

LOUISIANA CRISIS RESPONSE SYSTEM - IMPLEMENTATION PLAN UPDATE



December 16, 2021

AGENDA

- Louisiana Crisis Response System
 - Services/Timeline
 - Soft Launch
- Implementation Updates
 - LSU Workforce Development Update
- Implementation Topic: Resolution Focused Crisis Response
- Next Steps

FOUR MAIN CRISIS SERVICES

All services are time-limited and offered to individuals experiencing psychiatric crisis until the crisis is resolved and/or the person returns to existing services or is linked to other behavioral health supports as needed.

*pending budget approval

This schedule reflects a soft launch of services as aspects of the system are still being built

Mobile Crisis Response (MCR)

March 2022

Behavioral Health Crisis Care (BHCC) Centers

April 2022

Community Brief Crisis Support (CBCS)

March 2022

Crisis Stabilization (CS)

July 2022*

OBH CRISIS RESPONSE SYSTEM – SOFT LAUNCH

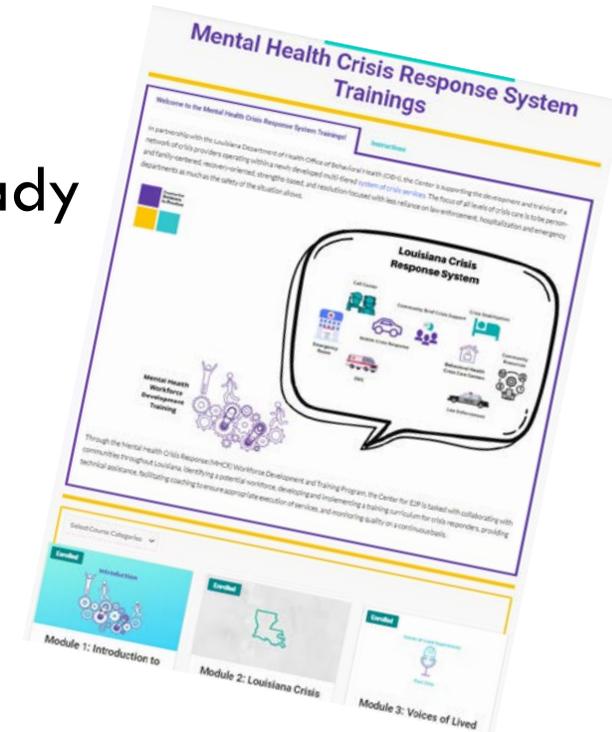
- Phased in approach to service implementation as aspects of the system are developed
- This can include temporary modifications in staffing, hours of operations, referral processes, and response times while:
 - Local coalitions are developed and implemented; and
 - Processes for triage/dispatch are identified and implemented via a unified, statewide system
- This soft launch will provide ample opportunity for team training and coaching and supporting the teams through initial implementation
- Data will help 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

IMPLEMENTATION UPDATES

- Continued work with MCOs related to service implementation and ongoing monitoring; including:
 - Triage and dispatch function
 - Referral and process flows
 - Data collection/reporting functions
- Ongoing collaboration with 988 workgroup and other stakeholders
- LSU Workforce Development Update

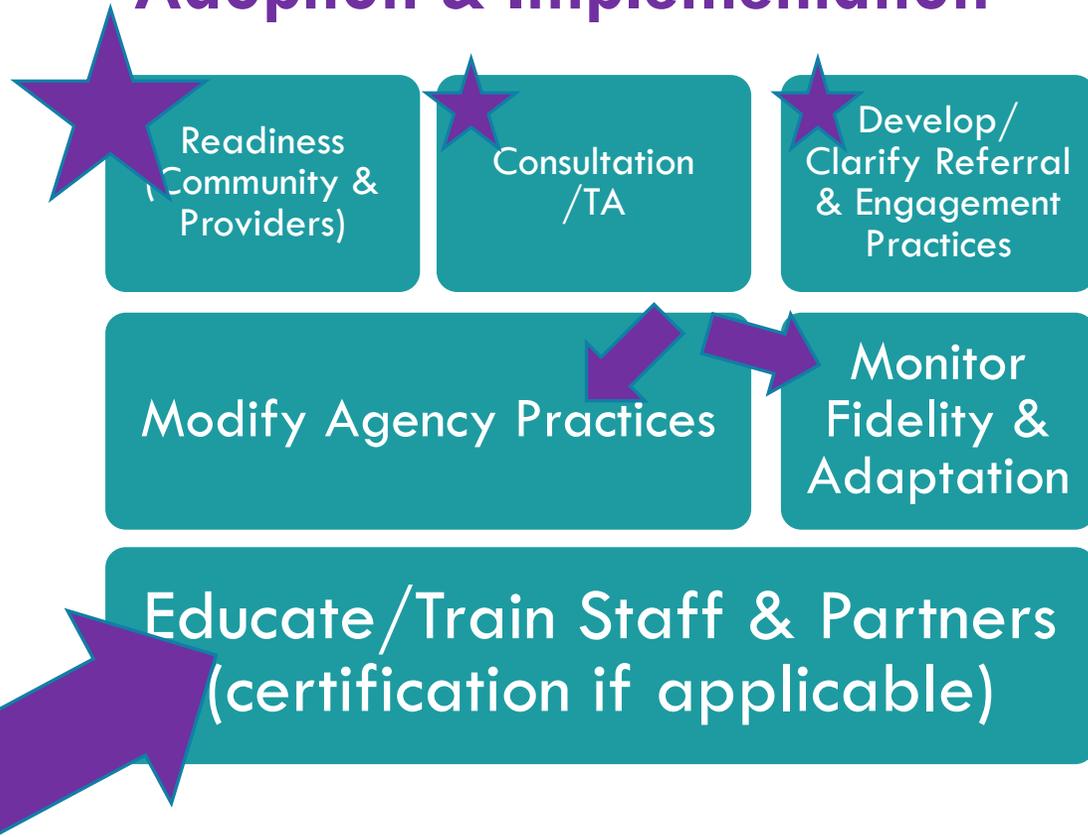
WORKFORCE DEVELOPMENT UPDATE

- Initial launch and first training cohort selection
- Coverage, gaps and helping areas/organizations become ready
- Next steps...
 - Forming first training cohort (Dec 2021)
 - Initial training (Jan 2022)
 - Continue outreach with key collaborators
 - Coaching (first six months)
 - BHCC and CS training (Spring)
 - Establish ongoing revolving schedule of training for new staff, organizations, etc.
 - Collect information on training and service delivery to adjust process as needed



SUPPORTING IMPLEMENTATION & SUSTAINABILITY

Adoption & Implementation



Service Delivery & Sustainability



IMPLEMENTATION TOPIC: RESOLUTION FOCUSED CRISIS RESPONSE

Kappy Madenwald, MSW, LISW-S

Peer Panel:

- Carla Neely, PRSS
- Nancy Hughes CPSS, B.A.
- Angéla Lorio, PRSS

COUNTING THE DAYS

Two services launch in *March, 2022*

Service models have been finalized

Teams have been identified to participate in trainings

MCOs are involved in numerous tasks necessary to launching the services

Training curriculum is getting finalized

Protocols and collection methods are being developed

COUNTING THE DAYS

With the help of statewide and regional stakeholders, MCOs, and LSU, LDH has readied these new services for a soft launch

The balance of attention will soon shift to regions in which services will be provided

10 regions, each with their own unique characteristics, assets and challenges

One or more service providers—some of whom may be providing crisis services for the first time

It will take the work of more than just those new teams to get services up and running and making a difference for people in crisis and their families

WHAT IS IT ALL FOR?

These are services that have not been historically available in most of the state

In the absence of community-based crisis services many people have experienced more restrictive, intrusive and coercive interventions

For some, this has led to extended institutionalization. This includes individuals who have experienced long term stays in nursing homes with limited established pathways back to the community

These new services are designed to remedy those harms by offering safer crisis care

CRISIS CARE IS EXPERIENCED AS SAFER WHEN...

It is offered **early, voluntarily, locally, and in natural or community-based settings**

Teams use approaches that are **person-centered and collaborative, strength-based, and resolution-focused**

There is **minimal reliance** on interventions experienced as coercive; such as:

- Law enforcement involvement
- Involuntary evaluations
- Restrictions of property/movement/dress/natural supports
- Inpatient hospitalization—particularly if involuntary

SAFER CRISIS CARE EXPERIENCE

Significant shift in practice for much of the state

Crisis treatment provided in the community

Engaging individuals not known to the team

Responding to acute situations

Maximizing use of voluntary interventions

Use of less-restrictive solutions

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

SAFER CRISIS CARE EXPERIENCE FOR EVERYONE

How to achieve this?

Use of technology and logistical efficiencies

Seamless interface between mobile teams and call center teams

Gathering and using data to drive quality and systems improvement

Continuous consideration of safety

Diversifying the team

Use of approaches that calm crises and maximize choice

Engaging other systems and stakeholders to improve practices both *upstream* and *downstream* of crisis episodes.

Collective adoption of a *learning community* mentality

TRANSFORMATION READINESS

Making space for new learning with a:

Beginner's mind

Beginner's eyes

Beginner's Ears

Creating safety for new learning

Psychologically safe environments for training, coaching, team development and system development

Essential for innovation and system transformation

It is a parallel process to our work with individuals in crisis

SAFER CRISIS CARE EXPERIENCE

Two key provocative themes (spoken and unspoken) will flow throughout training and implementation:

Risks associated with providing crisis intervention

Attending to the “stories” we (the treatment providers) tell as we go about our work

- Stories about people in crisis
- Stories about our “job”
- Stories about the system

THEME 1—MANAGING RISK

Because we are working with individuals whose health care crises are life threatening, it is natural to be concerned about personal liability or corporate liability.

It is important to have a broad understanding of the ways that crises increase risk for individuals

But, we have to be aware that the system's response to crises can also put individuals at risk

THEME 1—MANAGING RISK

When we LEAD with a focus on OUR liability, we can miss important information, and we can make things worse

When we proceed without understanding how the person in crisis is experiencing care, we can make things worse

We are putting the person in crisis at risk of iatrogenic harm

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

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 and their family—when we view from their shoes



DIMINISHING THE NEED FOR COERCIVE PRACTICES

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:

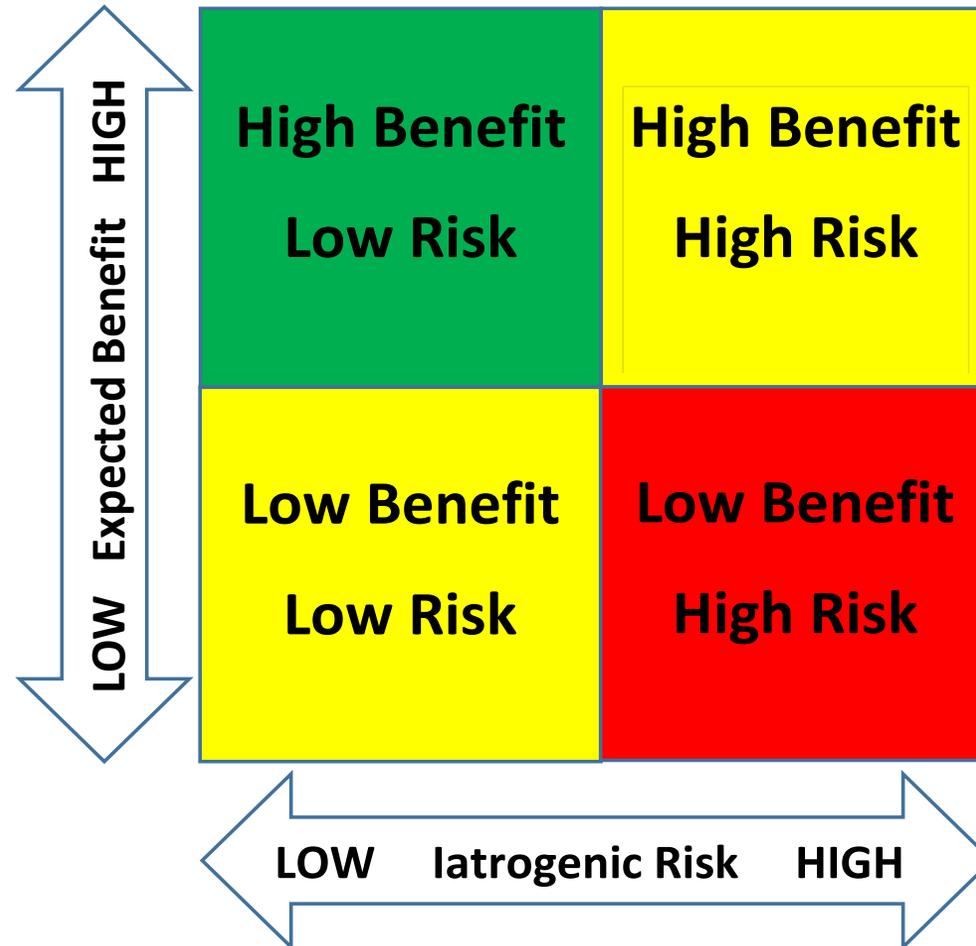
- Habit
- Convenience
- Cost
- Transportation
- Concern about personal or corporate liability

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

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.”

RE-THINKING HOSPITALIZATION



Historic Question

Does the individual meet criteria for psychiatric hospitalization ?

What hasn't always been considered

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?

THEME 2: STORYTELLING



THEME 2—STORYTELLING

What stories could IMPEDE success?

Historic deficit stories of individuals with behavioral health conditions

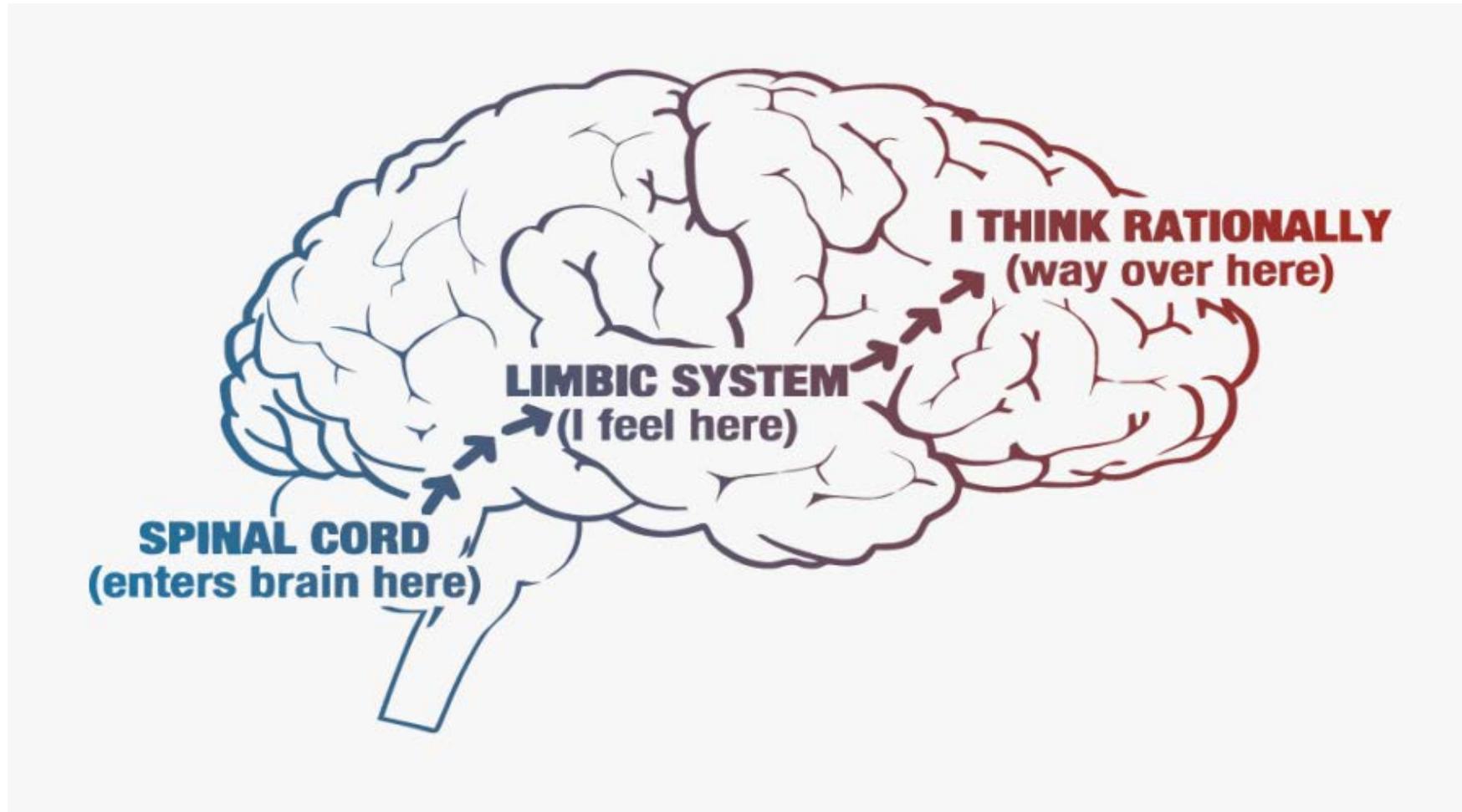
Stories about the parents of those individuals

Stories about how individuals use the system/treatment

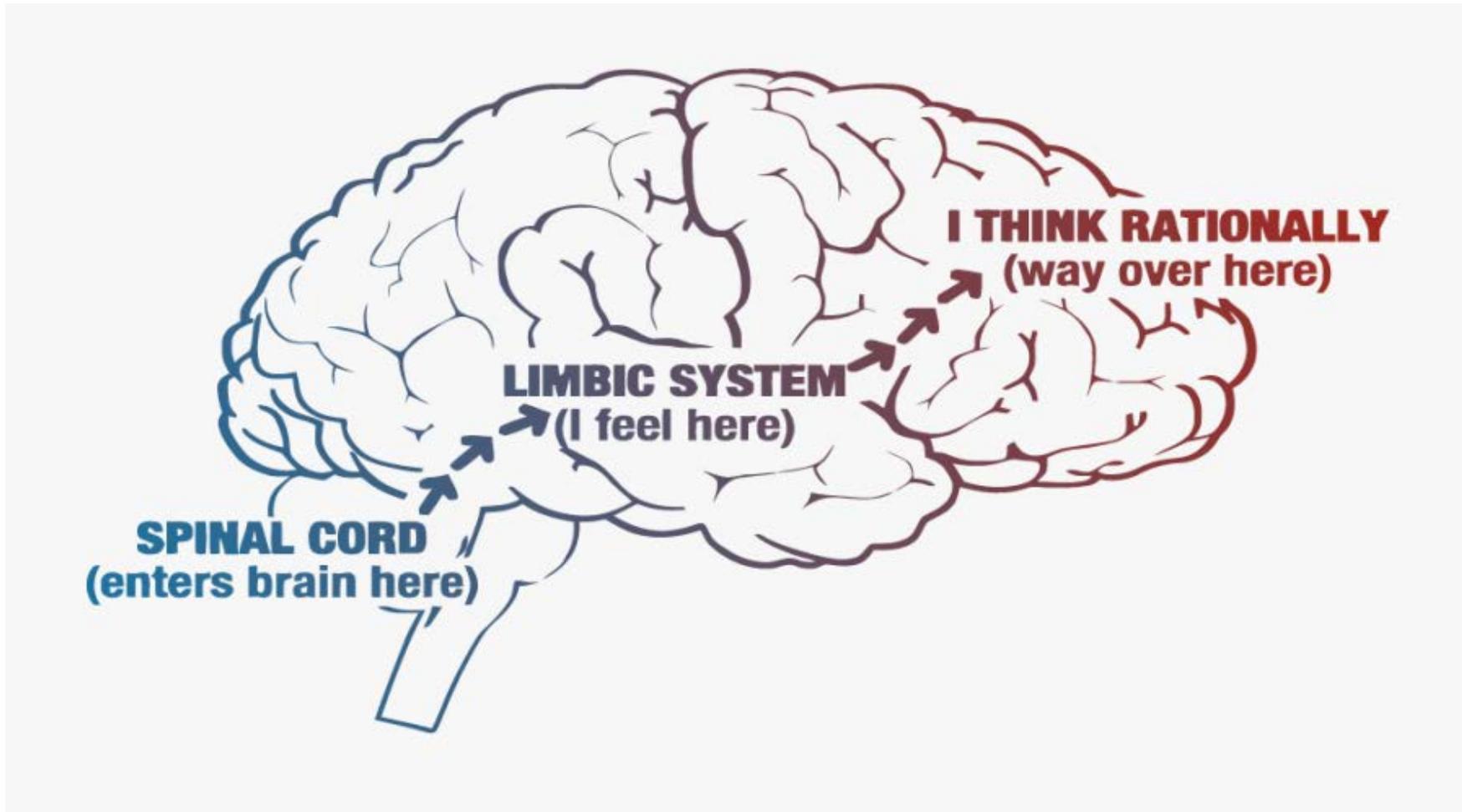
Stories about our (intervener/treatment provider) role/effectiveness

Stories predispose actions

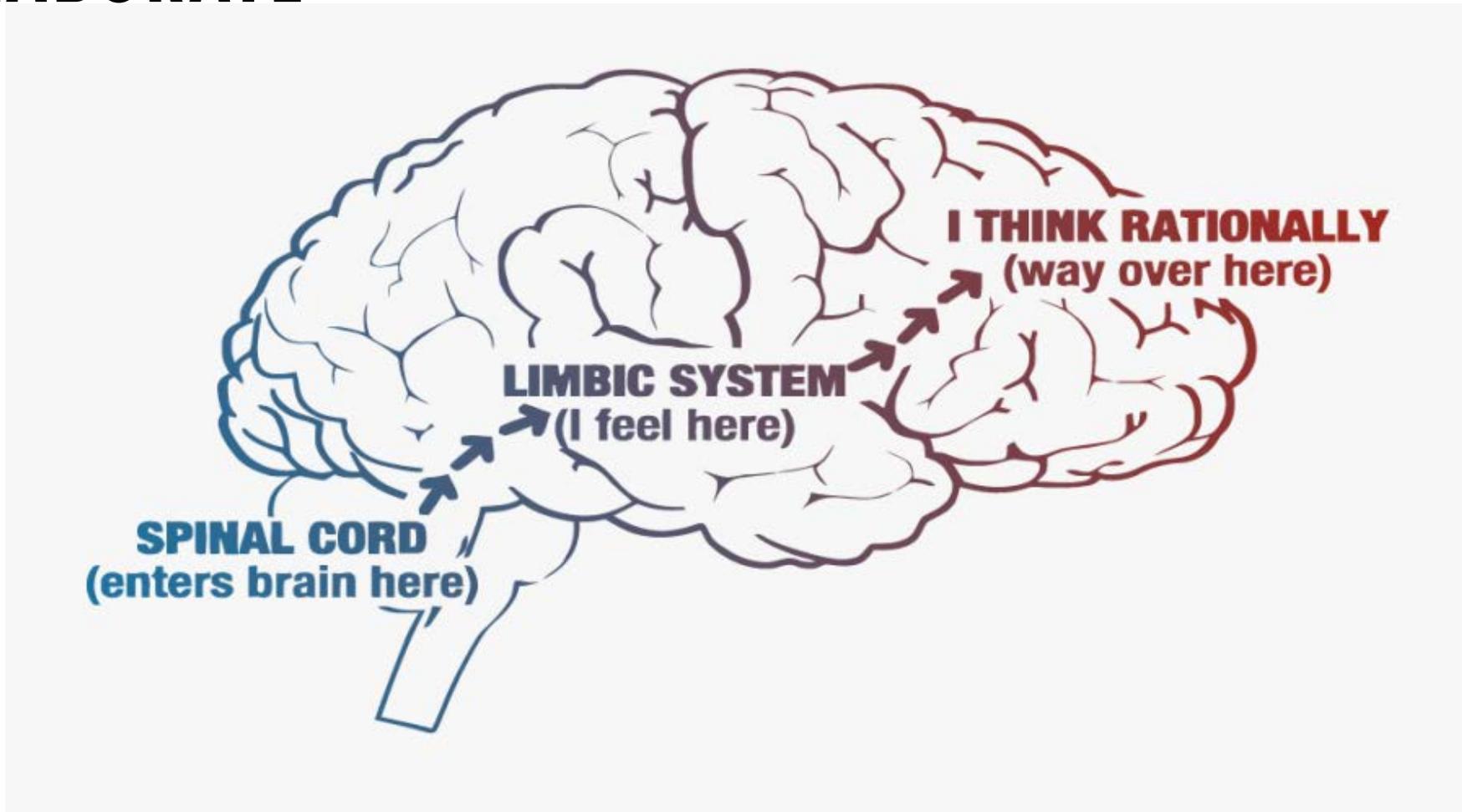
STORIES PREDISPOSE ACTIONS...



“FREQUENT FLIER WHO NEVER COOPERATES”



“CREDIBLE, CAPABLE, INTUITIVE AND ABLE TO COLLABORATE”



MARK RAGINS, MD: THE “FOUR WALLS”

I truly believe that to truly implement a recovery-based paradigm, we must change more than the signs on our doors or the forms that we use. We must change ourselves.

Looking back I can see “four walls” that we had to break through to change ourselves:

The Wall of the Medical Model

The Wall of Professionalism

The Wall of our Building

The Often Hidden Wall of Stigma and Prejudice Inside Us

“TO CHANGE THE SYSTEM, WE MUST CHANGE OURSELVES”

Beginner’s mind, ears and eyes

Getting very curious, listening to and learning from those with lived experience about what helps and what harms

Willingness to discard outdated habits of practice

Carefully examining the “four walls” within ourselves and our systems that are inhibiting our effectiveness

Commitment to collaborative learning

It is rare in one’s career to be a part of groundbreaking innovation and system change.



PANEL RESPONSE

NEXT STEPS:

- LSU-HSC Crisis Trainings (selected providers): January, 2022
- MCR/CBCS Go Live: March 1, 2022
- BHCC Go Live: April 1, 2022
- Budget Request for CS: 2022 Legislative Session
- CS Go Live: July 1, 2022 (pending approval of funding)
- Development of Statewide and Regional Crisis Coalitions for ongoing readiness and implementation updates
- Louisiana Crisis Response System Implementation Plan Updates - Statewide webinars*:
 - February 24, 2022: 2:30p.m. – 3:30p.m.
 - April 28, 2022: 2:30p.m. – 3:30p.m.

* Dates subject to change



QUESTIONS?



The presentation will be available at the My
Choice Louisiana website located at:

<https://ldh.la.gov/Crisis>