

HB-1032 Behavioral Health Crisis Study Stakeholder Meeting

Grand Junction, CO - 10/13/11

Meeting Summary:

The third HB-1032 stakeholder meeting took place on October 13, 2011 in Grand Junction with 15 people in attendance. Approximately one-third of the participants were consumers and two-thirds were behavioral health providers who represented Mesa, Delta, San Miguel, Ouray, Garfield counties and the surrounding region.

The goal of the meeting was to gather input on existing crisis services as well as priority areas for both an ideal and a feasible crisis response system. This report includes a meeting summary followed by a compilation of the worksheets and small group activity from this meeting:

- *Existing Services* – As with each meeting to date, identifying and gaining agreement on what services currently exist for crisis response posed challenges. In Grand Junction the main reason for this appeared to be service availability varies depending on geographic location. The Grand Junction area seems to have more services that can be accessed more quickly. While Colorado West covers a large portion of the northwestern slope, outside of the urban areas, distance does become a factor in access

There was general agreement that while a broad range of crisis services “exist”, their accessibility varies greatly by location and the service is not always adequate. For those residing near Grand Junction, there is a broader spectrum of adequate, accessible services. For those living in the many rural areas of the Western Slope, the options are more limited and may not be the most effective “response”. For example, in the Grand Junction catchment area, there are mobile crisis teams that include a trained mental health professional while in San Miguel County there is not any type of mobile crisis team. When polled, no one felt the current services fully meet the region’s crisis need. Most reported that the services mostly or sometimes meet the region’s needs.

Transportation was the most commonly reported gap in the existing services. This includes a consumer’s ability to get to a secure assessment site, options for transporting a client to detox or on an M-1, and transportation back home when the crisis has been resolved. Another identified gap is that crisis services are not accessible for all. Specifically, services for the dually diagnosed, developmentally disabled and sex offenders are non-existent or minimal. 23-hour observation was also listed as a gap as well as the need for 24-hour access to psychiatric services.

- *Ideal System* – Meeting participants requested we note their frustration with what they see as a lack of funding and commitment from the state to support crisis response. People expressed that passing legislation without any associated funds as well as the current funding situation does not send a message that crisis response is a genuine priority at the state level.

For this group, an ideal crisis response system would be fully funded, locally driven and aligned across agencies for seamless delivery of care. An ideal system would be comprehensive from the point of early intervention through crisis stabilization, respite and re-entry into the community. Warm lines, mobile units with a trained mental health

professional, adequate bed space and free transportation were also listed as part of an ideal system.

- *Feasible System* – Moving from the ideal to what is feasible given current funding, a number of priorities were identified:
 - Step up and Step down options
 - Improving psychiatric access (med samples available, some access to psychiatrist during the crisis, video access)
 - Creating a warm line
 - Increase community awareness and education on crisis and services
 - Work more closely with the state and also local collaborations to be innovative
 - Address transportation needs (ex. Colorado West has developed a partnership with law enforcement in one community so they have full time access to a secure vehicle where a mental health staff can transport a consumer without shackles and handcuffs)
 - Work with community to gain agreement to provide bed space for sex offenders in crisis
 - Develop consistent definitions of crisis response systems and services statewide

In summary, those in attendance expressed satisfaction with a number of the services they are able to provide or access. They clearly articulated the need for increased funding. This would enable them to expand their current services to be more accessible to all populations in crisis as well as to fill critical gaps such as transportation and/or effective mobile crisis teams. While general consensus was that local services are better, participants said they would be interested in some statewide components, such as a statewide hotline, if those components connect consumers directly to their local resource. Innovative local efforts and partnerships are clearly taking place and having an impact. Finally, given the diverse geographic nature of this state, it is likely we will continue to run into the problem of how to get existing services out to rural and frontier consumers in a timely and effective manner. These efforts, inputs and concerns should be considered and noted when reporting back to the legislature.

Agenda:

- I. Welcome (10 min)
 - Overview of HB-1032
 - Purpose and process of statewide stakeholder meetings
- II. Current service structures (45 min)
 - Observations of current services and gaps
 - Discussion on current services
 - Research on best practices and crisis models
- III. Visioning the future of crisis response (45 min)
 - Developing consensus in small groups on priorities for a future crisis response system
 - Share out top priority with the larger group
- III. Wrap up (15 min)
 - Next steps in HB-1032 process
 - Thank you for being here

Participant Activities and Input (Please note that information below was taken directly from participant worksheets. It has not been verified for accuracy):

1) What services currently exist in your community?

Service	Available to Medicaid and CHP+	Available to privately insured	Available to uninsured
Daytime comprehensive crisis outpatient services (counseling, medication stabilization, community crisis intervention, continuity of care, case management)	Yes *Counseling only in Garfield and surrounding region – rest are 90 or more miles away *Med stabilization can take a few days and is only for CO West clients		
24-hour comprehensive crisis outpatient services (counseling, medication stabilization, community crisis intervention, continuity of care, case management)	Yes *Counseling only in Garfield and surrounding region *Med stabilization can take a few days and is only for CO West clients		
24-hour crisis hotline	Yes – in most communities		
Crisis inpatient services	Depends – in some but not all communities *60-200 miles away in some cases and limited space		
Crisis intervention teams	Yes- except San Miguel/Ouray		
Mobile crisis teams	Depends – some communities have CIT, some have CO West staff and law enforcement on team, some have nothing		
Extended observation ("23 hour" services)	Depends – Yes in Mesa and Summit Counties, no in surrounding counties, CO West has a "bridge" room that can be used as well as ER, Garfield county only has it for detox		
24-hour psychiatric emergency services	Yes- if hospitalized. CO West is starting this non-hospitalized and it will be available to all. In Garfield County and surrounding region it is 60-200 miles away		
Detox Services (Social Model)	Depends – in some but not all communities		
Other:	Available services vary widely by community – it is different for more rural/frontier areas		

2) How well is the current crisis response system working in your community?

- Our services FULLY meet our crisis needs
- _7_ Our services MOSTLY meet the crisis needs
- _5_ Our services SOMETIMES meet our crisis needs
- _1_ Our services are inadequate and RARELY meet our crisis needs
- I am not sure/do not know

3) In your opinion what are the main gaps in services?

- 24 hr psychiatric services
- Minimal if any crisis response available for those who are dually diagnosed MI/DD
- No services that I am aware of for those dually diagnosed MI/sex offender or DD/sex offender
- Minimal services for children who are dually diagnosed (DD/MI) and do not meet the level of care for inpatient treatment but need behavioral stabilization or medication evaluation and stabilization
- Enforcing state requirements for behavioral health service to all populations including those with dual diagnosis
- Refer to Texas model. We do not have but need crisis residential services for adults and children, crisis respite for adults and children
- Lack of transportation makes access extremely difficult. No effective transportation
- Crisis workers may have 100+ miles between calls
- Need 23 hr observation capability
- Better way to transport people in crisis
- Detox
- Lack of funding
- Transportation when hospital detox is needed
- Colorado West is currently centralizing crisis response
- Colorado West has, within past month, developed medical, psychiatric crisis capacity
- 23 hour observation
- Immediate response
- Community ownership
- Emergency hold area other than jail
- Funding
- Those clients that are DD or are on the fence with more behavioral problems than strict mental health or SA. We do not have good resources for the behavioral issues
- Psychiatric care in crisis is difficult unless the person gets hospitalized
- Crisis/acute treatment units for children and adolescents
- Lack of mobile response to site where crisis is occurring. I believe this is due to limited resources
- Crisis for adolescents – gaps with bed space
- It is my experience that they have given good crises response but the procedures are sometimes a traumatic experience (ex – police handcuff and transport people in crises to the intervention)
- We need a warm line. As a peer I see the need for people who are not suicidal but very much in crises. This will aide in keeping people from escalating to M-1 and hospital stays
- Distances

- Staffing shortages after hours (1 on-call worker to cover 6 county region. That worker may be over 100 miles from the client in need)
- No detox

4) Does payer source impact access to crisis services in any way? If so, how?

- No (x 8 responses)
- Only for psychiatric hospitalizations
- It can slightly impact for those that are volunteering to seek services with insurance versus someone that is volunteering for services but does not have a pay source (only applies to psych hospital)
- Western slope have approximately 32-bed hospital. If that facility is full there are limited services for individuals who need 23 hour observations
- Payer source does not matter when initial services are requested
- In our community there is access to all services offered. The uninsured are often saddled with un-payable bills but the services are not withheld to my understanding

Visioning the future for Crisis Response – Responses from small group activity

IDEAL	FEASIBLE (priority level)	WHAT WOULD IT TAKE?
<p>+ Local + Warm Line + Funding + More beds – especially for children and adolescents and sex offenders + More CSU beds with better services + Crisis respite services + Funding for crisis psychiatry + Transportation by non-law enforcement or team to come to homes + More training to law enforcement to decrease penetration into legal area</p> <p>+ Crisis line to include some warm line + MCRT + Walk in + 23 hr observation + Step up/step down + Inpatient care + Respite + Transportation would be available for local and long-term + Adequate services for behavioral issues, staffing placement (all services to be able to serve clients with bx issues)</p> <p>+ Every county in CO would have a mobile crisis response team with a short response time and would include law enforcement + Aligned with MHC system + Crisis stabilization beds with access to psychiatry and full continuum of outpatient</p>	<p>➔ Local (already happening) ➔ Some psychiatric crisis service (1) ➔ Warm line (2) ➔ Provide beds to sex offenders w/community agreement (3)</p> <p>➔ Step up/step down (high) ➔ Transportation (high) ➔ Adequate services for behavioral issues (med)</p> <p>➔ Operated out of MHC system (1) ➔ Implement video (2) ➔ More community education on what crisis is and what it is designed to handle (3) ➔ Continuation of all current services (4) ➔ CO West is working with DOLA for step</p>	<p><i>Working to increase funding Agreement- model/volunteers/ training Community agreement</i></p> <p><i>All would take money</i></p> <p><i>Already collaborating with DOLA Working to create 24 hr access to psychiatry Centralizing crisis Working on transportation in Craig – model could be replicated (no</i></p>

