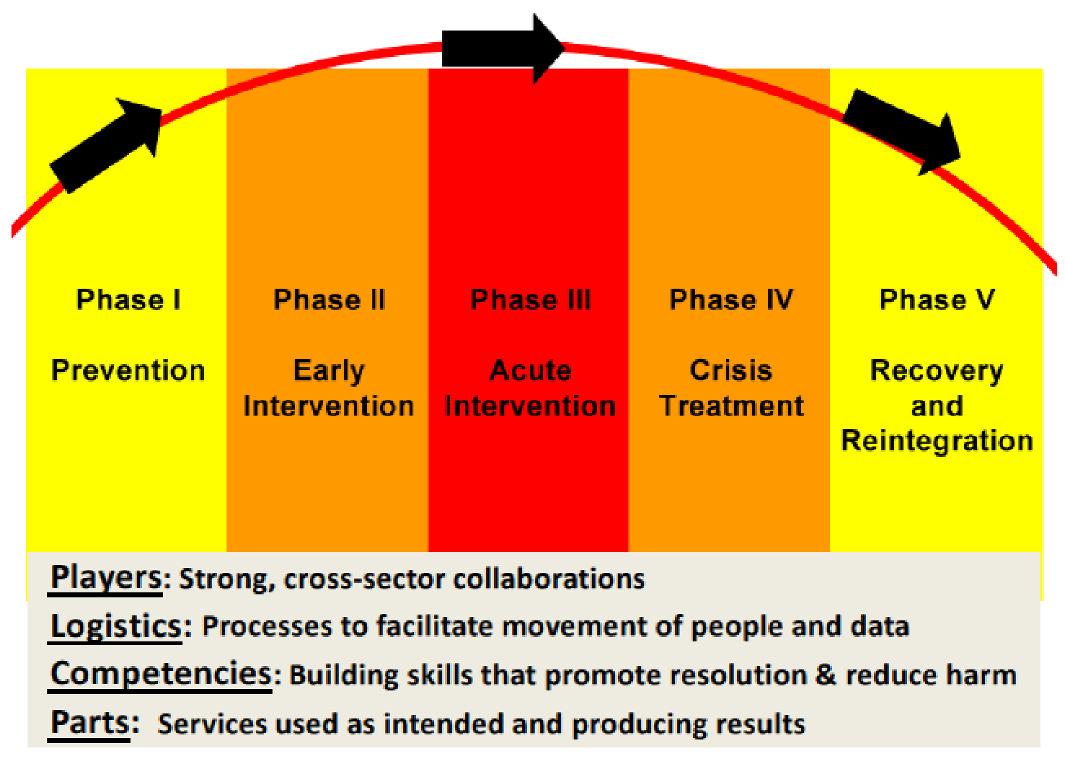
- The shift in service from “LPS designated evaluator role” to that of a provider of brief, relieving/resolving crisis treatment is quite complex
- For our colleagues who are accustomed to historic practices—it can feel risky to ask for something less intensive and less coercive
- This is a developmental, transformation process that will unfold over the course of many months and less intensely for another 1-2 years IF it is purposefully managed

Four core competencies that promote safer crisis care

- Delivering interventions that are person/family-centered.
- Delivering interventions that are strength-based.
- Delivering interventions that are resolution-focused.

Four core competencies that promote safer crisis care

The fourth competency is the ability to deliver crisis services within the context of a broad, interconnected, **crisis system of care**



More on these competencies later…

But first…

- » There are two overarching themes that states, communities, and teams grapple with during this type of crisis system transformation
- » Reaching new understanding here is necessary before it feels prudent to using the core competencies in crisis situations

Theme 1: Managing risk

Because we are working with individuals whose health care crises can be life threatening:

» It is natural to be concerned about personal risk/liability and corporate risk/liability.

» It is important to have a broad understanding of the ways that crises increase risk for individuals—there are whole health considerations

» But, in addition to all of that, we have to be very aware that the way the system responds to crises can also put individuals at risk

Theme 1: Managing risk

- When we LEAD with a focus on OUR liability, and when we LEAD with making things safer for us, we can miss and misunderstand important information, and we can make things worse
- When we proceed without understanding how the person in crisis is experiencing our care, we can make things worse
- We are putting the person in crisis at risk of iatrogenic harm

Are you familiar with this term?

Iatrogenic Harm

- Harm caused by treatment
- Generally unintended
- Often avoidable
- Iatrogenesis: *Brought forth by a healer*

ANY intervention, regardless of provider intention introduces a risk of harm that would not otherwise be present

Use CHAT to share examples of iatrogenic harm in the behavioral health field

Iatrogenic Harm

When there is iatrogenic harm, it implicates us, as providers of the treatment and it implicates the systems in which we operate

- But, this also gives us power
- We are in the driver's seat to find ways to reduce risk of harm
- It requires continuous improvement of our craft, policies, and processes
- Iatrogenic harm is easiest to recognize when we orient ourselves to the care experience of the person in crisis and their family—when we view from their shoes

Diminishing the need for coercive practices

» Coercive practices have an iatrogenic impact

» Though there may be a guise of safety, coercive practices sometimes have less to do with imminent risk and more to do with one or more of the following:

- Habit
- Convenience
- Cost
- Transportation
- Concern about personal or corporate liability

» Operating in a trauma-informed fashion requires the system to re-examine practices and mitigate these harms

Habits can be the hardest to change: *"This is how we do it here"*

"Public institutions and service systems that are intended to provide services and supports to individuals are often themselves trauma-inducing. The use of coercive practices, such as seclusion and restraints, in the behavioral health system; the abrupt removal of a child from an abusing family in the child welfare system; the use of invasive procedures in the medical system; the harsh disciplinary practices in educational/school systems; or intimidating practices in the criminal justice system can be re-traumatizing for individuals who already enter these systems with significant histories of trauma.

These program or system practices and policies often interfere with achieving the desired outcomes in these systems. Thus, the pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing "business as usual."

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Diminishing the need for coercive practices

- Watch for/mitigate patterns across the crisis service spectrum
  - Routine use of law enforcement in some aspect of the crisis episode
  - Admitting facility preference for involuntary hold/admission
  - Restrictions by rule rather than exception, such as gowning, 1:1
  - Carrot/stick systems
  - Unscheduled and/or AMA discharge
  - Frequent referrals to child protective services
  - Routine use of security guards, seclusion, or restraints
  - Language around actions (what was the intention of the action?)

Theme 2: Storytelling

Crisis systems and habits of practice are built on the foundation of the stories we tell

What does it mean that we don't tell many "hero" stories?

Theme 2: Storytelling

What deeply held beliefs and stories IMPEDE our effectiveness?

- Historic stories of individuals with behavioral health conditions
- Stories about the parents of those individuals
- Stories about how individuals use the system/treatment
- Stories about our (intervener/treatment provider) role/effectiveness

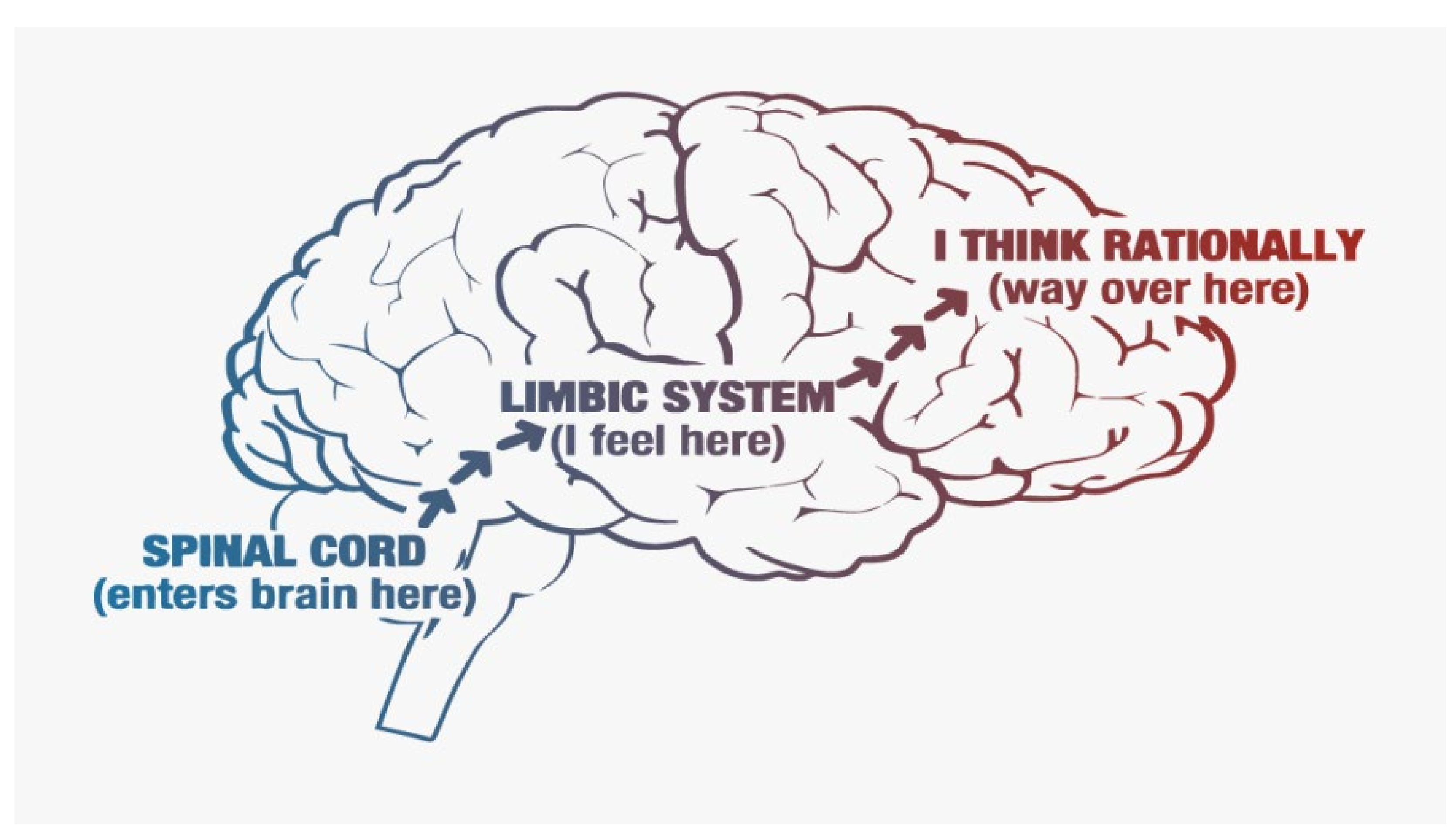
Stories predispose actions

Retraining the brain

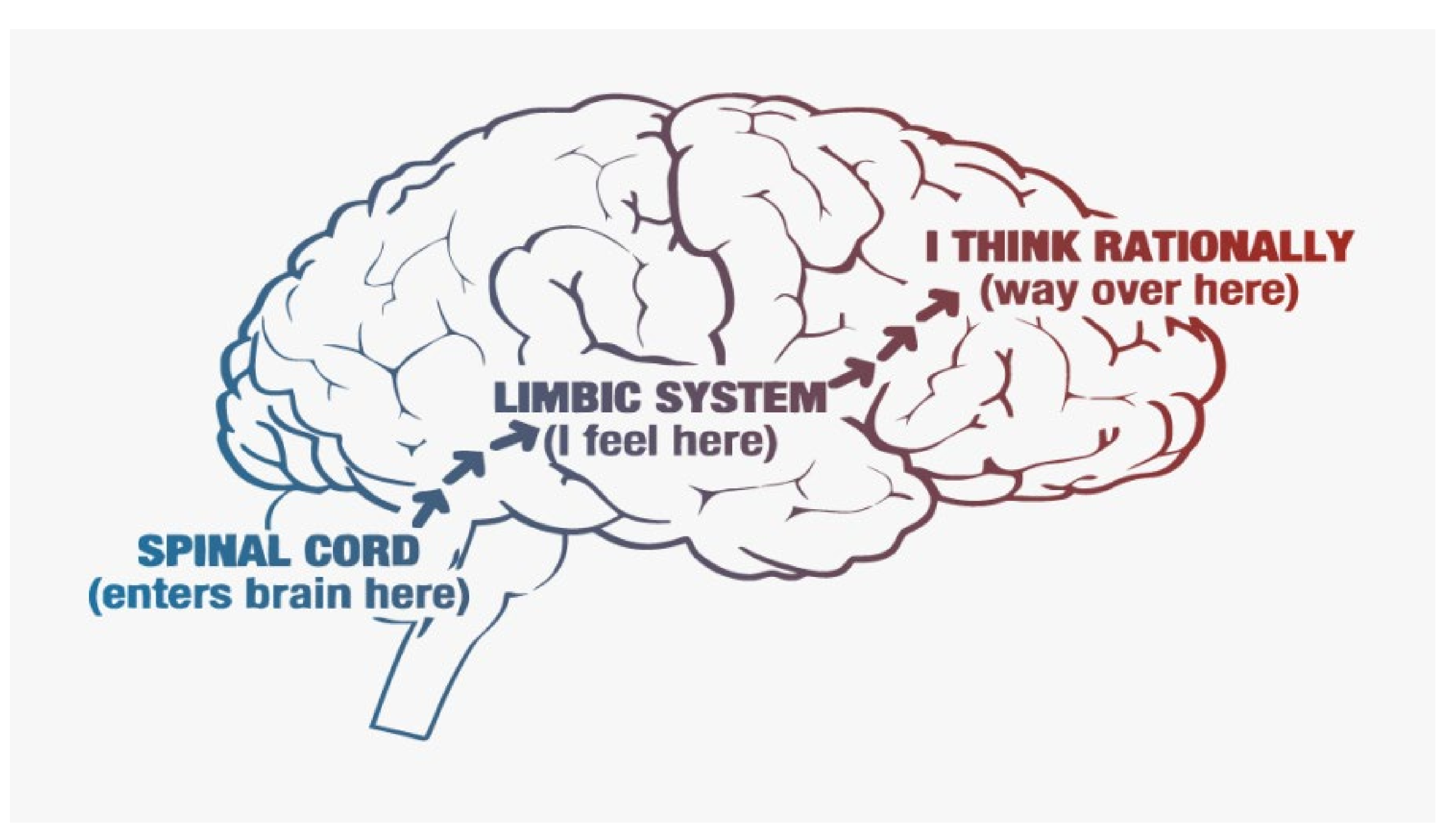
- Our brains are our number one tool in this work
- Can be trained to aid our work
- Must be vigilant to any deficit stories we tell, and actively work to change them

A person in crisis is never a barrier

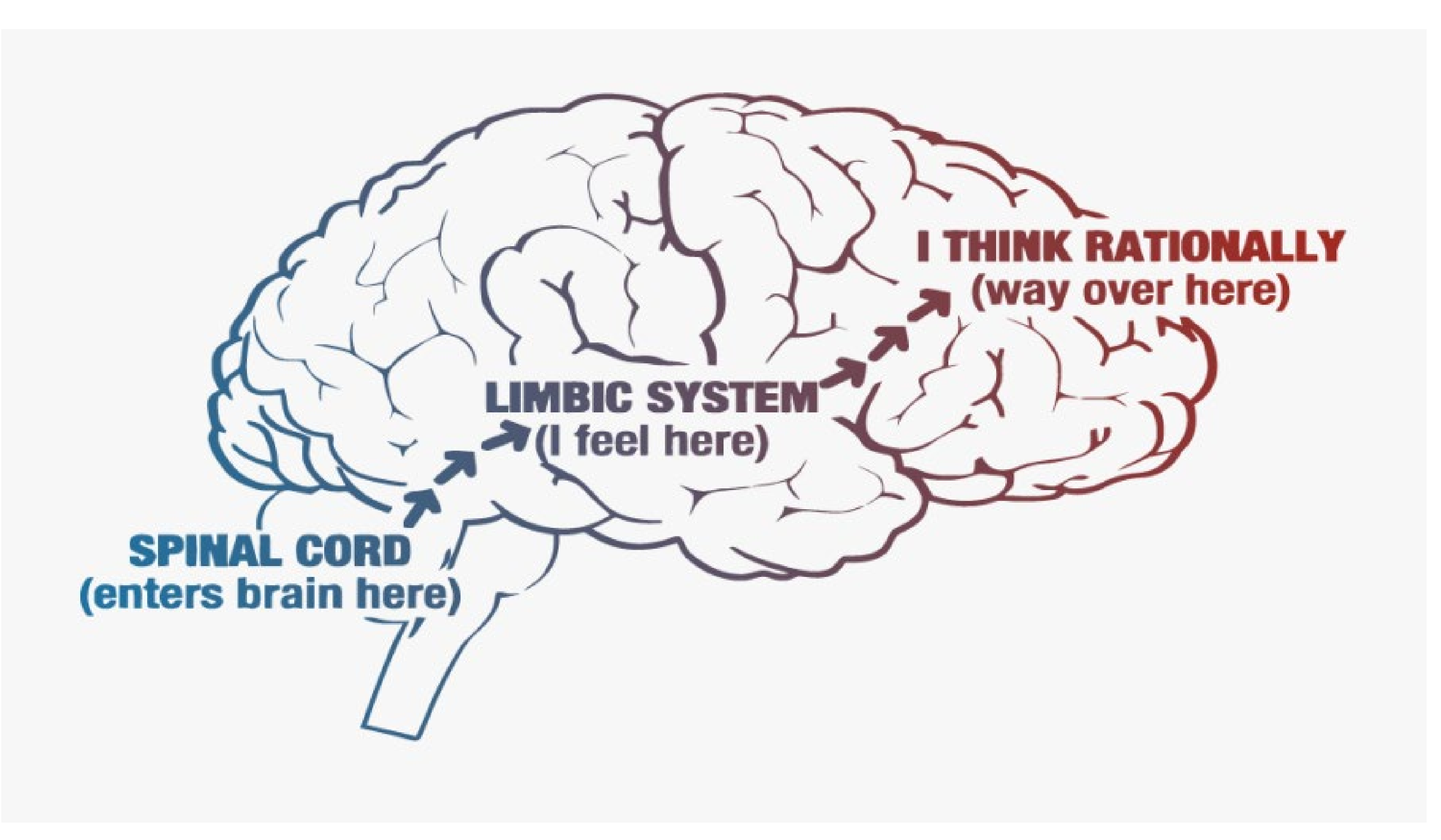
Stories predispose actions…



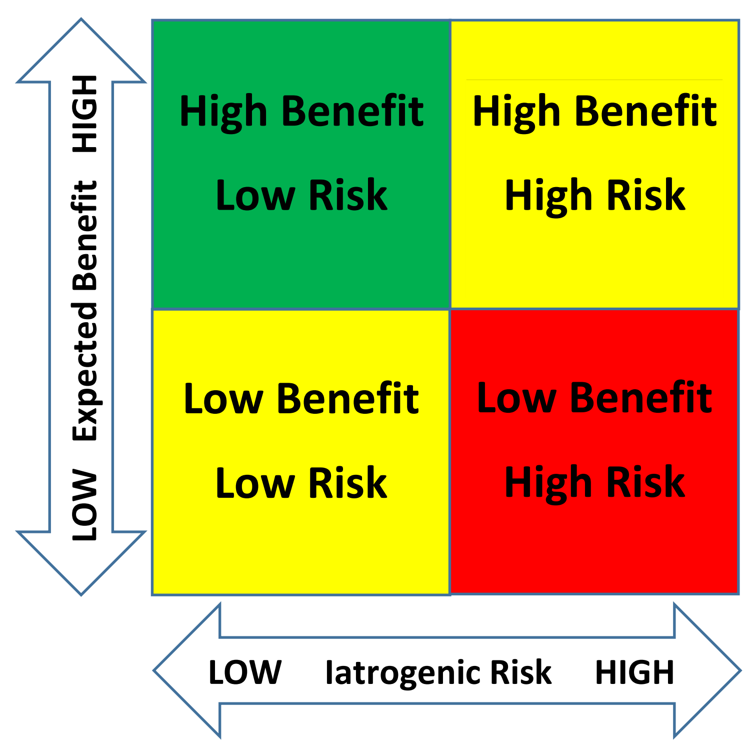
“Frequent flier who never cooperates”



A person who is “Credible, Capable, Intuitive, and able to Collaborate”



SAFER CRISIS CARE: Minimizing Iatrogenic Harm



The Allure of Inpatient Hospitalization

Within a lot of communities, there are deeply held beliefs and stories about psychiatric hospitalization:

- It is the best and highest quality service (other care is lesser care)
- It is a safer place
- Inpatient treatment is something you do to a person: "*He needs inpatient treatment*"

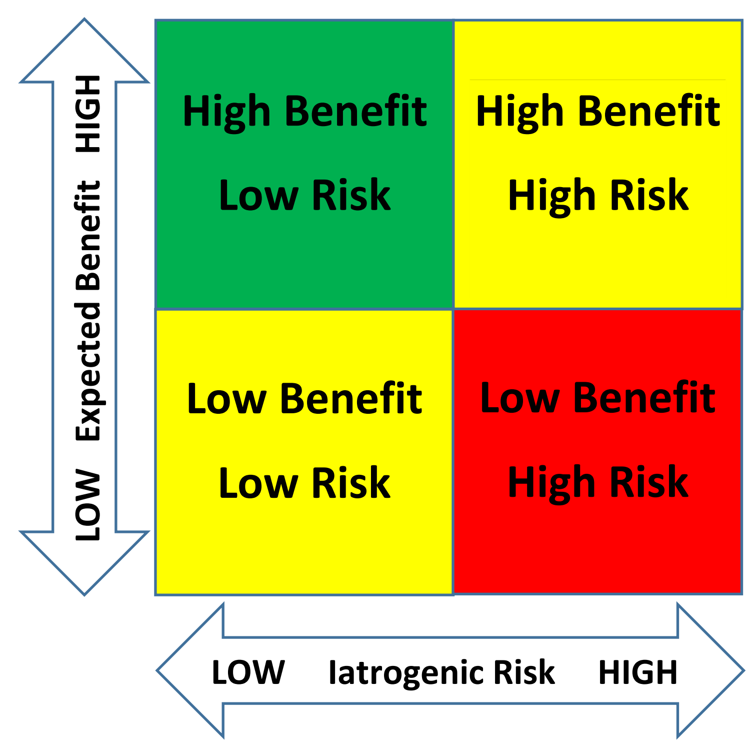
The Allure of Inpatient Hospitalization

- Fabulous tests will uncover the answer
- Excellent medication will treat the problem
- Sending to ED and subsequent inpatient treatment is always the best risk management and harm reduction strategy
- Individuals returning from inpatient treatment are now stable and can return to business as usual
- Individuals will be successfully linked to the proper, good, and effective treatment services following ED or inpatient treatment stay

Efficacy of Inpatient Psychiatric Treatment

Some practice-based evidence…

Re-thinking hospitalization



Historic Question	What hasn't always been considered		
Does the individual meet criteria for psychiatric hospitalization ?	What is the expected health benefit for THIS individual?	What are the risks of iatrogenic harm to THIS individual?	Are there alternatives that offer THIS individual equal/better potential health benefit, while decreasing risk?

These are consequential considerations

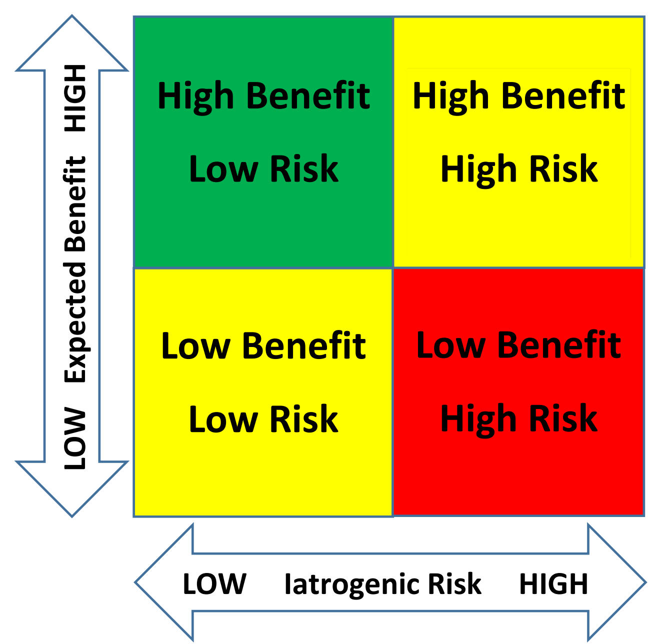
- You are eligible for knee replacement surgery
- It is effective___% of the time
- It causes iatrogenic harm ___% of the time
- Here are alternatives that could be considered…
- What are your thoughts about how to proceed?

Collaborative approaches reduce risk

- Individuals receive treatment recommendations from many sources

  "You need/your child needs…"

- Too often we emphasize treatment benefit and skip or minimize discussion of iatrogenic risk
- We can broaden this conversation with those in crisis and their families in shared-decision making fashion



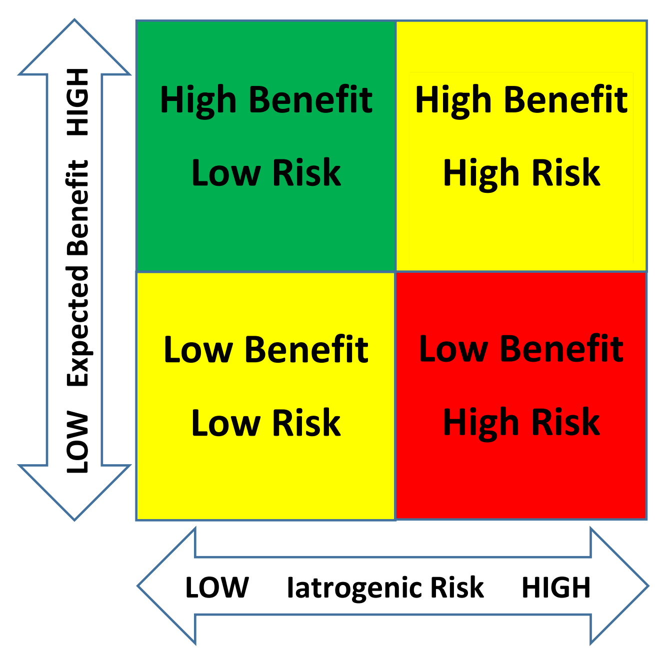
Shared decision-making

» *Are there good reasons to pursue it?*

» *Are there good reasons to avoid it?*

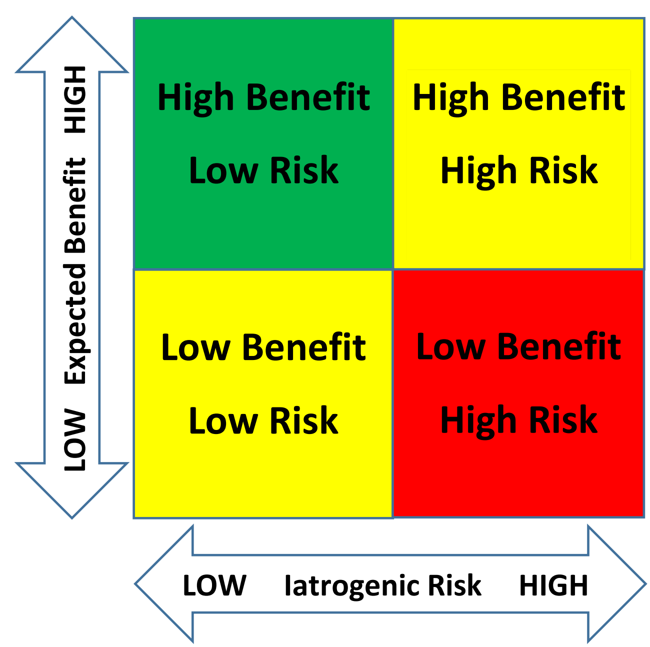
» *What concerns you most?*

» *How do you think you/your child will experience this option?*



Shared decision-making

- *How optimistic are you about the potential health benefit?*
- *How concerned are you about any harms?*
- *What could lessen the risk of harms?*
- *What could improve the outcome?*
- *Are there alternatives to consider?*
- *What would help you make this decision?*



True North Person and Family-Centered Care

Break

Aligning with True North

The experience of consumers and families and communities must serve as ***True North***

-Don Berwick

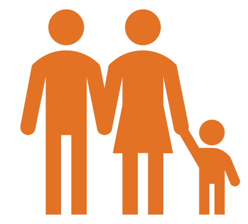
This means that the ordinal point (True North) for system quality is derived from the recipients' reality -- our lived experience, our needs, our beliefs and strengths, as well as our reactions to services extended on our behalf.

-Joyce Burland

True North person and family-centered care

- Is instead of, rather than in addition to, expert-driven care
- It is a shift in orientation
- Use of a compass helps us understand the substantial difference in orientation

Person and family-centered care

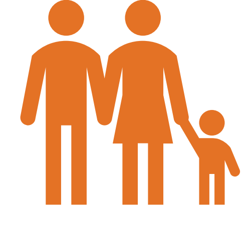


Intervener in “expert” orientation

Person and family-centered care

Intervener aligned in person/family-centered orientation

Person and family-centered care



Person and family-centered care

Shifting our orientation in care delivery

Person in crisis has minimal Power

Person in crisis has equal power

Person in crisis has maximal Power

Expert-Driven

Person/Family Centered

Person/Family Driven

Madenwald Consulting, LLC

Person/family-centered care is an "instead of" approach

- It requires a shift AWAY from the treatment provider lens.
- It requires me to align in a different way with every individual.
- Even when engaging a single person, "true north" for that person continually shifts requiring us to shift too.

Some notes about aligning with True North

- Perfection isn't possible.
- The True North for any individual is continuously shifting.
- Providing services and supports in this fashion means you are operating somewhat in the dark—but at least you know it.
- This is a strength-based approach, BUT a word to the wise…

Strengths aren't always pretty

STRONG-based interventions

Strengths go beyond positive attributes and talents.

- » Think STRONG
- » Look for what is DOMINANT and join there. Look for:
  - Concentrated focus
  - Intensity
  - Strong emotion
  - Resistance/avoidance

STRONG-based interventions

Some of these STRONG responses might turn us off or seem like signs of pathology--and even evidence of need for a higher level care. When I get *turned off* it is easy to revert to an expert-driven care orientation

Combining person-centered, strength-based approaches

» I step out of my expert interpretation about what I am seeing and re-orient to the lens of the person I am engaging.

Combining person-centered, strength-based approaches

» A credible, capable, intuitive person who is able to collaborate is…

- Refusing
- Insisting
- Angry
- Suspicious

» Now, how am I predisposed to respond?

Achieving Precision: Resolution-Focused Care

Resolution-Focused Care

- Person-centeredness is about a strength-based alignment
- Resolution-focus means using approaches that are resolving/relieving as evidenced by
  - Symptom reduction
  - Empowerment/health activation
  - Clarity
  - Diminished risk/REAL harm reduction
  - Diminished angst
  - Increased hope
  - Return to higher level functioning

Resolution-Focused Care

- Resolution-focused programs believe in their efficacy in providing what, for some people, will be an end-service

"We aren't providing crisis care, we are handing off crisis care.

And then they hand off and then they hand off…"

-Chris Tokarski, Executive Director

Mental Health Resources, Inc.

Resolution-focused care

» Provider intention will drive intervention (for better or worse)

» Essential to differentiate:

- Assessment vs. treatment
- Disposition vs. resolution

» Medical analogy makes this clearer…

If you are the person with the mangled foot, *<u>what are you in this for</u>???*

We can purposefully bring that intention to our work

- Intend to treat, not merely assess
- Envision an end goal of relief/resolution, not merely disposition
- Actively work to soothe the crisis state and restore executive function
- Relief/resolution can be incremental
- (Don’t view it as the next person’s job)

Intentions predispose actions

Relieving intervention at every point of contact…

- Each “touch” is an opportunity to engage, listen, affirm, and relieve
- Starts with the first phone call
- From every member of the responding team
- During any follow-up contact

Crisis relief/resolution as an intention

- *What has happened?*
- *What are you experiencing now?*
- *What is the hardest part about this for you?*

Crisis relief/resolution as an intention

» *I hear you…*

» *What would be most useful right now?*

» *What do you need?*

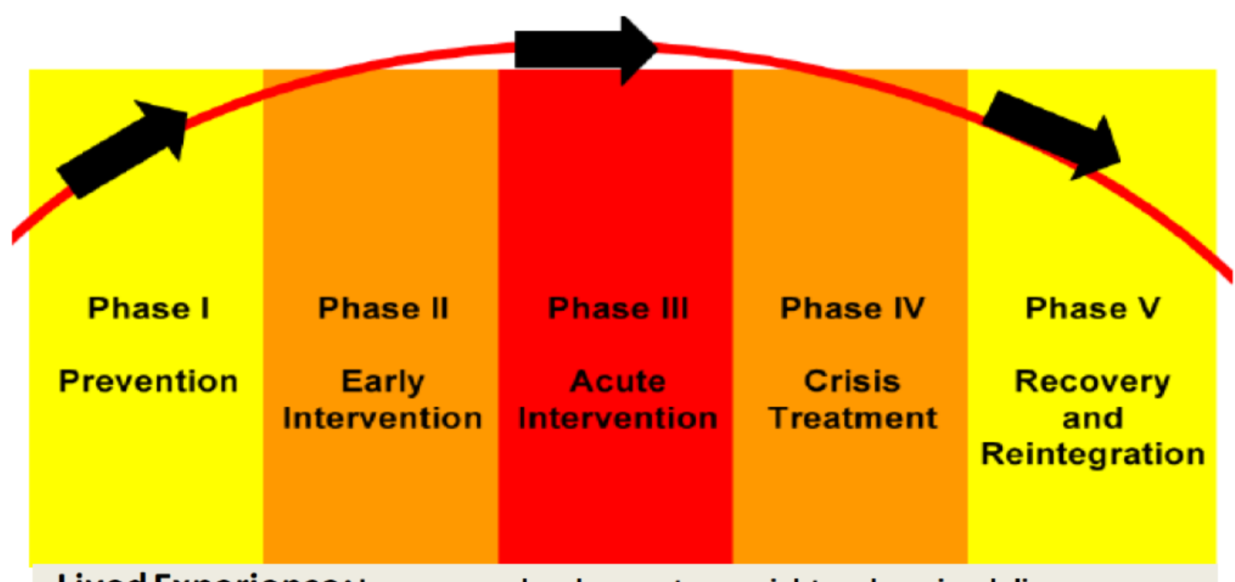
» *What are you trying to sort out?*

As we have these conversations the essence of the crisis becomes clearer

Getting to the essence of the distress

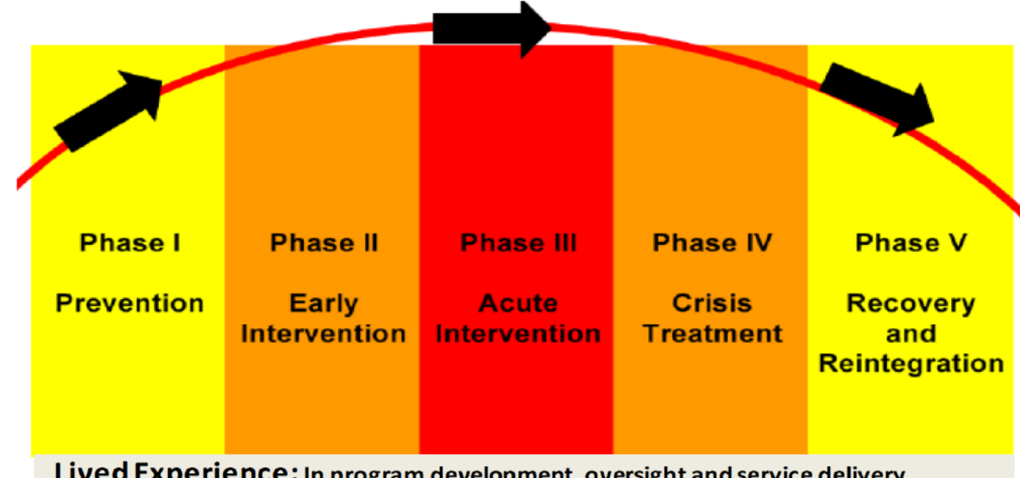
- Fear
- Sadness
- Anger/rage
- Loneliness/isolation
- Restlessness/boredom
- Hopeless/helpless
- Uncertainty/ambivalence
- Anxiousness/nervousness
- Guilt
- Grief/loss
- Pain
- Exhaustion
- Hunger
- Lack
- Stuck
- Misery
- Powerlessness
- Shame

Crisis system of care model



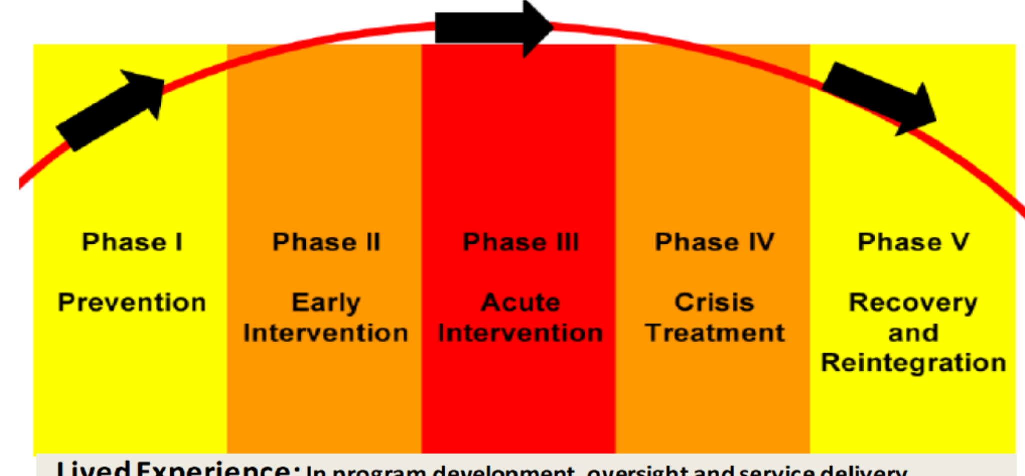
Crisis system of care model

- The management and treatment of mental health and substance use-related crises is a complex, systems-level, public-health need, and necessitates a commensurate response.



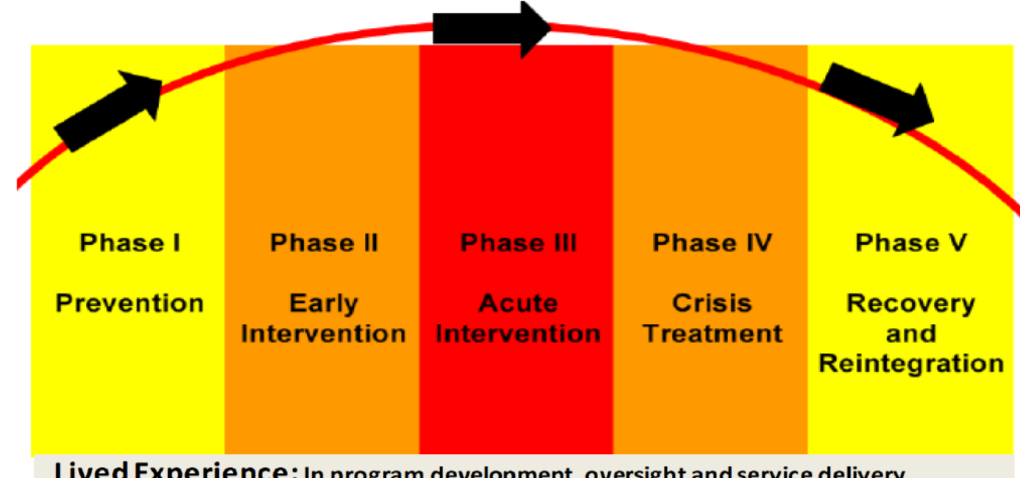
Crisis system of care model

- These challenges set crisis services apart from other types of behavioral health services
- No single entity or system owns full responsibility for managing crises
- For crisis teams, producing good health results requires high, external reliance



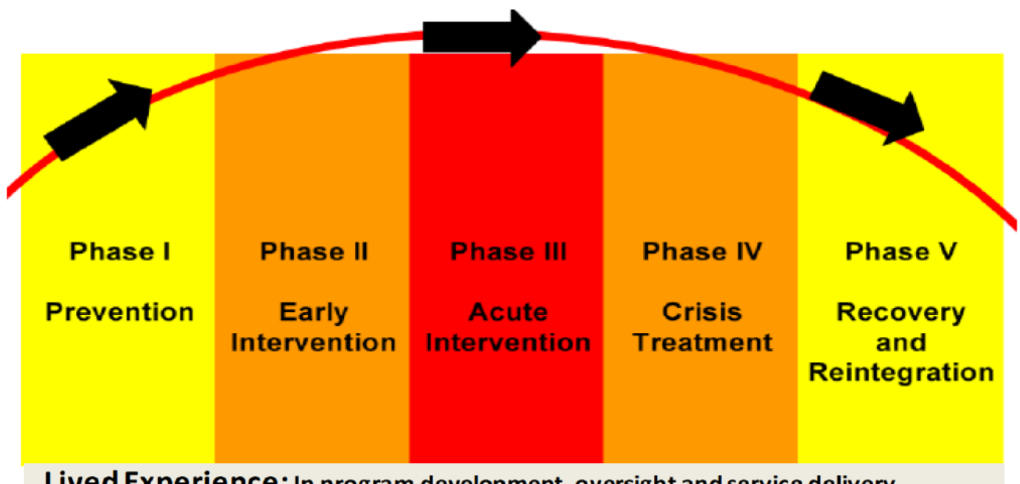
Crisis system of care model

» A single entity or system is not, on its own, sufficiently leveraged to address the multi-factored complexities necessary to operate a healthy and effective crisis system of care.

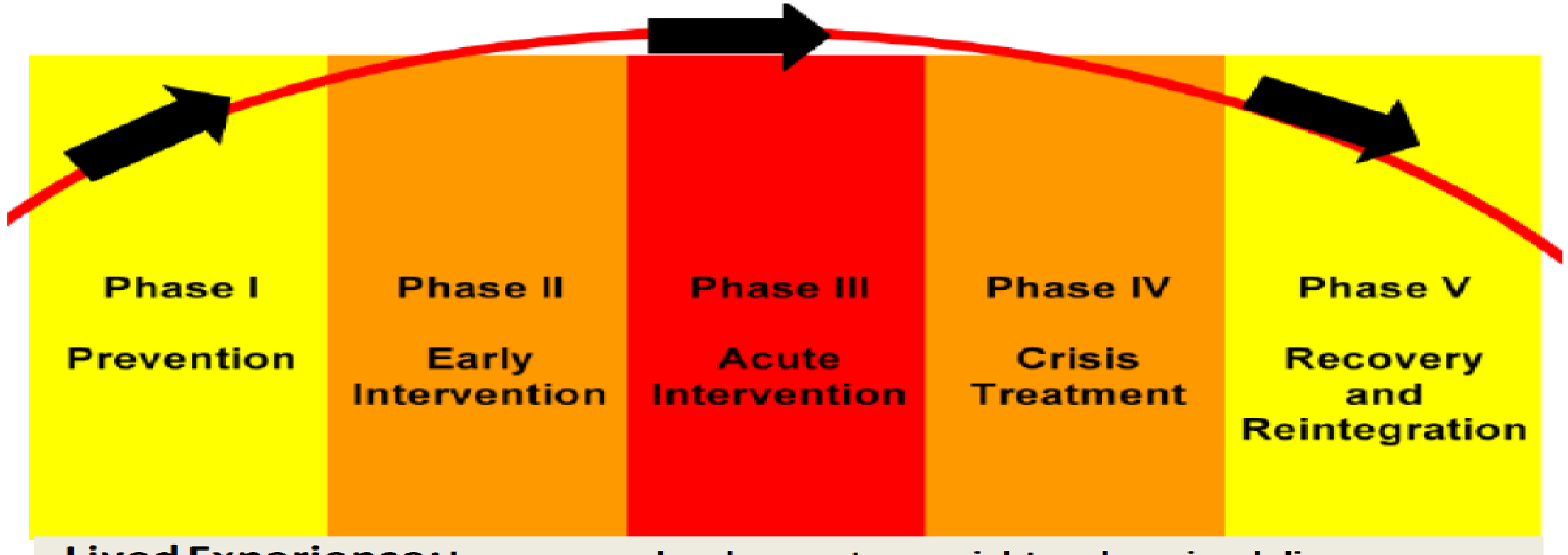


Crisis system of care model

- Crisis systems of care do not naturally exist
- Though they can look quite different, the best functioning crisis systems do have commonalities
- 10 commonalities are reflected in the CSOC model
- Investing in each gives depth and breadth to the CSOC



Crisis System of Care Model



Lived Experience: In program development, oversight and service delivery

Players: Strong, cross-sector collaborations

Logistics: Processes to facilitate movement of people and data

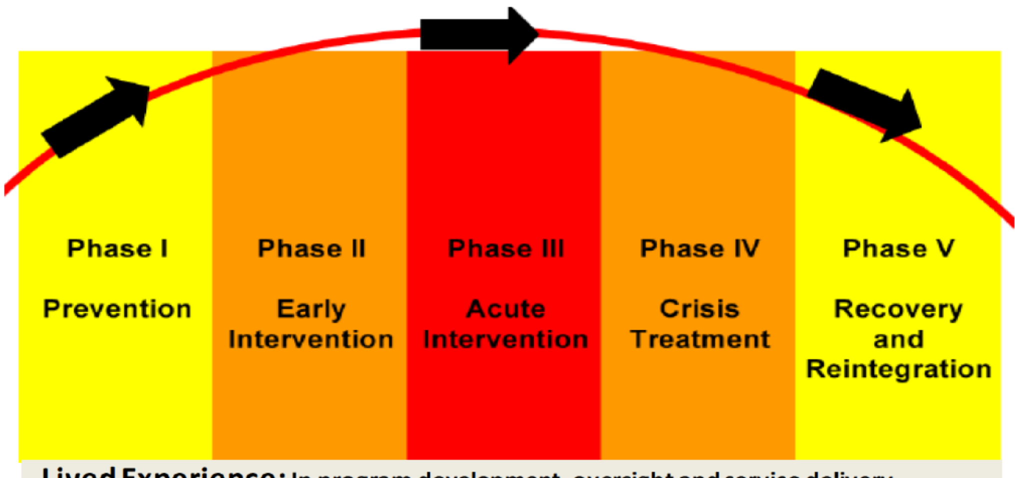
Competencies: Skills that promote resolution and reduce harm

Parts: Services used as intended and producing results

Source: Kappy Madenwald, Madenwald Consulting; Steve Day, Technical Assistance Collaborative

Crisis System of Care Model

- While there are common characteristics in effective crisis systems of care…
- …they tend to work best when idiosyncratic—making the most of the local assets, cost structures, evidence-based practices, and vision



So, in summary, here are some of the things I have learned

1. When we lead with worries about our own liability, we will get it wrong

2. We can and must reduce iatrogenic harm in the delivery of crisis intervention and treatment services

3. Iatrogenic harm implicates us—and that gives us POWER

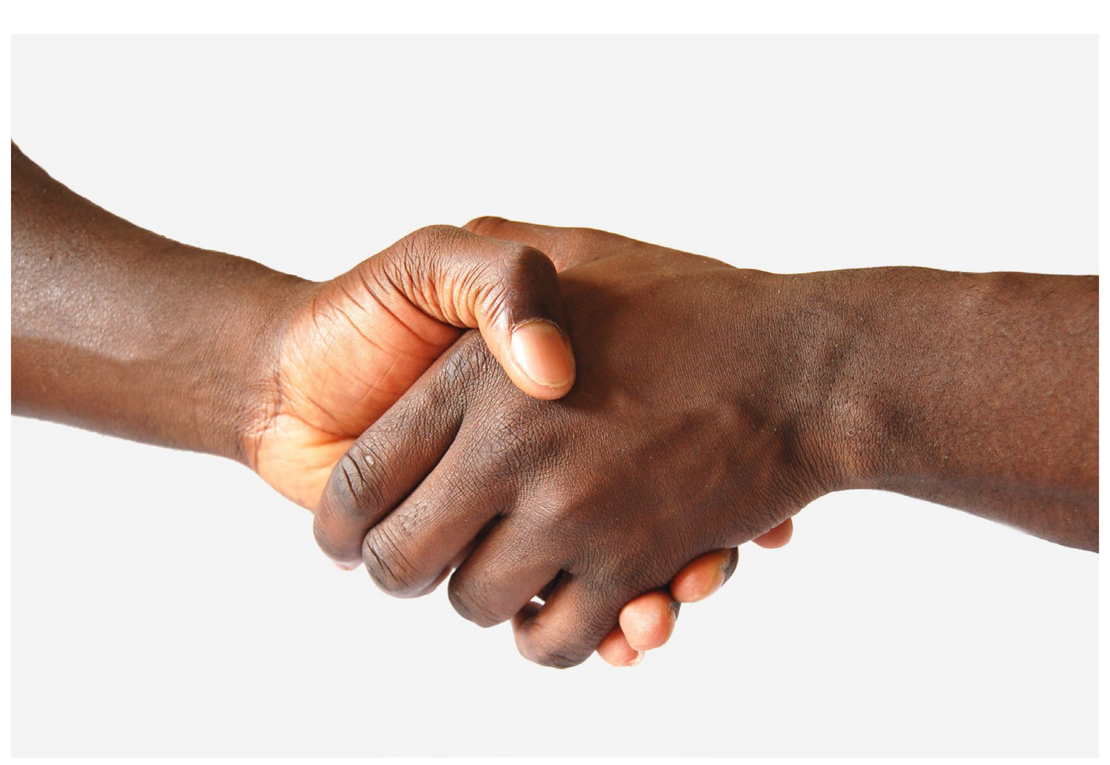
So, in summary, here are some of the things I have learned

4. Crisis systems are built on the foundations of the stories we tell

5. When we engage individuals as credible, capable, intuitive and able to collaborate, we are predisposed to use productive and relieving approaches

6. We can deliver relieving interventions to everybody at every point of contact

You don’t have to get there overnight…



Sliding the bar…

- Gain clarity and consensus on the risks of current practice
- Employ the key competencies in crisis situations
  - Person-centered, understand the essence
  - Strength-based and collaborative
  - Resolution/relief-focused, brief treatment
- In settings that are, as often as possible
  - Natural
  - Community-based
  - Local

Sliding the bar…

- Actively work to push interventions that are often experienced as coercive further downstream
  - Law enforcement contact
  - Initiation of involuntary processes
  - Call to child protective services
- Even when you use these coercive interventions, continue to engage individuals in person-centered, strength-based and resolution-focused fashion

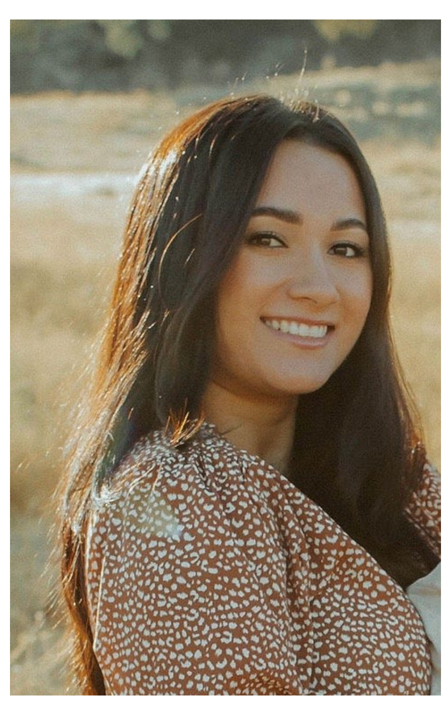
Sliding the bar…

- And most importantly, let those who use crisis services serve as teacher and barometer of change

Thank you…

BREAK

Panel Discussion



Sydney Gurrola, Family and Youth Partnership coordinator, SSYAF

Priscilla Ward, LCSW, Crisis provider and trainer

Tom Orrock, LMFT, Chief of Community Enagement and Grants MHSOAC

Panelist Questions

- What are your thoughts about this element of transformation?
- Do you have examples to offer of crisis care that was experienced as iatrogenic and care that was experienced as safe and helpful?
- Kappy described crisis services as "necessarily systemic" and that to get good results requires the development of a broader crisis system of care inclusive of a wide array of system partners, with planning and investments both UPSTREAM of a crisis episode and DOWNSTREAM of a crisis episode. In your experience, is it important to consider crisis services from this broader systems lens?
- Mobile Crisis Response will be available as a Medicaid treatment service for people of all ages for the first time--what kind of impact do you hope it will have for children, adults and their families?

Questions?

Resources

- Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
- Shared Decision-Making: https://www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making
- Intentional Peer Support https://www.intentionalpeersupport.org/