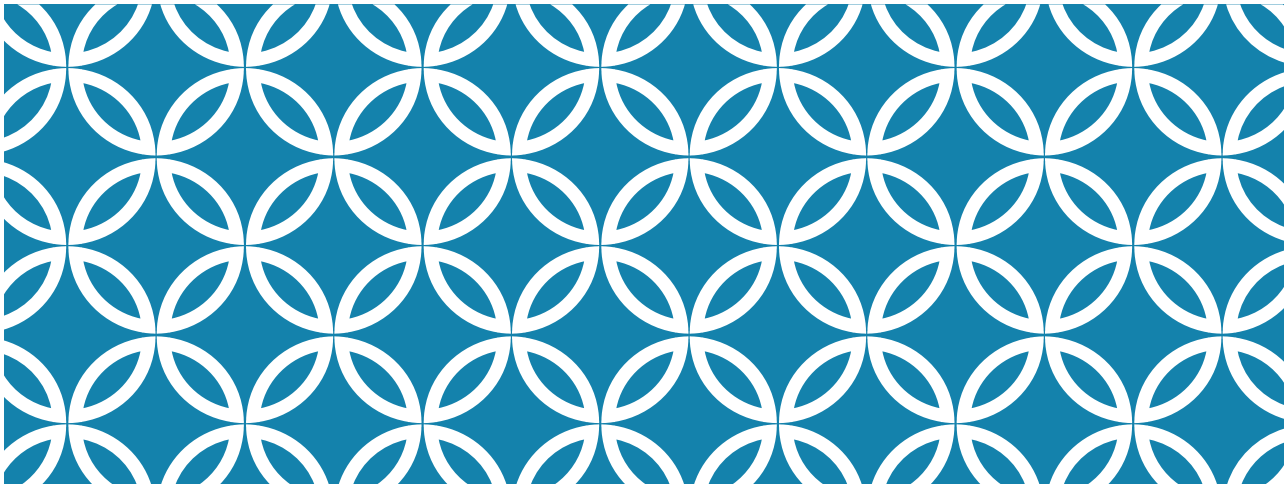


NATIONAL DIALOGUES ON BEHAVIORAL HEALTH PRE-CONFERENCE

Responding to Adult and Child Crises Now: The Question is How?

November 13, 2022
New Orleans, LA

PRESENTERS

- **Linda Henderson-Smith, PhD, LPC, CPCS, CCMP** - Beacon Health Options
- **Lisa St George, MSW, CPRP, CPSS** – RI International
- **Jeff Vanderploeg, PhD** –Child Health and Development Institute (CHDI)
- **Ann Darling, LCSW** – Louisiana Department of Health Office of Behavioral Health
- **Sarah Becker- MSW** – Child Health and Development Institute (CHDI)

- Discussant **Stephen Phillippi, PhD -** LSU Center for Evidence to Practice

OVERVIEW

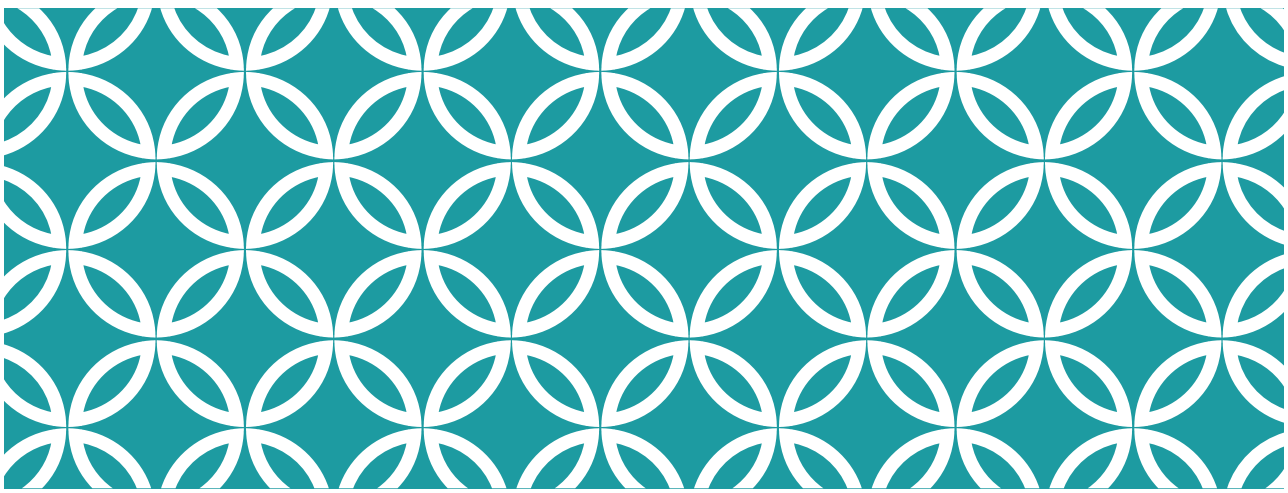
- This session will examine behavioral health workforce issues impacting child and adult crisis systems and workforce issues as well as a range of potential solutions.
- A panel of state and national experts will engage attendees in a discussion of the:
  - Current landscape of crisis systems;
  - Lessons learned from implementation; and,
  - Ways to address known or predicted issues in behavioral health crisis response.
- Discussions will include working with adults and children in crisis; the role of peers and family members; integrating diversity, equity and inclusion in policy and practice; and, other special initiatives.

LEARNING OBJECTIVES

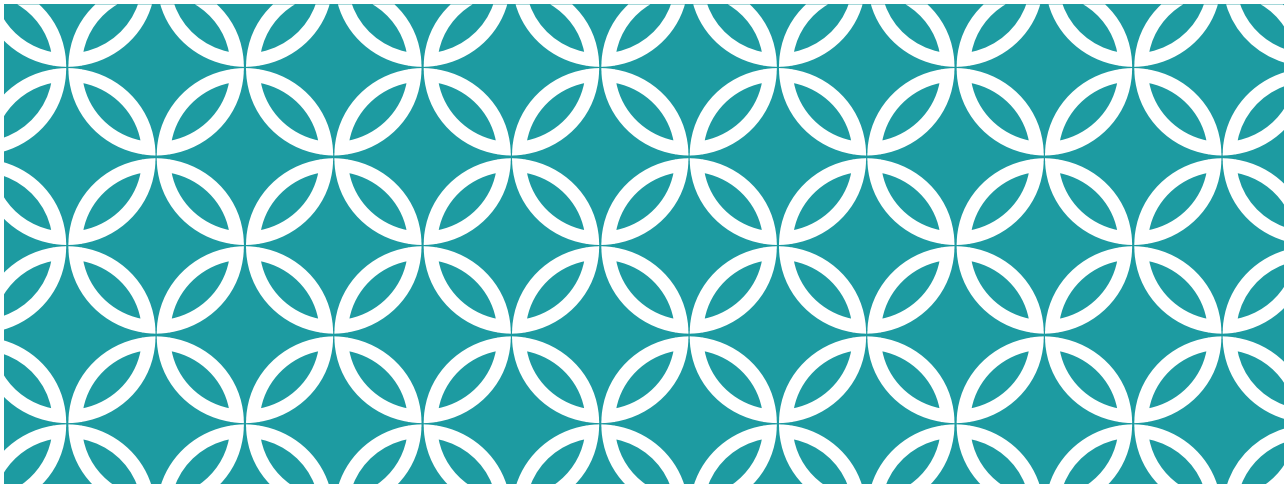
- Participants during this session will:
  - **Examine** current behavioral health workforce issues facing the rollout of crisis and 988 services.
  - **Understand** child and adult crisis response workforce differences.
  - **Discuss** the different roles of peers/people with lived experiences in child vs. adult crisis workforce.
  - **Explore** diversity, equity and inclusion in crisis policy and practice associated to workforce.
  - **Discuss** the hiring, training, competencies, supervision, and support needs of a crisis workforce.
  - **Examine** anticipated issues and potential solutions to burnout, attrition, implementation, stigma, and technology use related to the crisis workforce.

AGENDA

- **Introductions**
- **The Landscape of Crisis & workforce**
  - 11:30AM BREAK
- **Lessons Learned from Implementation**
  - 12:45PM BREAK
- **Ways to Address Known, Predicted, & Expected Issues in Crisis Work (Policy & Practice solutions)**
- **Adjourn**



INTRODUCTIONS



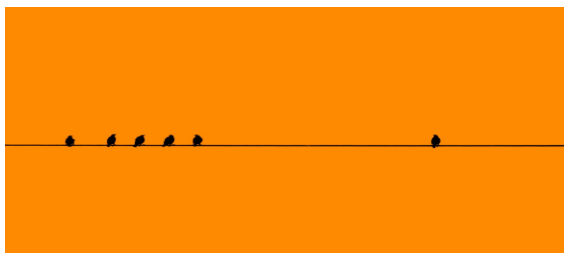
THE LANDSCAPE OF CRISIS & WORKFORCE

CRISIS WORKFORCE: A GENERAL OVERVIEW

CRISIS IN SERVICES

- A **fragile BH workforce** caring for itself AND **individuals seeking care** in new ways from a struggling field of professionals.
- **Providers have one foot in serving those in crisis and the other in managing their own crises** amidst pandemics, national staffing shortages, and service demand that is higher than ever.

- Nearly **1 in 5** Americans (52.9 million) are living **with a mental health condition** (SAMHSA, 2021).
- CDC household survey in 2020 found that 38% of adults experienced anxiety or depressive symptoms-- **a 27% increase over the previous year** (Vahratian et al, 2021).
- **Over half (53.7 – 57%) are not receiving care** they need (SAMHSA, 2021; Michele & Jojek, 2022).



- BH continues **decades-long workforce shortage.**
  - **Noted** in **1999** national data (DHHS, 1999) **and, as of 2021, only 28.1% MH needs met in health professional shortage areas throughout the US** (HRSA, 2021).
  - **4.5 MILLION new BH providers are needed NOW!** (SAMHSA, 2020), and we haven't seen the **full extent of 988 and crisis response systems being implemented.**
- **People continue turning to ED without resolve.**
  - State & County studies: **MH wait 16.6 - 21.5 hrs for admission or referral** (Nesper et al, 2016).

ADULT CRISIS SYSTEM

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LOUISIANA CRISIS RESPONSE SYSTEM (LA-CRS)

- Implemented in conjunction with an Agreement with the Federal Department of Justice related to individuals with serious mental illness in Nursing Homes.
- Agreement has been the impetus for service expansion in Louisiana, with clear expectations related to the development of a crisis system.
- Since 2018, OBH has worked with Medicaid and national experts to develop a system and services that achieve these requirements. This work has included:
  - Analysis of the existing crisis service array/network
  - Exploration of national best practices
  - Attainment of feedback from stakeholders related to an ideal crisis system via a RFI
  - Development of a Crisis Vision and Framework https://ldh.la.gov/assets/docs/MyChoice/CrisisFramework.pdf
  - Collaboration with the Louisiana State University Health Science Center (LSUHSC) Center for Evidence to Practice (E2P) with a focus on provider training and system readiness
  - Implemented the initial crisis framework via soft launch of services in March 2022
  - Additional information about LA-CRS can be found at https://ldh.la.gov/crisis

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VISION FOR LA-CRS

OBH has worked to finalize the service design associated with crisis system of care that is modern, innovative and coordinated. The vision is that the system:

- Results in a crisis continuum that includes and respects a bed based crisis service but does not rely on that level as the foundation of the crisis continuum;
- Values and incorporates “lived experience” in designing a crisis system and in crisis service delivery and is built on principles of recovery and resiliency using person-centered processes;
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports;
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings;
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response.

FOUR MAIN LA-CRS SERVICES

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All services are time-limited, and

Available to individuals:

- **21 years of age and older, AND**
- **With Medicaid and linked to a Managed Care Organization, AND**
- **Who are experiencing emotional distress, AND**
- **Who are not on a legal commitment and able to voluntarily participate in services.**

Mobile Crisis Response (MCR)

Community Brief Crisis Support (CBCS)

Behavioral Health Crisis Care (BHCC) Centers

Crisis Stabilization (CS)

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DESCRIPTION OF LA-CRS SERVICES

- **Mobile Crisis Response (MCR)** – a mobile service that is available as an initial intervention for individuals in a self-identified crisis, in which teams deploy to where the individual is located in the community. The service is available twenty-four (24) hours a day, seven (7) days a week and includes maximum one (1) hour urban and two (2) hour rural face-to-face/onsite response times.
- **Behavioral Health Crisis Care (BHCC) Centers** – a facility based service that operates twenty-four (24) hours a day, seven (7) days a week as a walk-in center providing short-term behavioral health crisis intervention, offering a community based voluntary home-like alternative to more restrictive settings.
- **Community Brief Crisis Support (CBCS)** – a face to face intervention available to individuals subsequent to receipt of MCR, BHCC, or CS. This ongoing crisis intervention response is intended to be rendered for up to fifteen (15) days and are designed to provide relief, resolution and intervention through maintaining the member at home/community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers.
- **Crisis Stabilization (CS)** – a short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization, including nursing home placement.

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LA-CRS IMPLEMENTATION – SOFT LAUNCH

- Working towards 24/7/365 implementation via a soft launch of services with some programs initially operating 40 hours a week.
- Phased in approach to service implementation as aspects of the system are developed.
- Can include temporary modifications in staffing, hours of operations, referral processes, and response times.
- Provides ample opportunity for team training and coaching and supporting the teams through initial implementation.
- Data helps drive the real time process evaluation to know what strengths and challenges are being experienced in the new system so corrective action can be taken.

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LA-CRS STAFFING

- Primary focus on unlicensed and peer staff for front line engagement/ intervention within all crisis services.
- Support by LMHPs as needed for back up and more intensive clinical interventions.
- Staffing considerations related to licensure standards and service provision.
- Opportunities for shared roles within the program and amongst sites within individual provider organizations when feasible.
  - Plans approved by LDH

CHILD AND ADOLESCENT CRISIS SYSTEM

Child Health and Development Institute

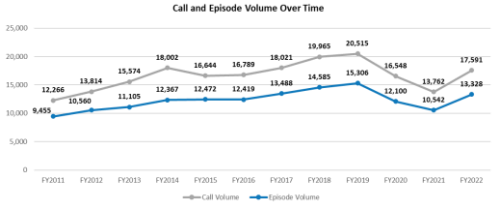
CHILD/ADOLESCENT CRISIS SYSTEMS

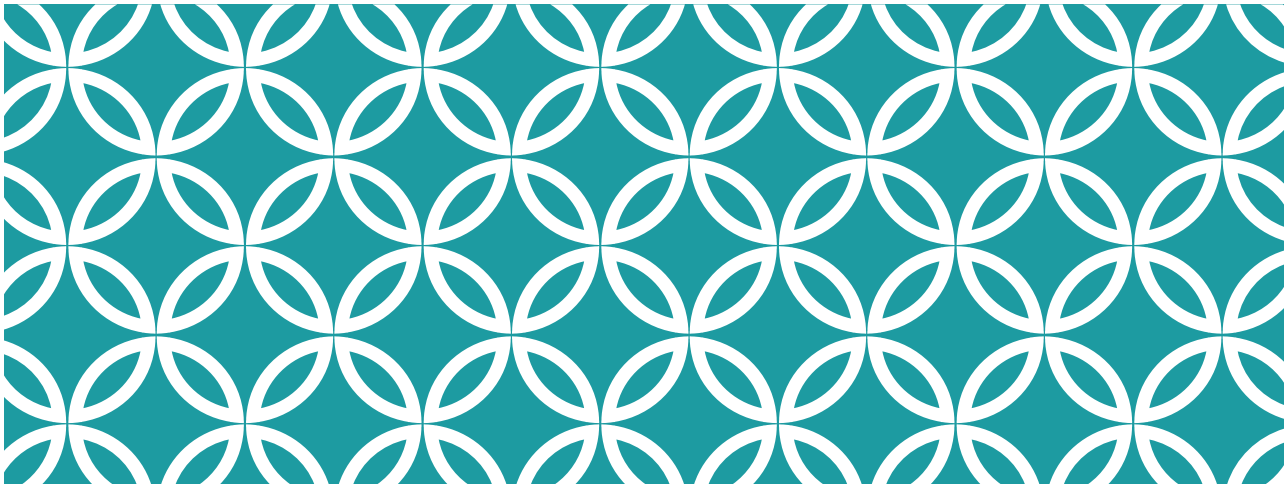
Values and Principles

Most clearly articulated in MRSS, but many apply to other parts of the child/adolescent crisis continuum:

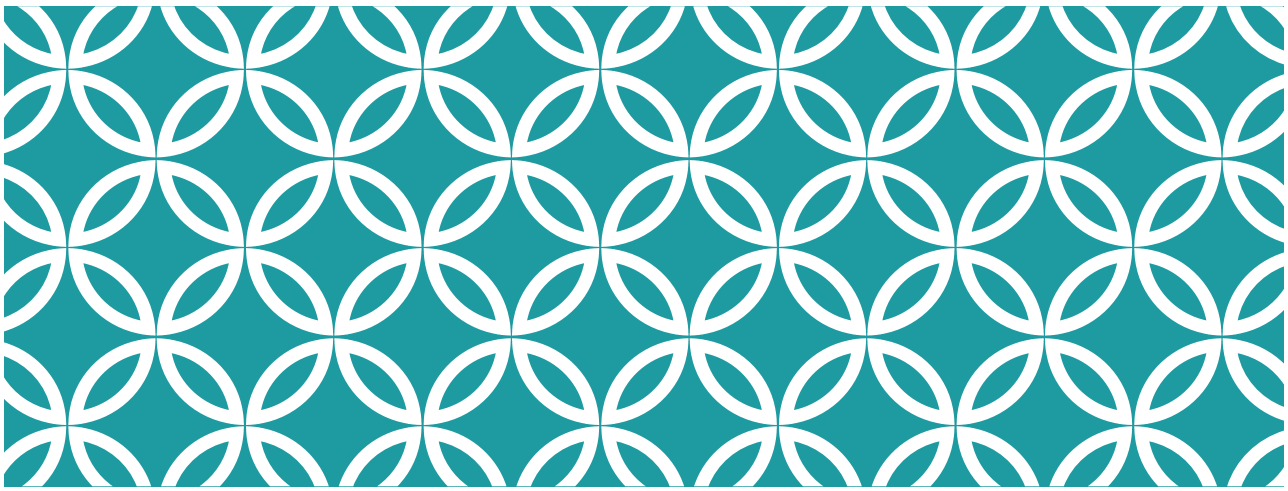
- **Crisis defined by caller -** youth, caregiver, school, police, ED, etc. No "screen outs" based on call center or provider determination of acuity.
- **High utilization** – Divert from EDs, inpatient, out-of-home placement, suspension/expulsion, arrest whenever possible
- **Face-to-face response** – 90% mobility in some states; services in home, school, community. Contrast with 20% mobile expectation in adult MRSS.
- **Rapid response times** – many states 1-2 hours; some as low as 45 minutes.
- **Family-and community-centered –** caregivers/family involved in care; connections to systems of natural supports (not just "treatment")
- **Equitable, culturally humble, linguistically appropriate -** see CLAS standards
- **Developmentally appropriate; trauma-informed**
- **Collaborative** – partner with behavioral health, education, child welfare, juvenile justice EDs/hospitals, law enforcement, others.

Each of these has important implications for workforce development!!!!





DISCUSSION



ROLE OF PEERS AND FAMILY MEMBERS

WORKFORCE CHALLENGES ARE OPENING DOORS FOR PEER SUPPORTERS

- Current climate of workforce shortages everywhere.
- Creates opportunities for peer supporters to play even bigger roles in more positions (hospitals, crisis, outpatient, housing, respite, crisis respite….you name it).
- Peer supporters can assist clinicians through engagement and linkage back to the clinical team.

TRAINING AND DEVELOPMENT OF PEER WORKFORCE

- Who do we mean when we talk about peer supporters?
- State certification necessary when invoicing Medicaid for billable services.
- Need secondary training to prepare them for work in crisis services.
- Various organizations have crisis training for peer supporters.

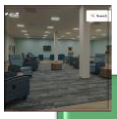
CORE CRISIS SERVICES – PLACES WHERE PEER SUPPORT IS VITAL

Someone to Call

- Crisis Lines

Someone to Come to You

- Mobile Response Teams
- Assessments



Somewhere to Go

- Facility-Based Crisis Receiving Centers
- Ø Jails
- Ø Emergency Department

OTHER SERVICES SUPPORTING CORE CRISIS SERVICES

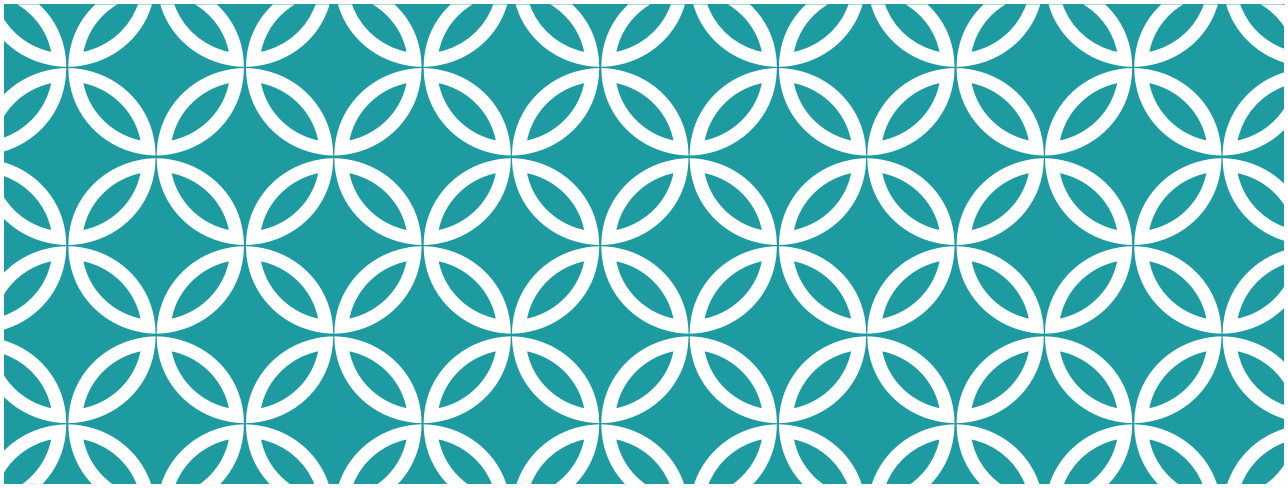
Peers belong everywhere!

SUPERVISION FOR PEER SUPPORTERS

- Peer Supporters must be present in numbers that will impact the persons served.
- Supervision of peer supporters works best with a Peer Lead or Peer Manager overseeing a group.
- Training supervisors both those with lived experience and those without, how to lead peer team is vital.
- Respect for the peer support perspective must be present throughout the organization.

PREPARE THE ORGANIZATION FOR PEER SUPPORT

- It is not often the environment that is difficult; it is teams not understanding their work, their ethics, their skills.
- Get to know what to expect and how to create positive environments for everyone!



INTEGRATING DIVERSITY, EQUITY AND INCLUSION POLICY AND PRACTICE

HOW EQUITABLE IS OUR SYSTEM RIGHT NOW?

Communities characterized by both racial/ethnic diversity and poverty see:

- Lower rates of long-term retention in treatment (Acevedo et al., 2018)
- Stigma and cultural beliefs about psychiatric issues as barriers (DHHS, 2001; Watson & Hunter, 2015; Alang, 2019)
- Historic misdiagnosis of brown and black children and adults - i.e. ADHD, schizophrenia (Gara et al, 2018)
- Individuals with limited English proficiency (LEP) have greater difficulty accessing care and preventative services (Masland, Lou, & Snowden, 2010)
- The closing of more than 120 hospitals in rural areas in the last decade (Center for Health Care Strategy, 2020)
- More than 75% of all U.S. counties are mental health shortage areas (SAMSHA, 2016; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009)

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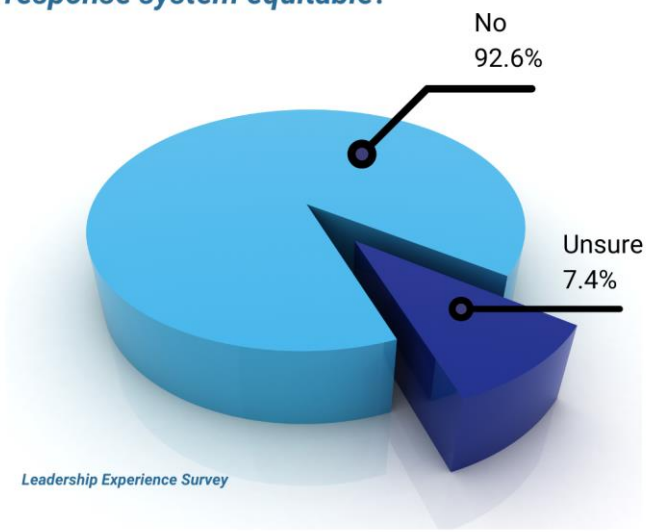
Uplift groups who are historically invisible!

- •People who identify as LGBTQIA+
- Black, Indigenous and people of color (BIPOC)
- Rural communities
- Immigrants, refugees, and non-English speaking people
- People living with disabilities
- Older adults
- People experiencing homelessness or housing instability
- Formerly incarcerated or justice-involved populations
- Survivors of trauma
- Neurodiverse people

Is the current psychiatric emergency response system equitable?



Leadership Experience Survey

100% of respondents advocated for cultural context training

93% advocated for de-escalation and Mental Health First Aid training

89% advocated for training to assess primary language choice of callers.

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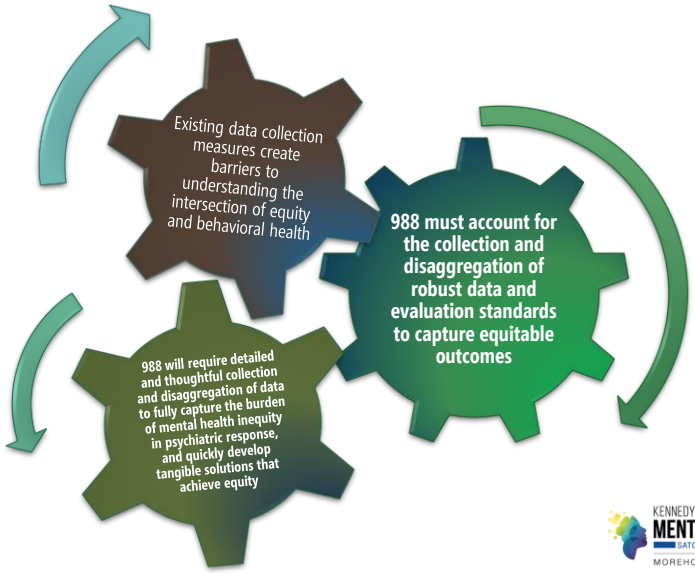
POWERING EQUITABLE DATA IN 988



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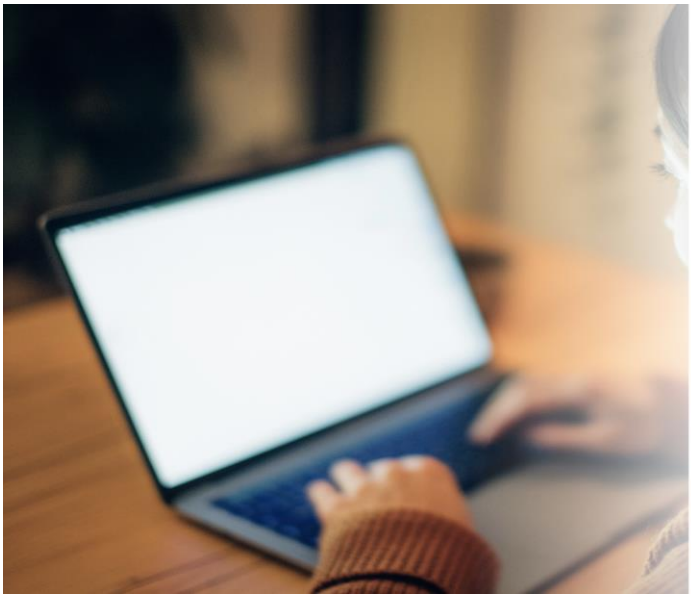

"There are many gaps in the existing service network that despite best efforts in outreach are lacking in terms of inequities in system access, infrastructure, staffing, hours of services, availability of specialty providers for referrals, and many more limitations."

- Survey respondent

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HOW CAN EQUITY BE EMBEDDED INTO 988?

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LAW ENFORCEMENT PARTICIPATION IN PSYCHIATRIC EMERGENCY RESPONSE SHOULD BE AS NEEDED

"There is too much unintentional harm that happens when law enforcement gets involved". Another said, "Involvement of law enforcement often results in explicit or implicit coercion of people to accept treatment, which is both unethical and ineffective (or worse, resulting in escalation)." – Survey Respondent

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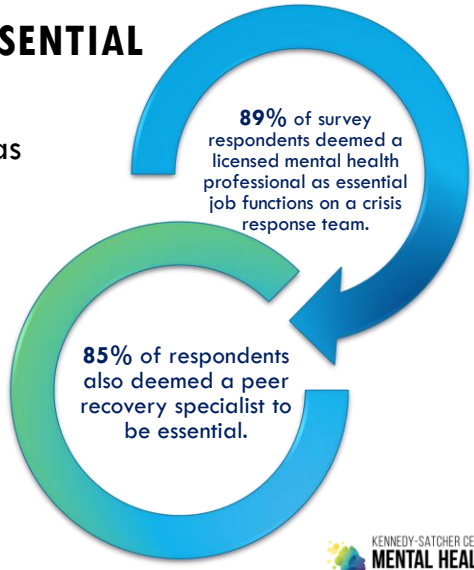
USE OF TRAINED MENTAL HEALTH PROFESSIONALS AND PEER RECOVERY SPECIALISTS IS ESSENTIAL

The literature review and survey note that as available:

- A psychiatric nurse or licensed prescriber for consultation
- Medical translator
- Cultural community leaders

Advancing:

- Telehealth licensing compacts
- Incentives to recruit workers to the rural landscape



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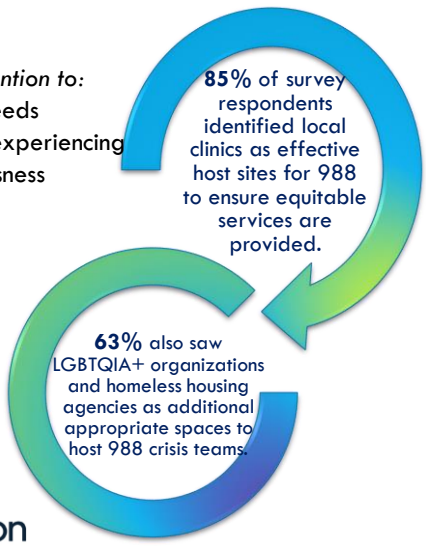
LEVERAGE LOCAL CLINICS AS CRISIS RESPONSE HUBS FOR 988 CALLS

Specific attention to:

- Tribal needs
- People experiencing homelessness



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GIVE THE CALLER A CHOICE TO USE GEOLOCATION SERVICES

- Many respondents agreed that to maintain and promote safety, and ensure more good than harm, allowing callers to have the option to opt in or opt out of geolocation services can guarantee that the best response is truly caller-centered and caller-empowered.

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FUTURE IMPACT

988 is a critical moment to ensure that historic failures are rectified and done so in a culturally attuned and client-empowered manner.

Quarterly, the following will be examined based on publicly available information:

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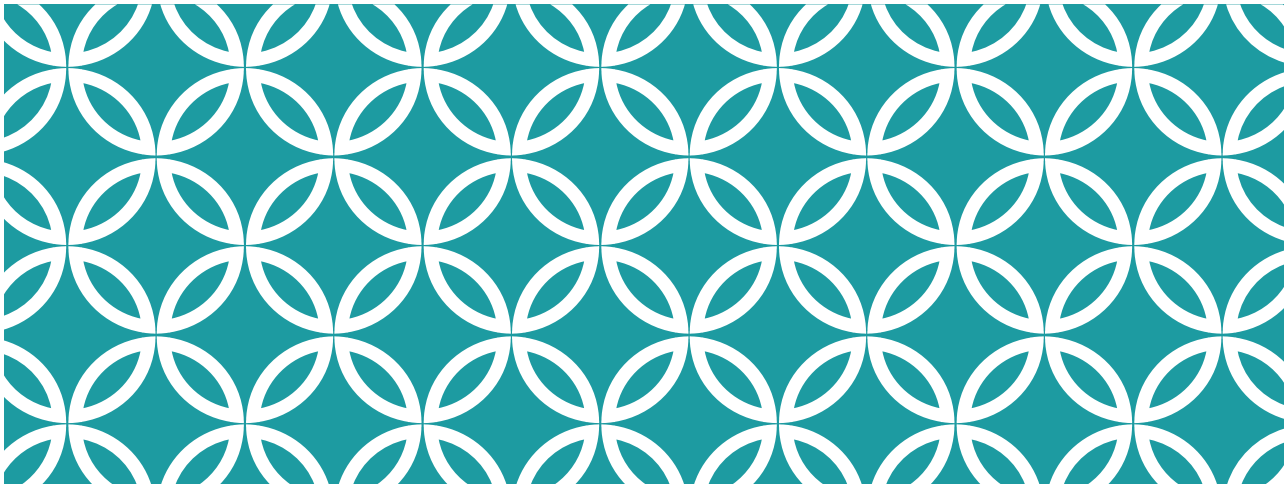

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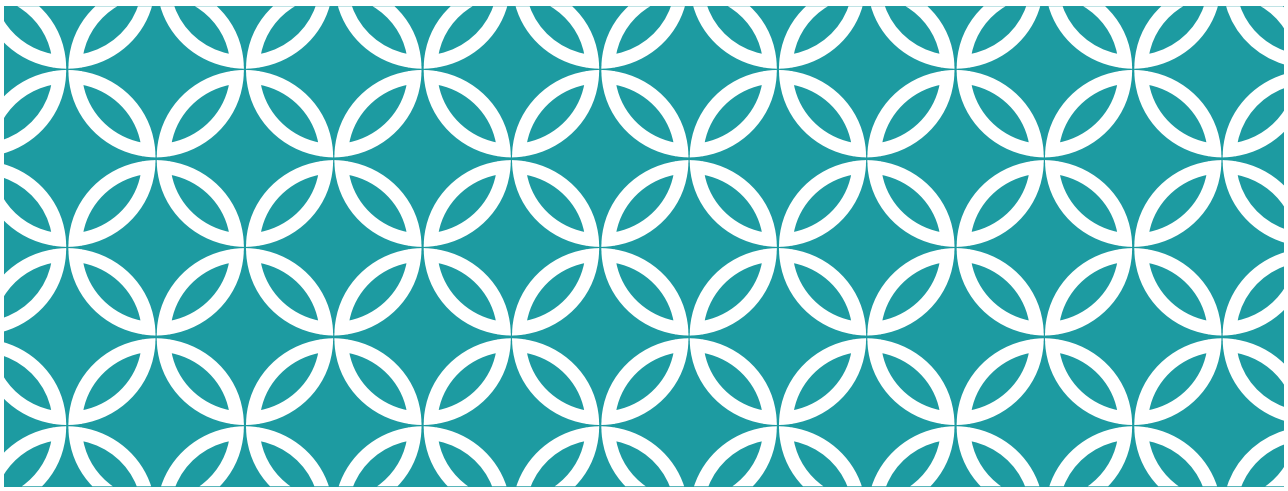


BREAK TIME!

LESSONS LEARNED FROM IMPLEMENTATION

TRAINING/COMPETENCIES NECESSARY FOR THIS WORK / HOW TO HIRE

HIRING: JOB POSTINGS, INTERVIEWS AND ANY MESSAGING: APPEALING & EXCITING

We are NEW; Chance to Build a New Service; Very Rare in Someone's Career

Many Times, We Change the Trajectory of Youth and Families Lives & **Not Overstating it to Say WE SAVE LIVES!**

Both Preventative and Responds to the Highest Risk Youth in Our Communities

Avoids Hospitalization, "Lock-ups," Suspensions

HIRING: CHAMPIONING THE YOUTH MRSS MODEL

- Crises are Better Resolved Face-to-Face in Homes and Local Communities
- Almost All Families Want Us to Come to Them
- On Most Days, at Most Times, In Most Locations We Can Do It
- We Can and Do Divert From Hospitals and JJ Involvement
- Families Define the Crisis
- ALL Families Have Strengths

HIRING: MYTH BUSTING

No one wants to work in crisis programs	No one wants to go to people's homes	No one will work nights and weekends
Community-based work is always unsafe	Families don't want staff in their homes	It can't be done

APPEALING ABOUT THE JOB ITSELF

Ever Changing/ Fast-Paced
Team Environment
Exposed to Everything (Until The Very Next Call)
Excellent Resume Builder
Flexible Interventions and Ways to Help Families
Short-Term
MOST STAFF LOVE IT!

APPLICANTS

If program type (crisis) is relatively new, may not have applicants with much relevant experience.

Applicants only know what they know; staff will need lots of support and training.

High-level competencies; at least some experience with youth and families; general exposure and knowledge base.

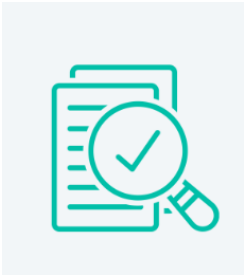
YOUTH MRSS: KNOWLEDGE & SKILL BASE

Youth Development and Intersection with Crisis Situation (6-year-old v. 16-year-old)	Youth Specific Stressors, Mental Health Challenges and Risks	Focus: Youth AND Caregiver AND Other Family Members AND Youth Serving Systems AND Other Professionals (Often Leaders)
Intervention and De-Escalation Potentially of Many People	**Respect** **Empowerment** **Partnering** **w/ Parents & Guardians**	Mental Status, Risk Assessment, Diagnoses, Safety Plan

THE INTERVIEW

Interviewer: Totally embrace the MRSS & assume need to bust myths	Model what applicants can expect: positive feedback; friendly; strength-based; helpful	Give applicants the tools they need to be successful in interview
Mixture of knowledge-based & scenarios	Apples to Apples Comparison	**Focus on program need & overall fit** **Try not to compromise or settle too much ☺**

TRY TO TEASE OUT



- ❑ Judgement and common-sense
- ❑ Flexibility, ability to think on one's feet
- ❑ Attitudes towards those we are trying to help
- ❑ Willingness to ask questions, receive supervision & learn
- ❑ Humility, compassion, integrity
- ❑ Likeliness of being a good teammate
- ❑ Confidence
- ❑ Ability to represent program well in the community
- ❑ Ability to engage with both adults and youth
- ❑ Self-awareness
- ❑ Self-care
- ❑ **Red Flags: "Know it All's" Critical/Condescending (even slightly)**

SCENARIO IDEAS: NOT KNOWLEDGE-BASED PER SE

Spotting youth & family's strengths, needs & risks; safety planning

Next Steps/Goals/ Strategies: Youth & parent/ guardian & family

Two very similar youth with similar risk but different outcomes. Ability to differentiate

Escalated situations: 1) Youth & family 2) Dissatisfied Referrers 3) Co-Workers

CRISIS TRAINING FOR PEER SUPPORTERS AND OTHER PARAPROFESSIONALS

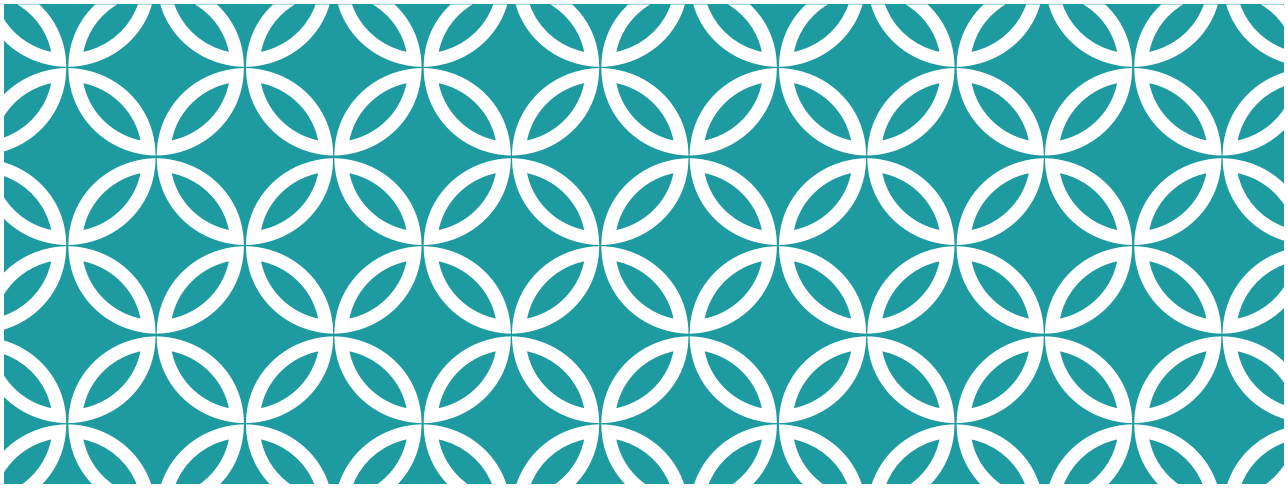
- Fifteen Module Training – Can be bought area by area
- Everything from Warm Lines, to Expectations for Peer Supporters Working in Crisis to Medication Assisted Treatment and Overview of Diagnoses
- But – MUST REMAIN PEER

RECRUITING

- Hire peer support specialists who are trained, that way you know they have a lived experience of mental health challenges or substance use, suicide, trauma, or veteran.
- Begin to seek other team members with lived experiences, use advertising that says, "lived experience preferred…"
- Lived experience is a qualification.
- Lived experience is a gift, stop seeing as stigmatized.

WHAT QUALITIES TO LOOK FOR

- In crisis work we need someone with guts, and a huge heart, compassion, but wisdom to think quickly and find solutions.
- Fearless but gentle.
- I would hire the qualities and train them for the specific position before I would hire someone and think that I could create that wisdom and compassion and strength.
- Someone ethical – know the ethical guidelines they must adhere to.



LESSONS LEARNED: **RAPIDLY HIRING AND RETAINING- CALL CENTERS / 988**

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Crisis Contact Center Equitable Clinical and Operational Considerations

LESSONS LEARNED

An equitable comprehensive system of care requires equity to be embedded in all phases of the crisis system development

- Human Resources
- Staff Support
- Training

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LESSONS LEARNED: **TRANSDIAGNOSTIC WORKFORCE KNOWLEDGE/SPECIAL & UNIQUE WAYS TO ENGAGE PEOPLE ACROSS DISCIPLINES**

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FLEXIBLE CLINICAL SKILL SET

Figure 28. Top Six Client Primary Presenting Problems by Service Area

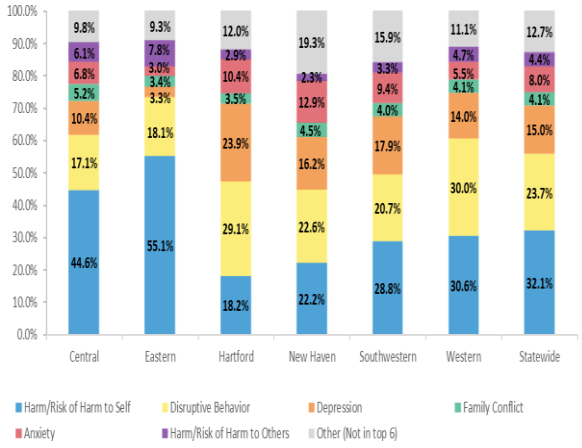
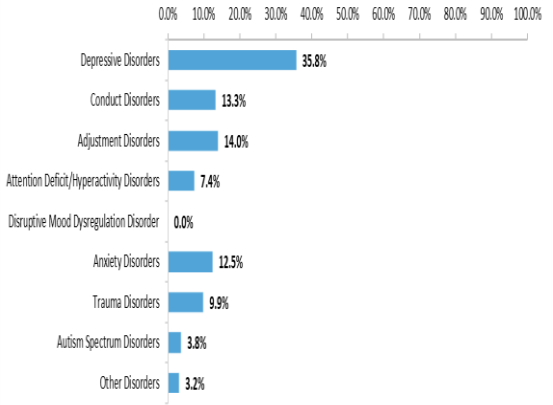


Figure 29. Distribution of Primary Diagnosis Categories* at Intake Statewide



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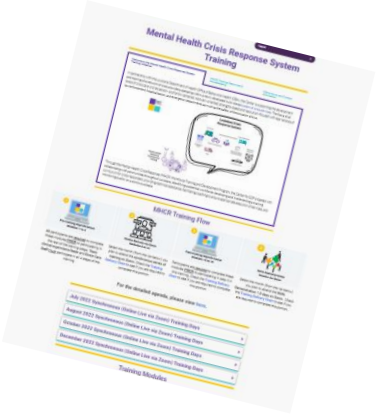
MRSS TRAINING MODULES

- Crisis Assessment, Planning, and Intervention
- 21st Century Culturally Responsive Mental Health Care
- Columbia Suicide Severity Rating Scale (C-SSRS) online training
- Question, Persuade, Refer (QPR) – (managers train staff)
- Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT)
- Addressing Violence Risk in Children and Adolescents
- Traumatic Stress and Trauma-Informed Care
- An Overview of Intellectual and Developmental Disabilities using Positive Behavioral Supports
- Autism Spectrum Disorder
- Problem Sexual Behavior
- School Refusal
- Emergency Certificates
- Disaster Behavioral Health Network (DBHRN)

TRAINING AND NETWORK DEVELOPMENT

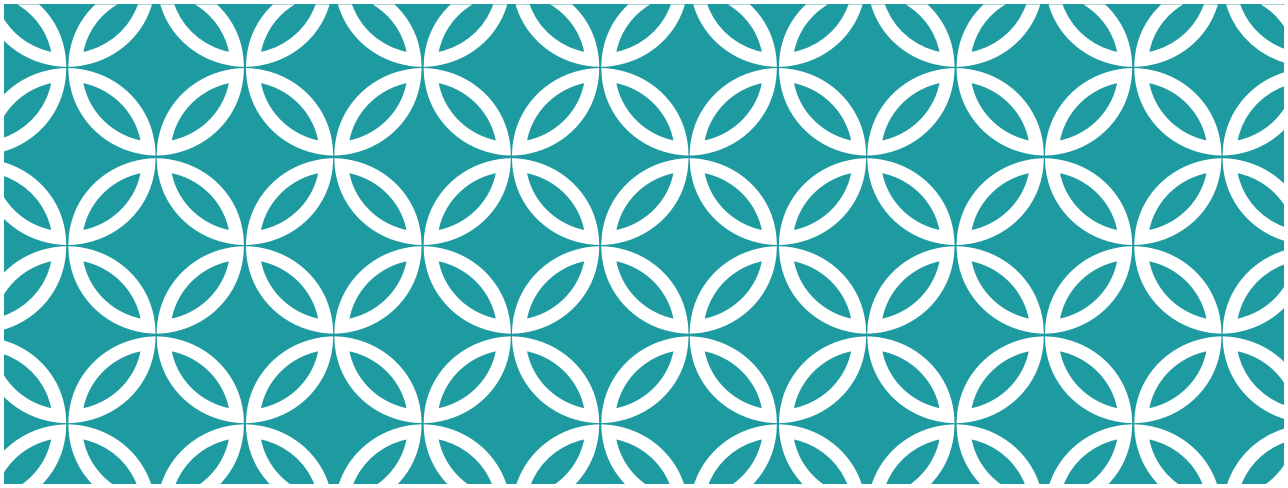
LSU conducts training to MCOs and providers with **over 600 individuals trained to date** in topics such as:

- Modern Crisis Systems
- Crisis Response Teams
- How Brains Respond to Stress
- Person-Centered Response
- Crisis Response Process & Triage
- Adult Mental Health Conditions
- Safety
- Crisis De-escalation & Follow-up
- Self-Care
- Tools for Crisis Recovery

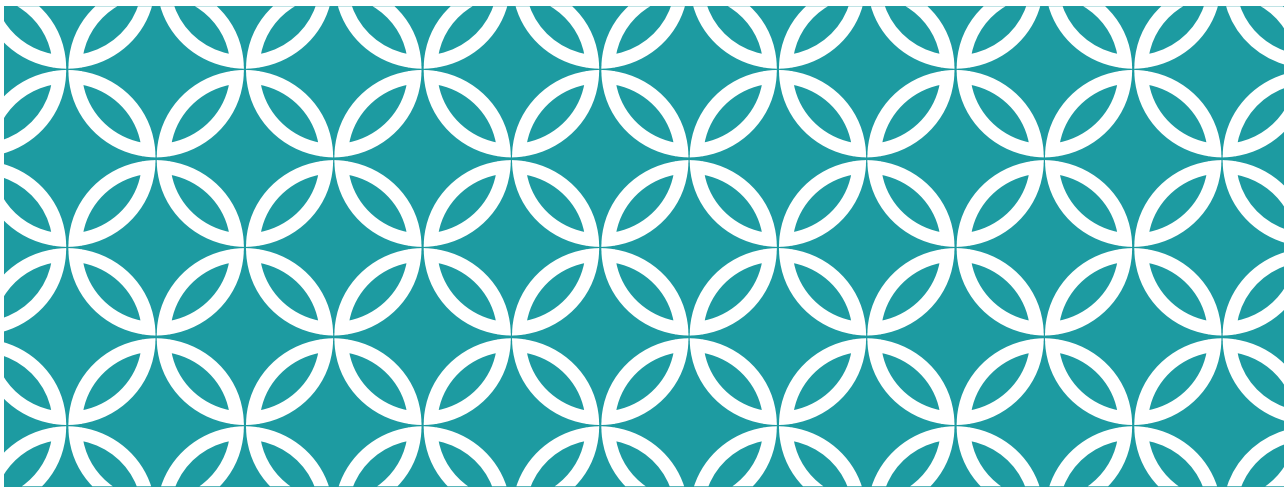


TOOLS PEER SUPPORTERS CAN USE

- Motivational Interviewing type skills
- Cognitive Behavioral Tools
- Peer support work goes far beyond them sharing their story – like other helping professionals, most of their time should be spent listening and asking open-ended questions
- Peers sharing too much story can harm people with trauma, peers must have good sense about what and when to share
- Sharing should ALWAYS be for the good of the person served



DISCUSSION



LESSONS LEARNED: **START UP, SUPERVISION & RETENTION**

LOUISIANA DEPARTMENT OF HEALTH

LA-CRS IMPLEMENTATION: LESSONS LEARNED

OBH is working with Louisiana State University Health Science Center – New Orleans (LSUHSC-NO) School of Public Health, Center for Evidence to Practice on the implementation of:

- Readiness for Provider / Service Implementation
- Initial / Ongoing Training
- Ongoing Coaching within Programs
- Development of Learning Collaboratives across Programs
- Ongoing Meetings with System Partners
- Continuous Quality Monitoring & Improvement

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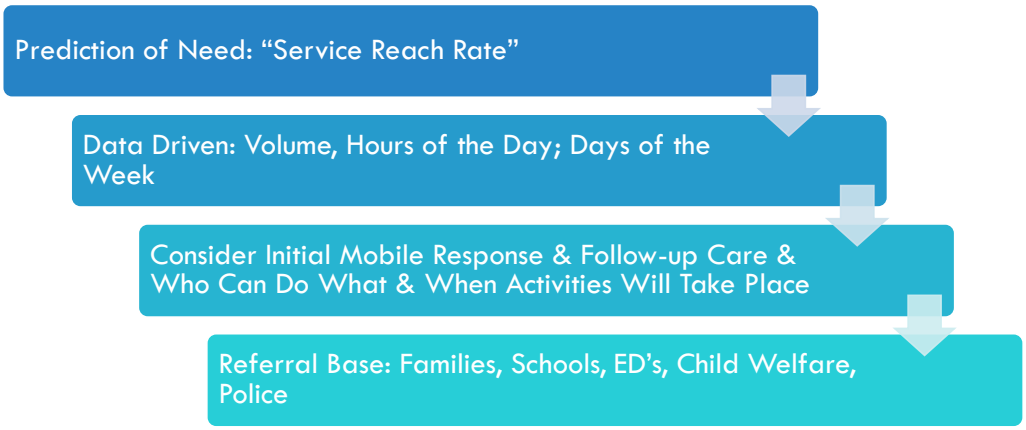
START-UP STAFFING



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MRSS SUPERVISORS/ MIDDLE MANAGEMENT

Champion MRSS and Often All-Star Players
Comfortable in high-risk situations- able to respond in calm manner
24/7 availability
Can see both the forest and the trees
Strong strength-based and collaborative partnerships
Lens towards data-informed quality improvement and oversight
Ability to multitask, juggle, change direction as necessary
Strong (& rapid) assessment and conceptualization skills
Compassion, true ability to support staff
Knowledgeable of community systems, resources, how to access and criteria
Knowledgeable of youth and family rights

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MANAGEMENT RESPONSIBILITIES: MY OH MY!!!

Day to Day: "Air Traffic Controller;" All Youth and Staff Present and Accounted For (AND SAFE!)
Staff Supervision (AND SUPPORT!)
"Kid Load" Throughput; Acuity; Follow-Up; Discharge AND Unrelenting Documentation Sign-Offs
Protocols and Procedures
HR: Hiring, Training, Performance, etc.
24/7 Scheduling
Practice Standards, Benchmarks, Monitoring & Reporting
Liability & Quality Assurance
Fiscal

MRSS STAFF AND SUPERVISION NEEDS

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MRSS: FIRST RESPONDERS OF THE BEHAVIORAL HEALTH WORLD

- Unique Culture That Others Don't Always Understand
- Lack of Recovery Time Between Exposures
- Unrelenting During "Busy Season"
- Long/ Unpredictable Hours; Little Control of Workday
- Increased pace has exponential effect
- Fear/ Diminished Sense of Safety
- Isolation
- Supervision and Structured Support is Often "Bumped"
- Compounded Stigma in Asking for Help
- **Respond to Everything + Exposed to Everything = TRAUMA**

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LISTENING FOR POSSIBLE TRAUMA IN OUR STAFF

ADAPTED FROM REUNION ISSUE 2

- **Feeling Helpless and Hopeless** "They'll never stop calling; It will never end" "I will never get caught up." "There is nothing that will help this family."
- **Inability to Embrace Complexity** "Well… he wasn't suicidal at time of the assessment."
- **Anger/Inability to Empathize** This is RIDICULOUS." "The parents are the problem."
- **Minimizing/ Avoidance** "This is NOT a crisis" "They didn't want a follow-up"
- **Sense of Persecution** "My supervisors are making my job impossible" "They don't get It"
- **Guilt** "I didn't do enough"
- **Fear** "I am going to mess up." "'Those people' are dangerous.
- **Grandiosity:** "No one can help them but me."

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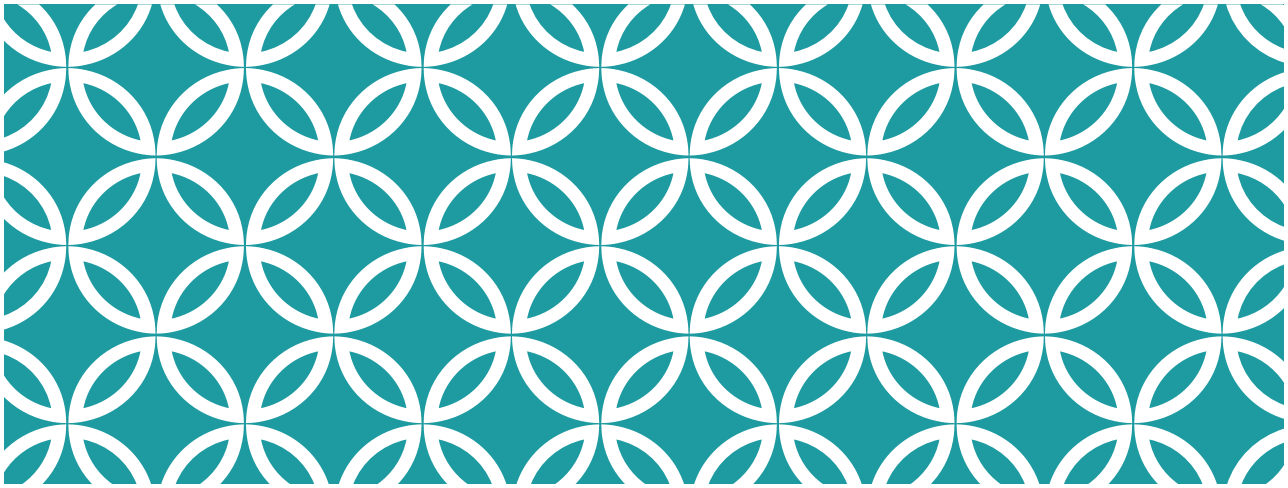
SUPERVISION IN THE CRISIS WORLD

Often Focuses On:

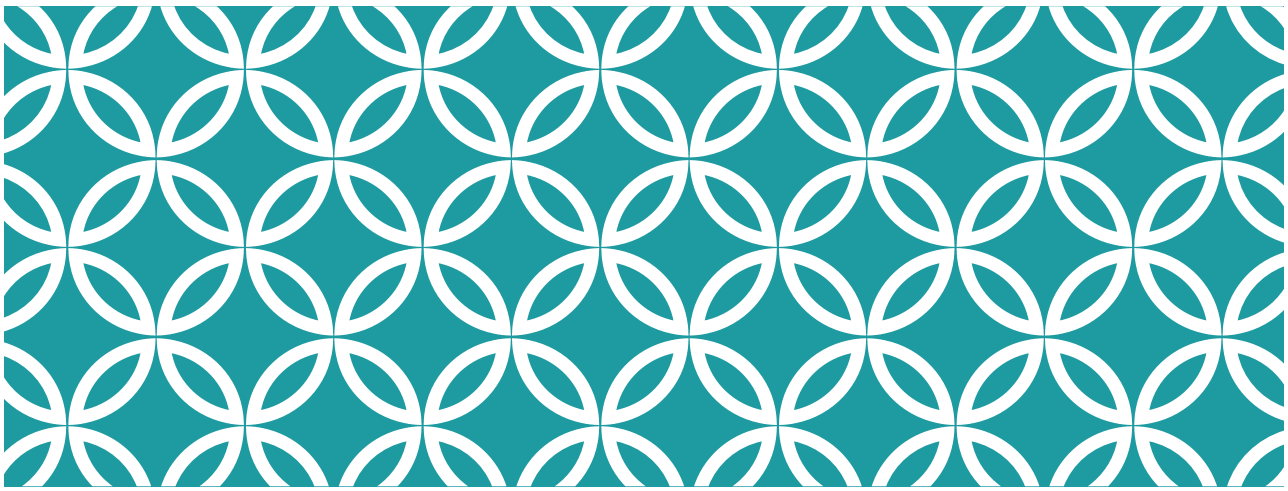
- Updating supervisor
- What hasn't been done (often paperwork, signatures and billing)
- Supervisor giving directives
- Prioritizing work to be done
- Risk/ Liability Management

What Staff Need:

- Support: Tangible; Concrete, Emotional, Informational
- Validation and Compassion
- Trust and Empowerment
- Sanctuary/Respite/ Sense of Safety
- Focus on Balance/ Self-care
- Mentorship, Focus on Growth; Knowledge Building; Strength Exploration
- Peer to Peer Support



LESSONS LEARNED: **WAGE & CAREER PATH FOR PEERS**



LESSONS LEARNED: **LANGUAGE OF WORKFORCE—EMERGENCY VS CRISIS / MCO PARITY**

LANGUAGE SUPPORTS ACTIONS

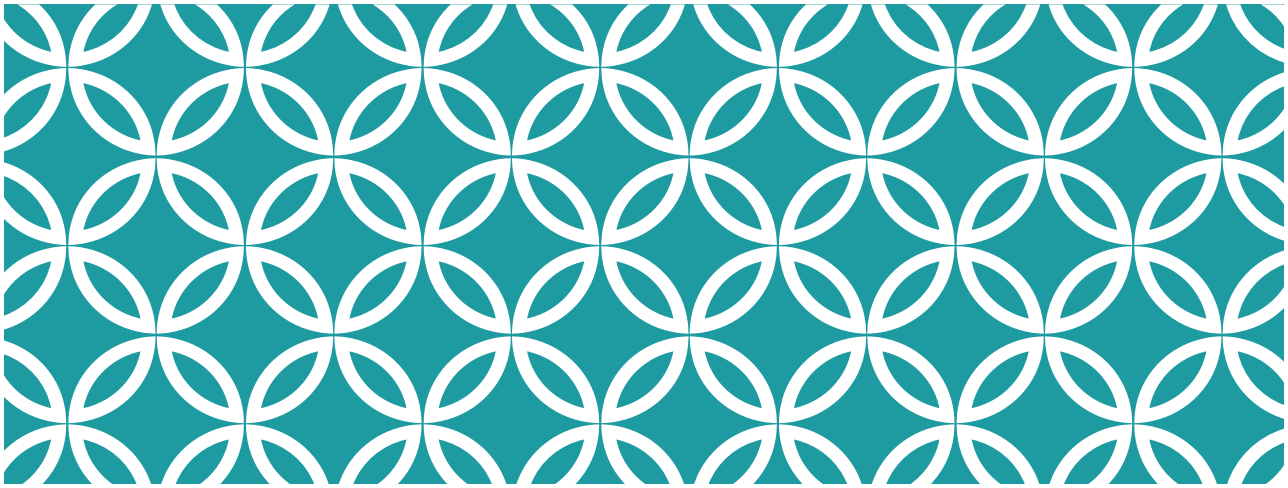
PARITY

All crisis work is not the same:

No
- **Crisis Residential – Hospital clearance, can refuse high acuity**

No
- **Crisis Respite – Hospital clearance, can refuse high acuity**

Yes
- **Emergency/Crisis Receiving Centers**
- **No wrong door, no hospital clearance, no jail, on-site hospital clearance, high acuity, and substance use**



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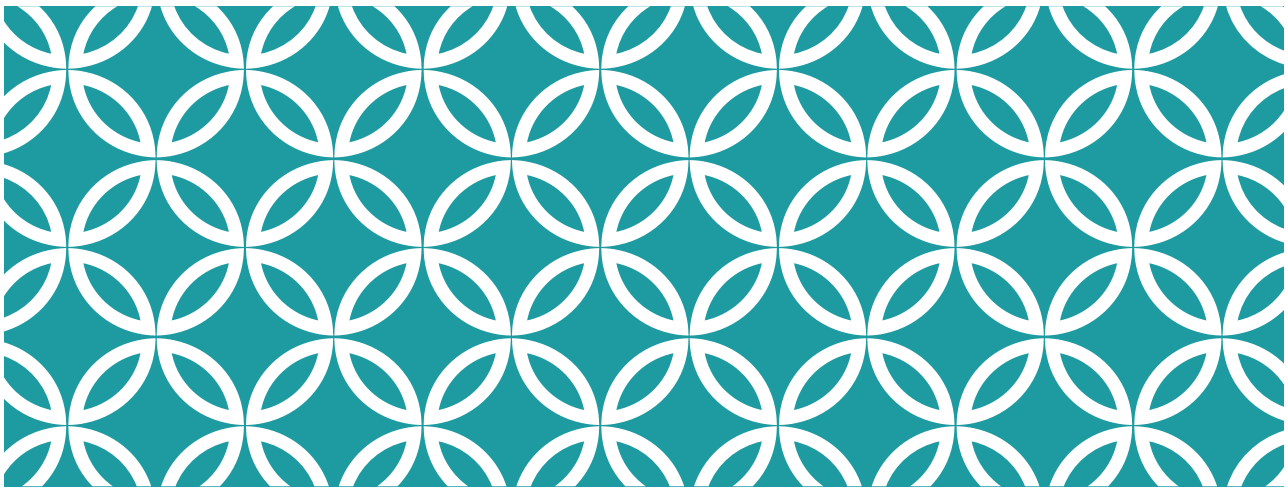
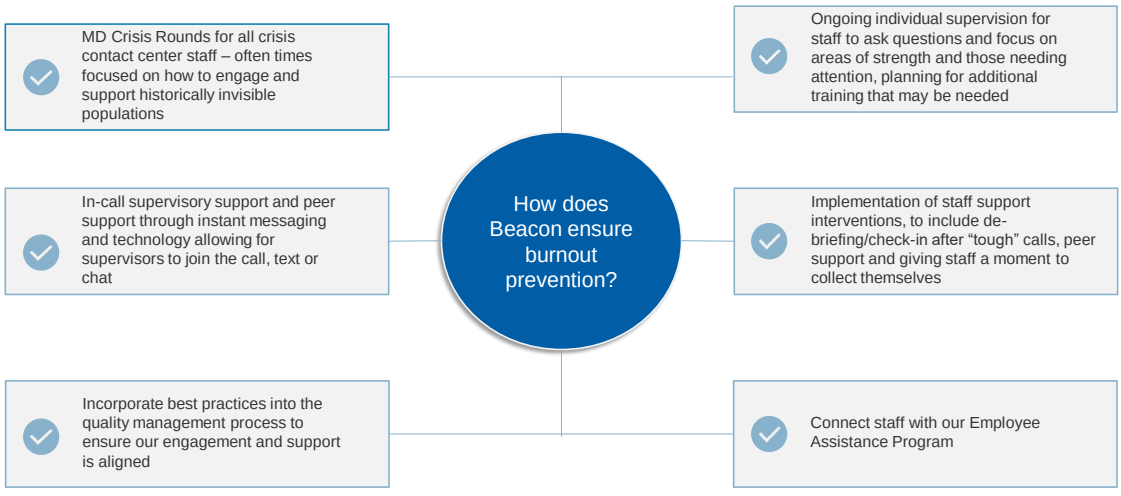


BREAK TIME!

WAYS TO ADDRESS KNOWN, PREDICTED, EXPECTED ISSUES IN CRISIS WORK (POLICY & PRACTICE SOLUTIONS)

BEACON'S RESPONSE TO BURNOUT PREVENTION



beacon health options

TRAINING AND NETWORK DEVELOPMENT

- OBH is working with Louisiana State University Health Science Center – New Orleans (LSUHSC-NO) School of Public Health, Center for Evidence to Practice to:
  - **Collaborate with communities** throughout Louisiana, developing a **readiness process for implementation** of these crisis services
  - Develop a **training curriculum for crisis providers**
  - Identify workforce and **implement training** curriculum and **ongoing coaching** to ensure appropriate execution of services
  - Continuous **quality monitoring & improvement**

WORKFORCE DEVELOPMENT-TRAINING

- Training is **NOT** management.
- It is an excellent tool for managers.
- Requires additional supervision.
- Requires CQI.
- Considerations–
  - orientation vs. on-the-job practice and correction
  - training over time
  - async and sync approaches

SUPPORTING IMPLEMENTATION & SUSTAINABILITY

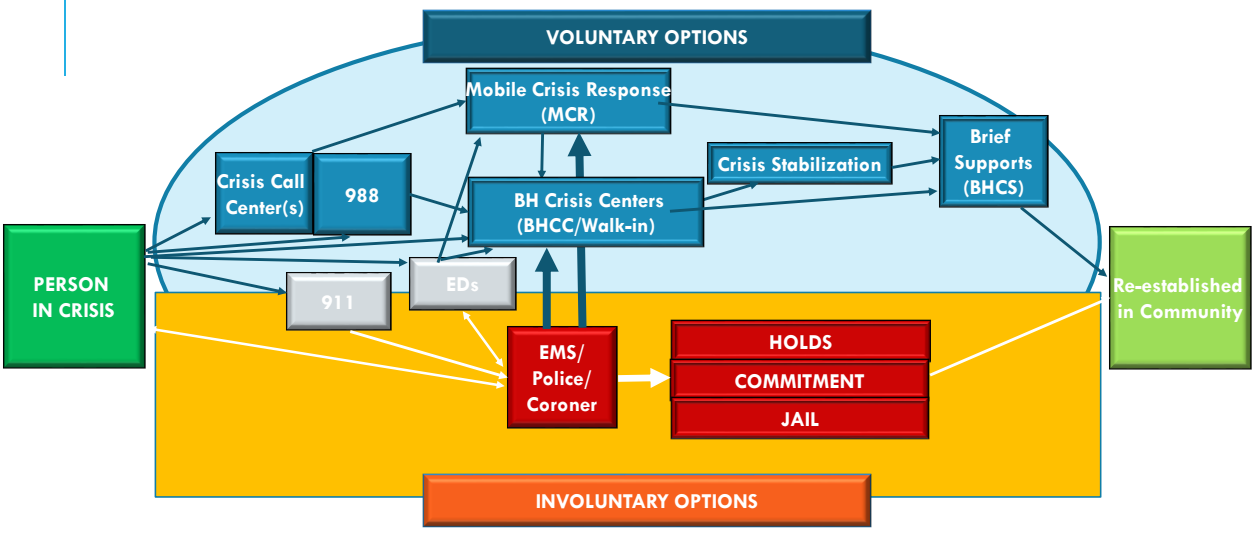
Adoption & Implementation

- Readiness (Community & Providers)
- Consultation /TA
- Develop/ Clarify Referral & Engagement Practices
- Modify Agency Practices
- Monitor Fidelity & Adaptation
- Educate/Train Staff & Partners (certification if applicable)

Service Delivery & Sustainability

- Supervision, Case Consultation / Coaching
- Supported Community Implementation
- Managing Data
- Staff Turnover
- Non-Routine Services/ Situations
- Monitoring Outcomes & Drift

THE VISION- A FULLER ARRAY OF CRISIS CARE



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OTHER WORKFORCE CONSIDERATIONS

Start-Up Staffing Model

- CT MRSS network comprised of 6 primary contractors operating 14 sites, collectively offering statewide coverage

- **Staff**
  - Psychiatrist/APRN (.20-.50 FTE). Psychiatric oversight, psychiatric evaluation, medication management, related clinical functions.
  - Manager (.60-1.0 FTE). Address administrative and clinical needs, manage budget, translate data reports to action, clinical supervision.
  - Clinician (multiple FTEs). Mobile response, initial stabilization, screening and assessment, crisis safety planning, treatment, referral to ongoing care.
  - Care Manager/Peer Support Specialist (potentially multiple FTEs, but not currently Medicaid reimbursable in CT). Partner with licensed Clinician, youth/family engagement, assist with assessment, provide ongoing follow-up, coordinate referral and linkages to care.
- Programs are required to staff at levels to meet benchmarks/standards including peak hours, days, months
- In CT, Urgent Crisis Centers (23-hour) and Sub-Acute Stabilization Centers (1-14 days) are currently in procurement phase

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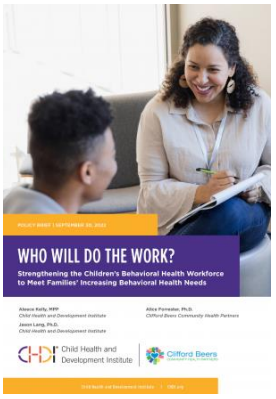
OTHER WORKFORCE CONSIDERATIONS

Addressing Contemporary Behavioral Health Workforce Challenges

- Increase rates and funding to match true cost of delivering care + inflation
  - *Over a 9-year period, the 45-min outpatient session rate increased 6.0%. It would have had to increase by 28.5% just to keep pace with inflation over the same time period.*
- Increase staff compensation levels
- Provide recruitment and retention incentives (sign-on and longevity bonuses, loan repayment programs)
- Establish high school and undergraduate pipeline programs
- Grow entry level pathways and utilize task shifting
- Reduce licensing barriers and costs
- Post in sites to attract diverse candidates, demonstrate a commitment to DEI, implement CLAS standards
- Increase staff well-being and support programs (peer learning, networking, sabbatical)
- Reduce paperwork and administrative burden
- Offer professional development opportunities



STIGMA

- Stigma exists.
- When hiring peer support workers I often see people with substance use history hired more favorably over peer support workers with Mental Health issues.
- Stop date with substance use – date recovery started.
- Behavioral health is cyclical – but people can manage their challenges with the right tools, like Wellness Recovery Action Plans (WRAP).

AFTER 23 YEARS OF WATCHING PEOPLE RECOVER

- It is real, and no illness is one that is unrecoverable.
- Set the bar high.
- Don't give up on people.
- Once they are employed they are an employee….not a person with an illness who happens to be working….
- Accommodation for medical appointment.

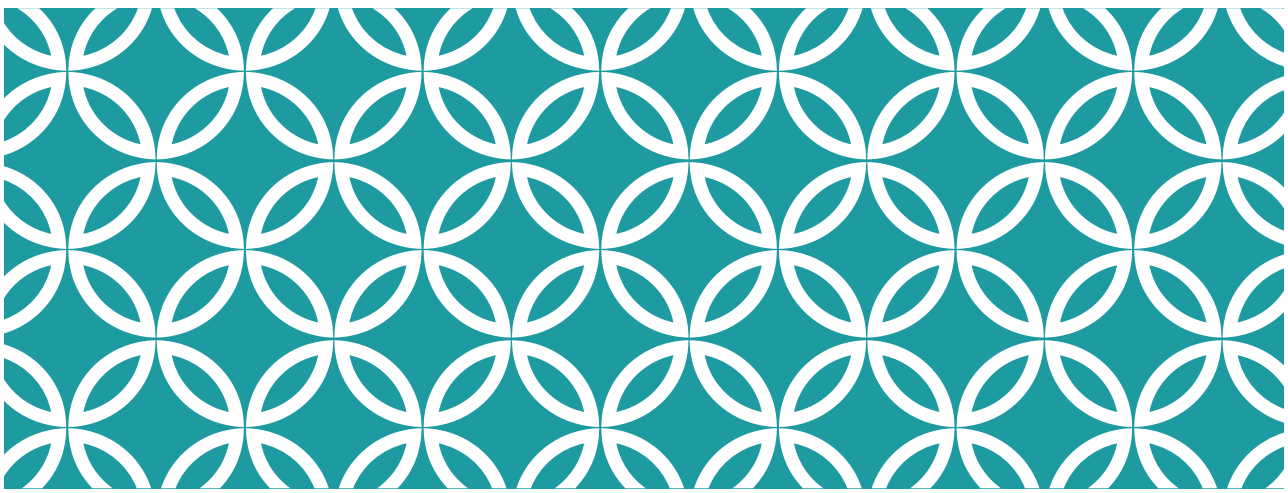
DISCUSSION

TELEHEALTH

- Our doctors are licensed across states: they can cover multiple states or fill in for each other, they use telehealth.
- Our nurse practitioners cover multiple sites in state using telehealth.
- Peer Supporters can provide classes (groups) on line (WRAP, WELL, etc.), our classes went from in person to on-line overnight.
- Facilities need on site RNs that is our biggest challenge.

CHILD VS ADULT SYSTEM WORKFORCE

- (**Linda** / **Sarah-** type of workers, ages serving, competence/confidence/desire to work with kids/families, less experienced, skill differences)



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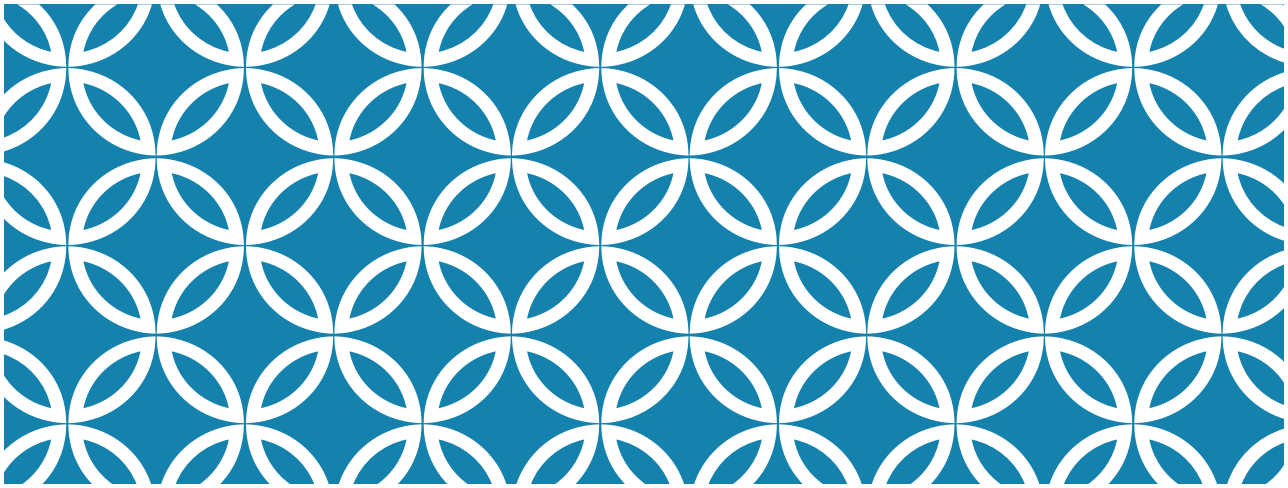

THANK YOU!