Toolkit for Improving Crisis Intervention and Emergency Detention Services

P-02224 (08/2018)

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Introduction

This toolkit was developed as part of the Wisconsin Department of Health Services Learning Collaborative for Crisis Intervention and Emergency Detention managed by the Division of Care and Treatment Services.

Behavioral health agencies representing all regions of the state worked with staff from the Division of Care and Treatment Services from February through June 2018 to discuss strategies and approaches on how to support people experiencing a mental health crisis in the community rather than sending them to a state mental health institute for care and treatment.

Agencies involved with crisis response services and the emergency detention process are encouraged to use the strategies and approaches included in this toolkit to improve local practices.

The Wisconsin County Human Services Association was a partner in the development of this toolkit.

Ten Essential Values for Crisis Response

The following are the 10 essential values from the Substance Abuse and Mental Health Services Administration that are fundamental in responding to any crisis situation.

1. **AVOIDING HARM:** Allowing a period of watchful waiting to minimize the duration and negative impact of interventions used.
2. **INTERVENING IN PERSON-CENTERED WAYS:** Seeking to understand the individual, their unique circumstances, and how their personal preferences can be incorporated in crisis response.
3. **SHARED RESPONSIBILITY:** The individual in crisis becomes an active partner in regaining control rather than a passive recipient in the time of crisis.
4. **ADDRESSING TRAUMA:** The importance of understanding the individual's trauma history and vulnerabilities associated with the crisis interventions used.
5. **ESTABLISHING FEELINGS OF PERSONAL SAFETY:** The importance of understanding for that person to experience a sense of security and personal safety.
6. **BASED ON STRENGTHS:** Identifying and reinforcing the resources on which an individual can draw on to recover from and protect from future crisis events.
7. **THE WHOLE PERSON:** Understanding that an individual with a serious mental illness in crisis is a whole person and though their illness is relevant it is not paramount to recovery.
8. **THE PERSON AS CREDIBLE SOURCE:** Never dismiss the person as a credible source of information—factual or emotional—in terms of understanding the person's strengths or needs.
9. **RECOVERY, RESILIENCE, AND NATURAL SUPPORTS:** The crisis response should contribute to the individual's larger journey towards recovery and resilience; fostering dignity and hope.
10. **PREVENTION:** The crisis response requires measures that address the person's unmet needs through individualized planning and promoting systemic improvements.

Providing Value to Consumers

There are eight types of process obstacles that get in the way of providing value to consumers. These obstacles should be reduced or eliminated.

TIM WOODS is a prompt to help clarify the value-depleting activities that take place during the delivery of a service or the production of a good.

Transportation—Moving things from one location to another unnecessarily.
Inventory—Making too much or too little.
Motion—Moving people unnecessarily.
Waiting—Delaying operations because pieces necessary for the work are missing.
Overproduction—Completing a task before it is needed.
Over processing—Performing unnecessary steps to get the desired result.
Defects—Failing to deliver the product or service right the first time.
Skills—Failing to use the skills and capabilities of the workforce.

What value-depleting activities impact crisis response services?
Participants in the DHS Learning Collaborative for Crisis Intervention and Emergency Detention identified the following value-depleting activities for crisis response services.

- Rework. Services were not done right the first time.
- Whitespace. Consumers experiencing delays and waiting while nothing is happening.
- Process time. It may take too long to execute a particular step in the crisis response.
- Process variation. There may be inconsistencies in crisis response that make it difficult to intervene and effect a change to the process.

Obstacles to Improvement

Partners in the DCTS Learning Collaborative for Crisis Intervention and Emergency Detention identified many issues that impact the quality of a crisis response. View these obstacles as a source of improvement and consider how to eliminate or minimize their effect.

Resources

- Lack of staff to fill key positions and all shifts.
- Lack of funding for social workers.
- Lack of prescribers.
- Lack of on-call therapists in jails.
- Lack of transport options.
- Lack of reimbursement for services from insurance and managed care organizations.

Knowledge

- Lack of consistent definitions across stakeholders for incapacitated and unconscious, emotional outburst and mental health disorder, behavioral crisis and mental health crisis, imminent risk and dangerous.
- Lack of clear understanding of who qualifies as a consumer under Wis. Stat. § 51.15.
- Lack of understanding what is required for an individual under a court order.
- Lack of understanding of crisis by health care providers, family, etc.
- Limited assessment training for providers, resulting in a low comfort level to perform assessments.
- Limited ability of providers to handle a client's risk of suicide.

Services

- Limited access to services and supports for people without a diagnosis.
- Limited availability of services and supports for voluntary consumers.
- Limited availability of services and supports for youth and young adults.
- Limited availability of services and supports for individuals with memory issues.
- Limited availability of services and supports for people with co-occurring disabilities (substance use disorder, physical disabilities, cognitive limitations, and aging).
- Limited stabilization options, especially for youth and young adults.
- Limited crisis beds.
- Limited public and private psychiatric hospital beds.
- Limited willingness of many private hospitals to admit children and high-risk individuals.
- Limited willingness to serve individuals requiring long-acting medication injections.

Coordination

- Limited sharing of private information due to state and federal regulations.
- Lack of communication between behavioral health agencies, family, hospitals, law enforcement.
- Lack of willingness among agencies to train all staff in key crisis competencies.
- Lack of clear lines of authority in mental health crisis.
- Lack of harmonization with county corporation counsel.
- Lack of interest among community services working as a system.
- Lack of consistent procedures and policies among agencies—behavioral health, law enforcement, etc.
- Lack of involvement of the crisis team by emergency departments.
- Lack of management for transports.
- Lack of options under insurance contracts for most suitable placements, limiting treatment.
- Lack of organization among agencies in discharge planning.

Timing

- Delays in talking with people due to high crisis line call volume.
- Delays in crisis team response due to size of the county or coverage area.
- Delays in emergency departments locating private, involuntary psychiatric beds.
- Delays in psychiatric hospital admission due to the need to obtain medical clearance.
- Delays in psychiatric hospitals receiving and admitting individuals.
- Delays in managed care organizations to address or treat decompensating clients, leading to longer inpatient stays.
- Delays in obtaining hospital-to-hospital consultation necessary for information exchange and transfer.
- Delays in scheduling follow-up appointments.

Data

- Lack of statistics to understand current state.
- Lack of information on needed services and opportunities for improvement.

Client

- Lack of understanding of mental health, leading to feelings of shame and delaying care.
- Lack of dedication to services and ongoing care from high-need individuals and/or voluntary clients.
- Lack of stable housing, creating difficulties in tracking and locating the individual for services and ongoing care.
- Lack of social supports, leading to more crises.

A Quick Guide to Positive Change

Consider implementing one or more of the following strategies to make quick, meaningful improvements to crisis response services.

- Collaborate with partners—emergency departments, schools, etc.
- Develop strong relationships with law enforcement and promote crisis intervention teams.
- Collaborate with adult and child protective services.
- Align services with and adequately respond to self-defined crisis.
- Identify individuals who are high system users and develop collaborative crisis plans that provide proactive crisis management.
- Use in-place and residential stabilization options.
- Add peer support specialist services to crisis team.
- Promote face-to-face assessment and intervention, making mobile crisis contact a priority.
- Use crisis to bridge to other services such as supports for sustaining prescriptions, overseeing medication self-administration, and maintaining abstinence and sobriety, etc.
- Ensure the crisis team is skillfully trained and regularly engaged in practice of crisis and risk assessment as well as crisis management.
- Use clinical supervision to enhance clinical decision-making on each case before allowing an emergency detention or a dismissal from detention.
- Provide thorough and universal follow-up after each hospitalization or situation involving suicidal ideation or intent.

Best Practices

There are many best practices for managing mental health crises in the community. This section identifies 24 of these strategies. Essential features of each strategy are identified along with examples drawn from participants in the DHS Learning Collaborative for Crisis Intervention and Emergency Detention.

- Assure a comprehensive understanding of the crisis.
- Assure adequate time with the individual in crisis.
- Collaborate with community partners.
- Collaborate with law enforcement.
- Commit to zero suicide and suicide safe care.
- Develop and utilize regional or statewide crisis call centers.
- Develop residential crisis stabilization programs.
- Ensure crisis providers have appropriate training and competence.
- Ensure timely access to supports and services.
- Focus on strengths-based and recovery-oriented service provision.
- Make a strong commitment to safety.
- Make it a priority to help the individual regain a sense of control.
- Make peer support available.
- Provide culturally and linguistically appropriate services.
- Provide referrals and assure follow-up.
- Provide services in the least restrictive manner.
- Provide trauma-informed care.
- Respect client rights.
- Respond to self-defined crisis without dismissing as not meeting criteria.
- Skillfully serve people with dementia.
- Support recovery from substance use disorder.
- Take meaningful measures to reduce the likelihood of future crisis.
- Use 24/7/365 centrally deployed crisis.
- Use data driven processes.

Assure a comprehensive understanding of the crisis

Concepts	Examples
• Create an approach where interventionists derive a comprehensive understanding of the crisis—not only what, why, and how the crisis developed, but the context of the situation—including when and when not the situation occurs. • Be mindful that crisis—especially recurring events—signals a failure to address an underlying issue. • Escape a restricted facility view of a crisis by using mobile crisis resources that develop a much more comprehensive situational picture in the natural environment.	• Establish a practice of meeting with family or having consultative calls with significant others. • Conduct a daily debriefing on all crisis cases and include multiple program partners as appropriate. • Offer remote access to crisis records, treatment history, and current plans on clients. • Develop avenues to access to primary treatment records.

Assure adequate time with the individual in crisis

Concepts	Examples
• Strive to fully understand the individual's situation both objectively and as experienced by the individual. • Avoid pressures to quickly resolve a crisis at the expense of not fully understanding what the individual is experiencing. • Assure face-to-face time with the individual is a core element of service. • Anticipate the individual will not be in a position to describe their situation clearly and concisely, particularly after being involuntarily transported for an evaluation.	• Communicate and collaborate with jail and youth services center, clarifying roles to assist with or mitigate the risk of crisis for the individual. • Provide consultative contacts with family and friends at outset and throughout the crisis. • Make information readily available and coordinated within the agency. • Create access between internal and external agencies to exchange current client information. • Facilitate outpatient provider collaboration. • Create multiple follow-ups and attempt follow-up action. • Provide in-home crisis stabilization. • Utilize collaborative anticipatory crisis planning (proactive) to avert crises in the first place. • Provide crisis planning for all individuals with settlement agreements or commitments.

Collaborate with community partners

Concepts	Examples
• Take purposeful actions to collaborate with partners to produce synergies. • Eliminate redundancy and waste in services to minimize frustration and bolster efficiency and effectiveness.	• Form a change team with the director and all mental health as well child and family supervisors and managers. • Partner with other service providers, such as adult protective services, child protective services, private sector, hospitals, stabilization facilities, homeless providers, and schools. • Become a mental health first aid trainer and provide training. • Facilitate partner or citizen review panels that include people with lived experience. • Establish a permanency roundtable and crisis dementia response steering committee. • Encourage medical director to reach out to doctors at inpatient facilities. • Include crisis-related training at monthly business meetings and during clinical supervision. • Encourage outpatient mental health providers to provide school-based consultation (ForwardHealth Update 2018-25). • Develop reciprocal and collaborative working relationships with Family Care managed care organizations, hold regular meetings.

Collaborate with law enforcement

Concepts	Examples
• Establish strong partnerships with law enforcement that promote mutual understanding, reduce frustration, and lead to better coordination. • Promote crisis intervention team training to improve police response and situational awareness. • Establish and use crisis drop-off centers to reduce unnecessary delays and unwarranted use of emergency medical care. • Become a Stepping Up county. • Promote excellence and professionalism in policing through the Wisconsin Law Enforcement Accreditation Group. • Do sequential intercept mapping.	• Support law enforcement use of mental health awareness flags in dispatch database. • Equip law enforcement with partial crisis plans. • Facilitate an evidence-based decision-making initiative, a model policy for law enforcement response to mental health crises. • Pair or embed crisis response staff with law enforcement. • Connect police with crisis staff at the scene. • Conduct staffing and system review with criminal justice partners. • Work with law enforcement to transport to the crisis center instead of an emergency department. • Provide transportation to hospital apart from police through crisis staff or paid or off-duty law enforcement.

Commitment to Zero Suicide and suicide safe care

Concepts	Examples
• Assess the level of suicide risk. • Use a universal screening tool to identify who is at risk for suicide. • Use collaborative safety planning that includes reduced access to lethal means and includes asking for assistance from family or significant others. • Engage individual in follow-up treatment with a provider adept in suicide care. • Provide follow-up caring contacts by phone, email, or text within 24 or 48 hours.	• Use the Columbia Suicide Severity Rating Scale. • Become a Zero Suicide organization. • Use the safety planning intervention. • Engage family and significant others in support. • Promote the gun shop project. • Make gun locks available through the crisis program. • Coordinate referrals and warm handoffs to capable, ongoing care and treatment that directly focuses on suicide. • Train staff on QPR, SAFE-T, cognitive behavior therapy for suicide prevention, and Collaborative Assessment and Management of Suicidality. • Utilize lock boxes for medications.

Develop and utilize regional or statewide crisis call centers

Concepts	Examples
• Establish a regional 24/7 clinically staffed hub/crisis call center that provides real-time, coordinated crisis intervention capabilities (phone, text, chat). • Use technology for real-time coordination across the system of care. • Utilize data for identifying service needs, performance improvement, and accountability across systems. • Train call staff to provide high-touch support to individuals and families. • Tap into available outpatient and inpatient services in the area.	• Affiliate with National Suicide Prevention Lifeline and access the stipend for doing so. • Partner with HOPELINE. • Use back-up resources when existing crisis lines or staff are occupied.

Develop residential crisis stabilization programs

Concepts	Examples
• Develop low-cost, short-term, sub-acute programs for individuals who need support and observation to avoid high-cost, hospital-based acute care. • Create stabilization services that operate in a home-like environment, using peer staff, offering 24/7 access to psychiatric and mental health clinicians. • Utilize 23-hour living room models with welcoming and accepting environment, conveying hope, empowerment, choice, and higher purpose. • Utilize peer-operated respite, providing restful, voluntary sanctuary for consumer guests.	• Use crisis beds in-lieu of, before, or after an inpatient hospitalization. • Offer centralized crisis center where all crisis functions are consolidated, allowing for receiving individuals from law enforcement. • Create youth foster homes for stabilization.

Ensure crisis providers have appropriate training and competence

Concepts	Examples
• Develop and deliver evidence-based and role-specific crisis training appropriate to the high-risk, high-demand role. • Train a variety of personnel who will be called upon in a crisis—crisis staff, peer support, and police. • Implement specialized training for law enforcement, such as crisis intervention team training. • Create and train on standardized screening and assessment tools and procedures to be used by all crisis providers.	• Enable crisis staff to write the emergency detention apart from law enforcement using staff qualified under Wis. Stat. ch. 48 or 938. • Adopt strategies from the crisis dementia innovation grants and dementia support teams. • Link specialized staff with crisis: opioid overdose outreach worker, peer support specialist, dementia specialist. • Train all staff in the use of naloxone. • Utilize Collaborative Assessment and Management of Suicidality, motivational interviewing, dialectical behavior therapy, trauma-focused cognitive behavioral therapy, cognitive behavior therapy for suicide prevention, etc.

Ensure timely access to supports and services

Concepts	Examples
• Take actions to reduce intensity and duration of distress. • Take actions to de-escalate the crisis, avoid narrowing options. • Make crisis services available 24/7/365. • Provide outreach or mobile services when individuals are unable or unwilling to come to traditional services on site. • Create access to a supervisor 24/7 to help solve problems quickly.	• Notify crisis services prior to involvement of the emergency department. • Use telehealth technology to extend capacity and range of services. • Establish same-day-appointment system or just-in-time scheduling with clinician or psychiatrist. • Arrange to have prescriber time at crisis center. • Encourage family mobile team to interface with child welfare to de-escalate and coach parents through crisis. • Provide transportation to services. • Streamline phone system.

Focus on strengths-based and recovery-oriented service provision

Concepts	Examples
• Assess the individual's assets and strengths at least as much as their clinical signs, symptoms, and deficits. • Utilize strengths-based planning to affirm an individual's sense of confidence and efficacy in resolving the crisis. • Emphasize strengths toward building resiliency and capability for self-management of the current situation and in the future.	• Determine service satisfaction through a survey. • Provide services that meet the individual on their terms. • Assess strengths and assets in equal proportion to symptom or problem identification. • Collaborate on crisis stabilization and safety planning. • Emphasize self-efficacy. • Complete crisis stabilization plan at discharge from hospital or other treatment service. • Use community resources—volunteer drivers, gas cards, etc. • Work actively with schools.

Make a strong commitment to safety

Concepts	Examples
• Ensure actual safety and perceptions of safety for clients and staff. • Establish safe policies and procedures, such as not requiring staff to visit homes alone, providing communication devices, and having ready access to historical information on client dangerousness. • Provide a ligature resistant, welcoming, non-institutional, and safe physical space. • Use appropriate staffing ratios to number of individuals being served. • Facilitate strong relationships with law enforcement and first responders. • Establish policies that emphasize no force first.	• Use standardized risk assessment protocols and tools. • Provide face-to-face assessment to the extent possible, using telehealth as a back-up. • Provide safe rooms for people who may be at risk of imminent violence. • Use Calm Harm app.

Make it a priority to help the individual regain a sense of control

Concepts	Examples
• Support the individual in regaining a sense of control as opposed to feeling as if he or she is spinning out of control. • Involve the individual in crisis to avoid the feeling that control is being wrested away, often provoking resistance that staff can inaccurately view as further evidence that the individual does not understand the crisis situation. • Provide informed decision-making, which is more than simply apprising the individual of risks and benefits associated with various interventions. • Reinforce personal responsibility, allowing the individual choice, even if it is suboptimal.	• Use motivational interviewing to help the individual discover one's own solutions and to reinforce self-efficacy. • Utilize collaborative crisis planning. • Use concurrent documentation by involving the individual in the writing of a response or crisis plan and related clinical documentation.

Make peer support available

Concepts	Examples
• Find ways to include peer-related experience in all services. • Connect individuals in crisis with others who have lived experience with mental illness and behavioral health crisis to reduce fear and isolation. • Share first-hand experiences of hopefulness. • Make peer-operated respite services available. • Promote diversity—language, racial, ethnic, LGBTQ, etc.—in peer supports.	• Use peer drop-in center. • Attach recovery coaches to adult services. • Include peer support for follow-up. • Develop and use peer warmlines. • Encourage use of peer-run respites. • Extend peer services to hospital emergency departments, law enforcement, etc. • Involve peers in crisis planning. • Offer family peer support. • Connect with local affiliates of the National Alliance on Mental Illness.

Provide culturally and linguistically appropriate services

Concepts	Examples
• Establish services congruent with culture, gender, race, age, sexual orientation, health literacy, military background, and communication needs of the individual being served. • Identify and improve areas to better engage and connect with individuals in crisis despite cultural and linguistic differences. • Provide clients with choice among crisis staff, beyond linguistic proficiency and cultural capability alone. • Assure accessibility for differently abled individuals.	• Hire for diversity in staff. • Provide ongoing diversity training for staff. • Employ an outpatient youth therapist.

Provide referrals and follow-up

Concepts	Examples
• Offer 24-hour, 48-hour, and one-week follow-up. • Provide outpatient scheduling 24/7. • Develop follow-up services that are linked, coordinated, and tracked for behavioral health, detoxification, homelessness, etc. • Coordinate with hospitals for follow-up care at discharge.	• Utilize 100 percent follow-up: multiple follow-ups and attempts to follow-up. • Implement the Purple Tube Project with dementia care plan and resources. • Provide outreach on psychiatric care to inpatient physicians. • Refer to the HOPELINE. • Collaborate with emergency medical services providing mental health support services. • Collaborate with homeless providers and Projects for Assistance in Transition from Homelessness. • Develop and use a facility discharge checklist.

Provide services in the least restrictive manner

Concepts	Examples
• Assure services follow legal requirements under Wis. Stat. ch. 51. • Help individuals stay connected to their daily world by providing services where the individual lives, works, and recreates. • Assure services are person-centered and avoid coercion. • Promote connection to resources in local environment. • Encourage natural supports.	• Expand diversion resources and options for voluntary services. • Offer walk-in mental health services. • Promote easy access to outpatient appointments. • Provide crisis supports after hospitalization. • Incorporate medication observation by outreach workers. • Establish a policy for clinical consultation before an emergency detention. • Provide direct access to services for the homeless. • Bring client to crisis facility rather than a hospital. • Train schools, therapists, etc., in the definition of a crisis and ask them to assess the individual before calling for crisis services.

Provide trauma-informed care

Concepts	Examples
• Recognize that individuals often have a history of victimization, abuse, or neglect. • Train staff to understand how past trauma may impact the individual's current status and their response to the current crisis or considered interventions. • Recognize that evaluating trauma is not asking blunt questions from a checklist but a sensitive and expert evaluation. • Apply the principles of trauma-informed care: safety; trustworthiness and transparency; peer support; collaboration and mutuality; and empowerment, voice, and choice.	• Train staff on practices to support trauma-informed care. • Include an assessment of trauma in the crisis assessment. • Employ collaborative crisis and safety planning that, to the extent possible, confers empowerment, voice, and choice for the individual being served. • Develop and provide peer support resources. • Train staff to use Trauma Screening, Brief Intervention, and Referral to Treatment. • Use trauma-focused cognitive behavioral therapy.

Respect client rights

Concepts	Examples
• Recognize an individual in crisis is also in a heightened state of vulnerability. • Assure all responders are well versed in the broad rights of consumers (confidentiality, informed consent, unwarranted seclusion or restraint, right to speak with an ombudsman or advocate, etc.). • Enact processes to support the values of shared responsibility and recovery that include an individual having a clear understanding of one's rights as well as access to an advocate.	• Provide an informational packet to all individuals assessed by the crisis team. • Conduct collaborative crisis planning with a focus on strengths and recovery. • Use trauma-informed, person-first, and recovery-focused language.

Respond to self-defined crisis without dismissing as not meeting criteria

Concepts	Examples
• Establish approaches that support open access, immediate action, and intervention for individuals identifying themselves in crisis, recognizing that crisis does not equate with need for hospitalization. • Create a culture that never puts an individual's concerns off—welcoming calls from any community member and avoiding a screen-out—that can tacitly encourage a crisis to escalate. • Establish practices to prevent minimizing concerns, recognizing that the overt presentation might mask deeper and bigger issues.	• Provide meaningful guidance and assistance to securing needed resources and referral to services. • Triage and offer or refer to immediate appointments. • Promote the HOPELINE. • Check in with clients at regular intervals. • Work with other service providers and partner to provide service as a coordinated system. • Walk the individual to where they need to be for services, make introductions. • Ensure that there is no wrong door to services.

Skillfully serve people with dementia

Concepts	Examples
• Establish an involved, broad-based, collaborative coalition of individuals interested in improving the dementia capacity of crisis response. • Review capacity of current dementia resources and training needs; identify strengths and gaps in needed supports and implement a plan. • Review crisis response results and make adjustments accordingly. • Use data to measure need and effectiveness, including emergency protective placement. • Focus on prevention as a strategy to reduce the need for crisis response. • Create resources that will provide supports for in-place stabilization. • Explore availability of and expand the number of facilities willing to accept people who need urgent placement.	• Provide in-home stabilization and transition services using specially trained dementia in-home health providers. • Develop collaborative relationships with dementia care specialists through the aging and disability resource centers. • Work in collaboration with in-home health providers. • Develop specialized training and adaptations for serving elders and individuals with dementia (Use the resources of the UW-Oshkosh Dementia Care Project Learning Center and UW-Green Bay Behavioral Health Training Partnership). • Develop skills in soothing strategies and music and memory. • Avoid attempts at reality orientation or debating when it is upsetting or counterproductive. • Utilize strategies attempted through the crisis dementia innovation initiatives. • Use crisis plans. • Include adult protective services staff in provision of crisis services. • Use Purple Tube Project with dementia care plan. • Use screening tools such as the St. Louis University Mental Status Exam, National Task Group Early Detection Screen for Dementia, or Mini-Cog.

Support recovery from substance use disorder

Concepts	Examples
• Provide training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) and American Society of Addiction Medicine (ASAM) criteria. • Train staff in motivational interviewing. • Develop detoxification resources through crisis, both medically managed and medically monitored (social detox). • Train and equip crisis staff with naloxone for opioid emergencies. • Assure that crisis staff are knowledgeable about substance use disorders and have current information on resources and treatment. • Develop policies and practices to assure that over time crisis can bridge clients to mainstream substance use disorder treatment providers.	• Train on and make referrals for substance use disorder services covered under Medicaid, including Comprehensive Community Services. • Use warm handoffs, link substance-using individuals to treatment resources, including those that provide medication-assisted treatment. • Employ crisis planning, crisis management, and regular follow-up to support and sustain individuals referred to substance use disorder providers. • Provide assistance to clients navigating insurance barriers to treatment. • Train staff in tobacco cessation resources from the UW-Madison Center for Tobacco Research and Intervention.

Take meaningful measures to reduce likelihood of future crisis

Concepts	Examples
• Establish measures across services to identify service gaps and promote improvement. • Share information, where able, across systems to address individual needs and support continuity of care. • Make linkages to address certain needs beyond the scope of the crisis program (ongoing behavioral health treatment, housing agencies, foster care, schools, etc.).	• Employ active crisis management. • Assign staff to oversee and follow the case over time. • Provide a high-risk crisis or care manager. • Use crisis to oversee and follow up on all individuals under settlement agreement or commitment. • Provide in-person and phone follow-up and welfare checks. • Provide medication delivery and supervised self-administration and contract with prescribers. • Distribute resource lists. • Provide community education. • Attach supported apartment program to crisis. • Conduct regular staffings or reviews involving crisis staff and potentially other partners.

Use 24/7/365 centrally deployed mobile crisis

Concepts	Examples
• Establish a centrally deployed in-person 24/7 mobile outreach and support service that provides assessment and intervention within a normal, comfortable environment (home, workplace, etc.). • Assure medical backup is available. • Recognize hospitalization is not inevitable and alternatives exist: consumer-managed peer respite, in-home stabilization, residential stabilization, same-day or next-day appointments, etc. • Utilize GPS-enabled mobile dispatch.	• Develop procedures that encourage crisis team to go to community residence and the individual's home. • Establish partnerships that support yet limit unnecessary law enforcement, emergency department, medical facility, or impatient involvement. • Develop a database that allows remote access to previous crisis screens and plans. • Cultivate a range of voluntary care options for mobile crisis staff. • Develop an outreach philosophy of building relationships, including to homeless shelters. • Maintain 24/7 access to crisis team supervisors.

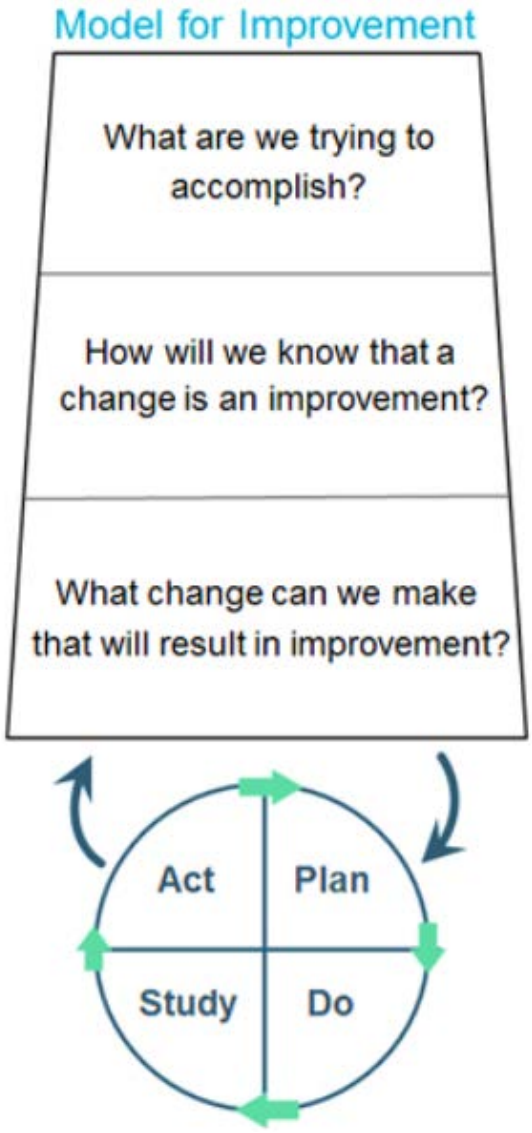
Use data driven processes

Concepts	Examples
• Maintain sound databases and use data to measure service needs and effectiveness. • Provide continuous and contemporary feedback to management and direct care staff on data measures.	• Make suggestions to Department of Health Services for useful Program Participation System reports. • Use the standardized definition of diversion and measure diversions from inpatient psychiatric hospitalization. • Measure call volume across different time periods. • Measure times in the process of opening and closing a crisis call. • Use data to identify high-frequency, high-likelihood, or high-consequence issues to address in the context of a risk matrix or failure mode effects analysis.

Model for Improvement

The model of improvement described in this section was initially developed by Tom Nolan and colleagues at Associates in Process Improvement as a framework for accelerating improvement in the business world. It since has been used extensively by the Institute for Health Care Improvement and NIATx.

The model has two parts. One part is three questions, which can be addressed in any order. The other part is the Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings.



Testing Change

The model for improvement is based on a trial-and-learn approach to improvement. The PDSA cycle describes how to test change by trying it, observing the consequences, and acting on what is learned.

It is better to run small cycles of change sooner rather than large cycles later, after a long period of planning.

Each properly done PDSA cycle is informative and provides the basis for further improvement. Once you have something that works on a small scale you can start implementing on a larger scale.

Challenges to address at each step

Step 1: Plan: Plan the test or observation, including a plan for collecting data.

- State the objective of the test.
- Make predictions about what will happen and why.
- Develop a plan to test the change. (Who? What? When? Where? What data needs to be collected?)

Step 2: Do: Try out the test on a small scale.

- Carry out the test.
- Document problems and unexpected observations.
- Begin analysis of the data.

Step 3: Study: Set aside time to analyze the data and study the results.

- Complete the analysis of the data.
- Compare the data to your predictions.
- Summarize and reflect on what was learned.

Step 4: Act: Refine the change, based on what was learned from the test.

- Determine what modifications should be made.
- Prepare a plan for the next test.

Science of Improvement

Set an Aim
Improvement requires setting aims. An organization will not improve without a clear and firm intention to do so. The aim should be time-specific and measurable. It should also define the specific population of people that will be affected. Agreeing on the aim is crucial; so is allocating the people and resources necessary to accomplish the aim.

Establish a Measure
Measurement is a critical part of testing and implementing changes. Measures tell a team whether the changes they are making actually lead to improvement.

Select a Change
There are many kinds of changes that will lead to improvement, but having specific changes from a limited number of change concepts is a good start. Change concept identified as a larger group will be useful in developing specific ideas for changes that lead to improvement. Creatively combining these change concepts with knowledge about specific subjects can help generate ideas for tests of change.

Test the Change
Use the PDSA cycle to test change.

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