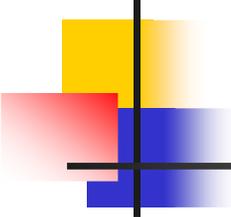


Crisis Services

NC Institute of Medicine Task Force on
Substance Abuse Services

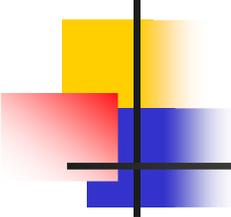
March 14, 2008



Overview

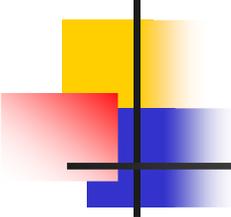
"An optimized crisis system is one that regardless of size or number of service providers has a community impact that is greater than the sum of its parts."

- This result is attained through:
 - Sameness of purpose
 - Clarity of role
 - Interconnectedness of communication
 - Leveraging of resources



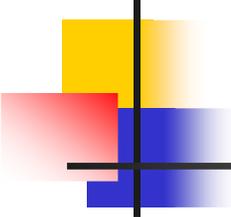
The Crisis Continuum

1. Prevention
2. Early Intervention
3. Acute Intervention
4. Crisis Treatment
5. Recovery and Reintegration



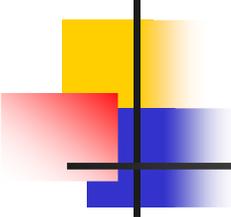
Seven Principles of Comprehensive Crisis Systems

1. Make crisis work routine
2. Strive for resource transparency
3. Incorporate crisis competencies across the network
4. Use data for planning, performance assessment and quality management
 - Hospital admissions and bed days
 - Medicaid and IPRS data
 - Special QM studies
 - System capacity indicators



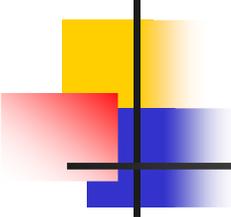
Seven Principles (Continued)

5. Assess and strengthen essential partnerships
6. Seek upstream solutions
 - First responder role/responsibility
 - ID Cracks in system – places where people are lost
 - Engage non-connected people quickly and at the right place (\approx 40 – 60% of admissions)
7. Address community expectations



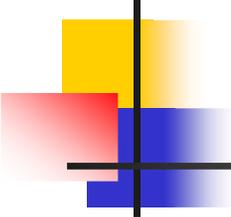
System-Wide Crisis Capacity

- Local acute inpatient care
- 24/7 phone response and face-to-face assessment, stabilization and referral
- Mobile team
- Crisis respite, 23-hour to 72 hour options
- Crisis facility
- Provider network clinical competencies (first responder, risk assessment, etc.)



Specialized Crisis Services

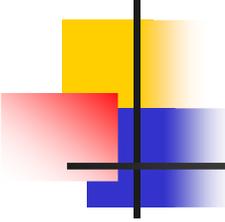
- Local detoxification
- Developmental disability competencies and resources (crisis respite)
- Substance abuse competencies and resources (SA assessments, peer supports)
- Child/adolescent competency and family focused interventions
- Physical health evaluation and treatment



Substance Use Treatment gap

- 196,000 persons in North Carolina needing but not receiving treatment for illicit drug use in the past year
 - 34,000 adolescents (12-17)
 - 66,000 young adults (18-25)
 - 96,000 adults (26+)

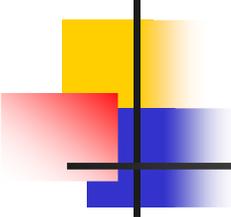
Wright, D., Sathe, N., & Spagnola, K. (2007). *State Estimates of Substance Use from the 2004–2005 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 07-4235, NSDUH Series H-31). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.



Substance Use Treatment gap

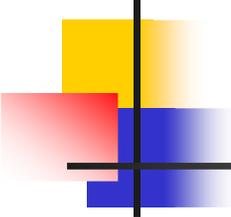
- 425,000 persons in North Carolina needing but not receiving treatment for alcohol use in the past year
 - 37,000 adolescents (12-17)
 - 125,000 young adults (18-25)
 - 290,000 adults (26+)

Wright, D., Sathe, N., & Spagnola, K. (2007). *State Estimates of Substance Use from the 2004–2005 National Surveys on Drug Use and Health* (DHHS Publication No. SMA 07-4235, NSDUH Series H-31). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.



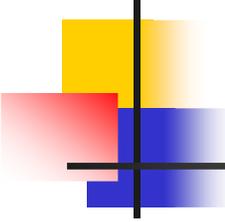
Substance Use Treatment gap

- As IOM's own Substance Use Task Force description points out—
 - The issue is complex
 - Barriers include
 - Lack of problem recognition by users
 - Under-identification by treatment providers
 - Awareness/access to continuum of treatment services
 - Stigma



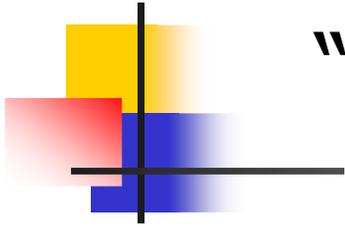
Substance Use Treatment gap

- Essential to recognize that even with abundant capacity, a critical number of individuals will not seek traditional services.
- Expanding the safety net means looking beyond traditional services/traditional providers to other means of harm reduction.
- This includes increasing the awareness and competency of experts in other systems who may be likely to intersect with persons using substances.



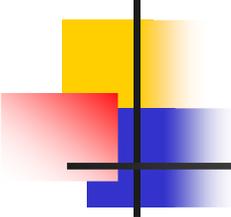
Substance Use Treatment gap

- SAMHSA has released a Quick Guide “Alcohol Screening and Brief Information (SBI) for Trauma Patients.
- Recommends a 3-Step Screen/Brief Intervention Process “capitalizing” on the opportunity to intervene at a time when consequences from use are high.
- Provides a model that will be adaptable to other medical settings
- Offers an array of screening tools and protocols



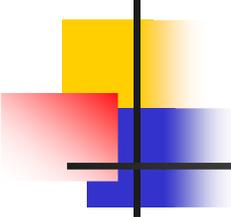
“ Brief alcohol interventions conducted in trauma centers have been shown to reduce trauma recidivism by as much as 50%.² Such interventions also reduce rates of arrest for driving under the influence³ and cut health care costs.⁴ For these reasons, routine care in trauma centers should include screening patients for alcohol misuse, providing brief interventions for patients who screen positive, and—when needed—referring patients to specialty assessment and treatment. ”

Excerpt from SAMHSA Quick Guide



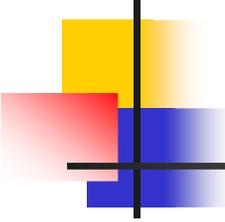
Conclusion

- The implementation of individual components such as mobile crisis and crisis stabilization units is necessary but not sufficient to attain a comprehensive crisis continuum
- The individual components must be part of an integrated system with clear clinical pathways and points of authority and accountability
- And, the crisis system depends on integration with and support of the MHDDSAS system and other parallel systems (health, criminal justice, housing, etc.)



Session Law 2006-66

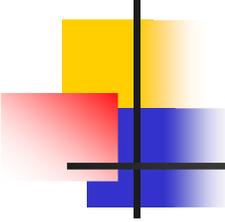
- The General Assembly passed Senate Bill 1741, Section 10.26 that appropriated funds and gave legislative requirements for the planning and development of a continuum of crisis services for consumers of all ages who are in need of crisis services because of mental health, developmental disabilities, or substance abuse.



Legislative Requirement

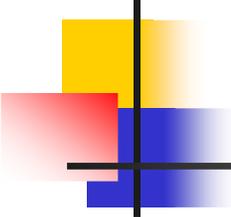
Plans had to address the following components:

- *24-hour crisis telephone lines,*
- *walk-in crisis services,*
- *mobile crisis outreach,*
- *crisis respite/residential services,*
- *23-hour beds,*
- *facility-based crisis services*
- *detoxification services*
- *in-patient hospitalization, and*
- *transportation.*



Additional Appropriations

- \$5,250,000 one time crisis service start-up funds, were appropriated in SFY 06-07.
- \$7,000,000 recurring funds for crisis service were appropriated in SFY 06-07.
- \$13,737,856 in recurring additional funds for implementation of crisis plans were appropriated for SFY 07-08.

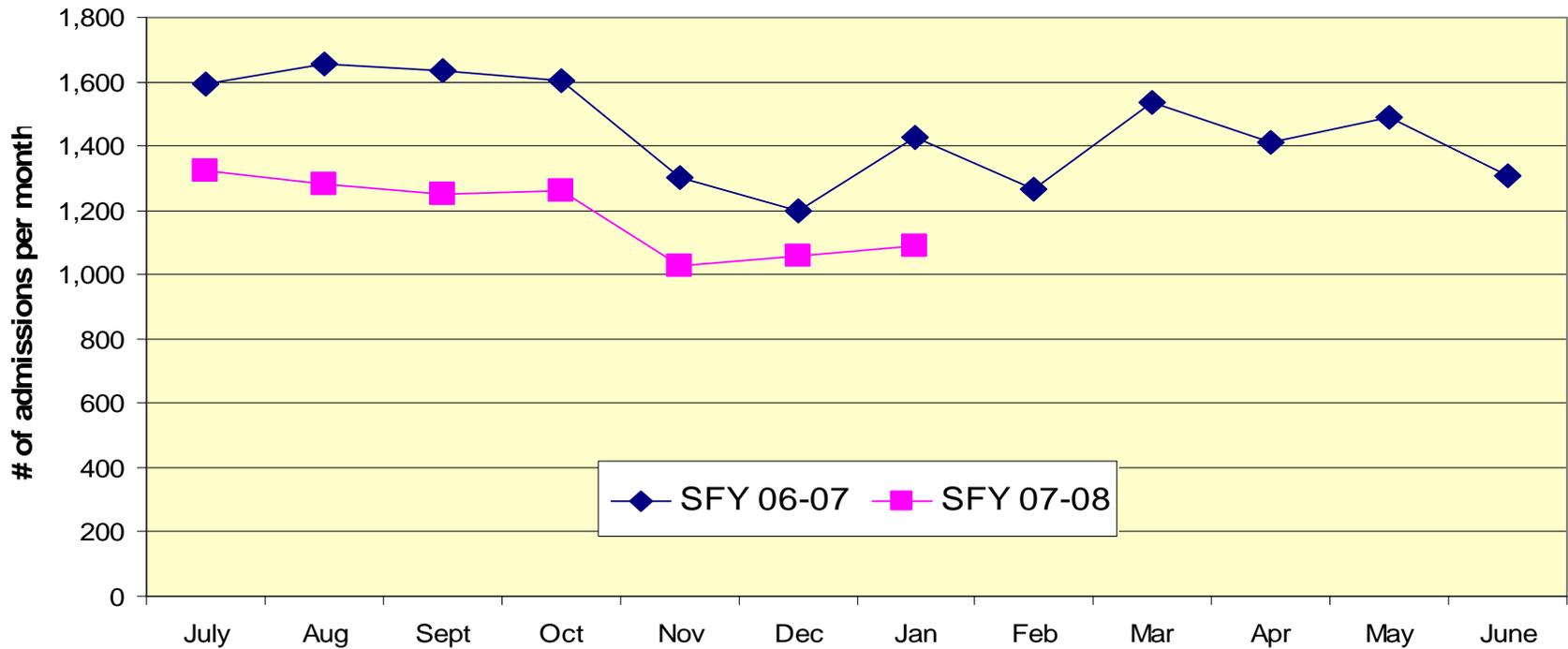


Crisis Service System Plans

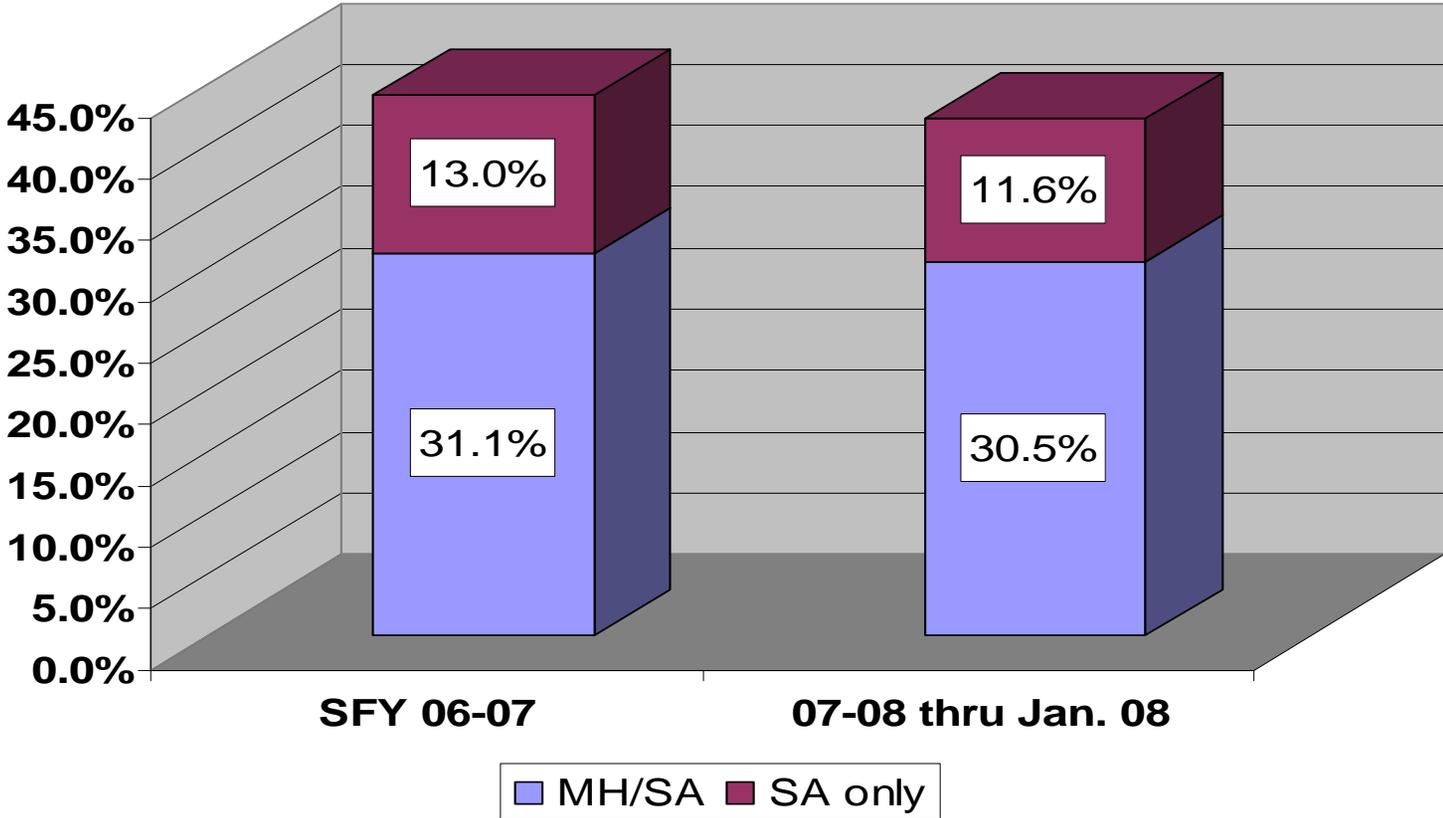
- LMEs developed crisis plans and submitted them by 3/1/07
- Plans were reviewed and when approved start-up funding was allocated to LMEs
- All of the LMEs have taken steps to implement their plans by identifying additional service providers and by increasing the capacity and effectiveness of current services.

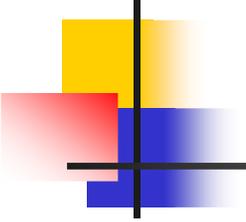
State Hospital Admissions

State Hospital Admissions FY 07 & FY 08



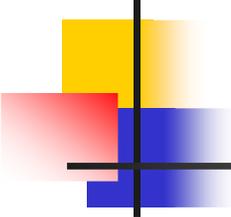
Substance Abuse State Hospital Admissions





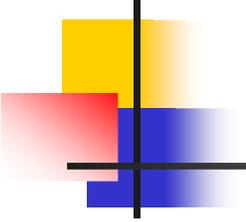
Use of Community Based Crisis Services in SFY 07

- 6,699 people with substance abuse disorders received crisis services last year.
- This represents 10.6% of the total number of adults with substance disorders served in the community.



Use of Community Based Detoxifications Services in SFY 07

- Social Setting Detoxification 1,142
- Non-hospital Medically Monitored Detoxification 1,311
- The rest received services such as Mobile Crisis services, Facility Based Crisis services, or services from an Assertive Community Treatment Team which are designed to be able to service all disability groups.



Division's Strategic Plan 2007-2010

- A Major Objective is to continue development of comprehensive crisis service system that is integrated with the existing community medical and public safety emergency response system that provide an effective, clinically appropriate continuum of services