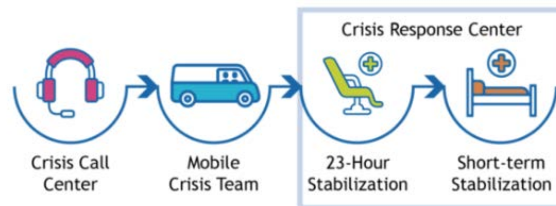
Suicide Prevention Subcommittee Tasks:

- Conduct an overview of the current infrastructure of the 988 Suicide and Crisis Lifeline system.
- Provide recommendations on how behavioral health managing entities may fulfill their purpose of promoting service continuity and work with community stakeholders throughout the state in furtherance of supporting the 988 Suicide and Crisis Lifeline system and other crisis response services.
- Evaluate and make recommendations to improve linkages between the 988 Suicide and Crisis Lifeline infrastructure and crisis response services within this state.

Assignment: Identify "Actionable" suggestions related to "A Safe Place to Go" element of the Crisis Continuum



Recommendations:

1. Create a **map that includes: 1) FL Lifeline Centers overlaid with 2) Locations of CSUs, CRCs and CCBHCs, also shaded with 3) the MRTs coverage areas).** Review the Map of drop-off points for CRCs and CSUs. Challenges exist with geography, both in geographically large counties, rural areas, and extremely populous. Too many individuals have to go to facilities very far from their homes/communities to receive treatment, which provides numerous challenges.
    a. Consider **aligning the distribution** of 988 centers with MRTs as a start, and then possibly with CSUs and CRCs (and even CCBHCs eventually). Could we mirror the DCF Regional approach?

2. Review adequacy of **funding of CRCs to expand available crisis services** and these identified initiatives. Include sustainable funding for **advertising/marketing to the public** of availability of CRCs.

3. Ensure that 988 and MRTs (along with CSU/CRC providers) are adequately represented, attending and contributing to meaningful conversations at already-established formal meetings such as **Regional Council meetings and local "Acute Care"** meetings.

4. Review the statutorily required **Transportation Plans** to ensure they appropriately highlight the relationships between 988 providers, Mobile Crisis and CSU/CRCs.

5. Create a **template for building out relationships** between 988 providers, MRTs, and CSUs/CRS (best practices, meeting quarterly expectations, etc.)
    a. Enhance communication of expectations (e.g., via Fact Sheets, standardized training materials) about **what to expect** at a CSU and/or CRC and/or CCBHC. Also, what to expect when you refer someone to call 988. Need this information from both perspectives.

6. Review **gaps in levels of care and service delivery** available (either due to non-existence or due payer restrictions) means that many times individuals in crisis are combined in "fishbowl" units that can be

traumatizing due to differences in populations, presenting symptoms and needs being combined in a "one size fits all" unit.

   a. Need to expand network of appropriate **Aftercare/Stepdown or sub-acute options** for folks either instead of CSU or as discharge disposition. (E.g., IOPs, PHPs/Day Treatment, Drop-in Centers, Clubhouses, Peer Respite.)
   b. Identify **youth-specific needs and gaps** in the available resources. Utilize CRCs (or similar facilities to assess, stabilize and link those under 18yo.
   c. Review unique needs of **pregnant women and parents of young children,** as participating in inpatient crisis services necessitates childcare options (minimize separation from children and appropriate childcare supports to minimize trauma to all parties.)
   d. Identify unique challenges with crisis response for **homeless** individuals and expand resources.

7. Increase access to **telepsychiatry/APRN/MD, 24/7** to help avoid Baker Act and/or release Baker Act prior to inpatient admission.

8. Review **Marchman Act pathway (i.e., facilities and resources)** now that 988 is for behavioral health crisis and not just suicide prevention.

9. Clarify role of **hospital emergency departments and enhance protocols** for responding to behavioral health emergencies in general medical hospital EDs. When folks are delivered to the hospital ED from a crisis call, how are they managing these situations.
   a. Role of **EMTs/paramedics/community paramedicine programs** (at the CRC/CSU in order to avoid hospital ED presentation).

10. Engage/formalize and enhance the **participation/role of peers/advocates** throughout the crisis care continuum—even 24/7 at CRCs to help engage individuals who present voluntarily (and help avoid involuntary Baker Act) and to support families navigating the crisis care system.

11. Focus on expanding and enhancing **alternatives to the Baker Act, Living Room models, Drop-in/Clubhouse, Peer Respite**, etc.

12. Facilitate **humane crisis/Baker/Marchman Act transportation** (i.e., how can we avoid police cars and handcuffs) throughout the state.

13. Develop an assessment/**template to assess how CSUs/CRCs are performing** based on national best practices for crisis care/psychiatric hospitalization and provide consultation and technical assistance. Incentivize improvements. This is not referring to establishing the "floor" of licensure/designation, but rather how to help facilities incorporate better practices with additional resources. Envision a process similar to the statewide ROSC initiative, to provide guidance on how providers can "step up" the quality of care provided in CSUs and CRCs, and enhance consistency and standards so that there is consistent experience across the state. Includes self-assessment tools and then ME assistance in assessing as well. Need to develop what those standards are.

14. Develop best practices for CSUs/CRCs to address language and **cultural competency standards**, e.g.:
   a. Review for needed best practices for addressing **immigration/legal status** concerns.
   b. Develop best practices for CSUs/CRC to address **LGBTQI** competency standards (i.e., training, templates, and guidance documents), especially as these impacts: 1) Kids/parents communication of preferences, 2) Room assignments, 3) Safety checks, etc. to ensure protocols for contraband checks to be least invasive/intrusive/stigmatizing/traumatizing.

15. Enhance communication throughout the **discharge planning process** and actual discharge recommendations to individuals and their family members. Family members have difficulty accessing the treatment team and are sometimes simply called to pick their loved up because "they are being discharged now." Consider Discharge Liaisons or other enhanced discharge communication to help prevent quick return to crisis state/readmission.

16. Ensure all CRCs and CSUs have access to the **knowledge base of available community resources** similar to the resources that 211/988 have.

17. Develop a **"Caring Contacts"** program to coordinate between CSUs/CRCs and 988 centers for providing 48-hour post-discharge f/u calls to individuals who have been discharged from CSUs.

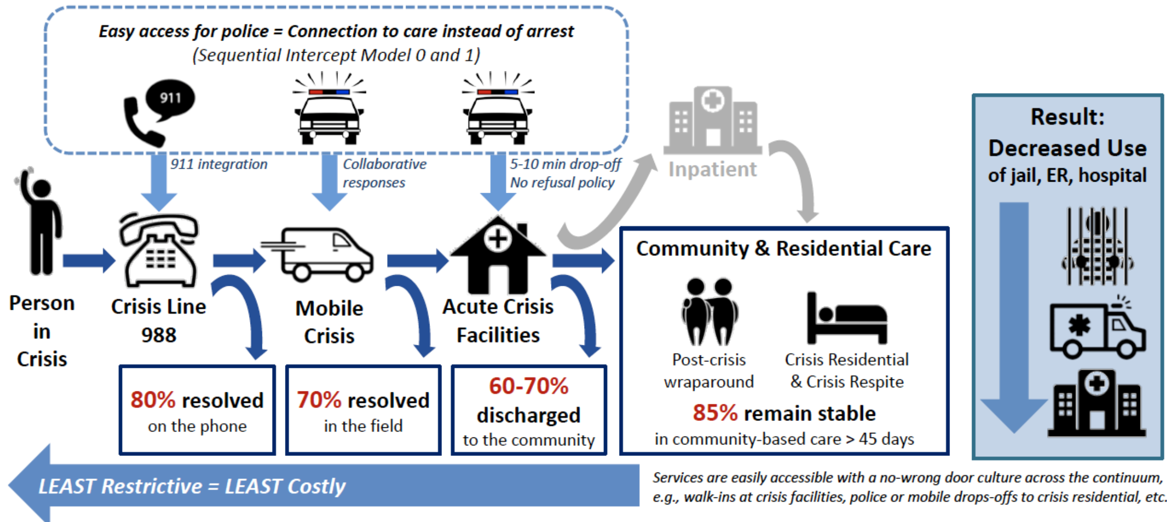
18. Provide better guidance and technical assistance/consultation to remove barriers in communication between entities due to **privacy concerns** (**HIPAA/42 CFR Part 2)**. Better understanding and dissemination of allowable activities under "care coordination" and "emergency communications."
    a. Acknowledge **warm handoffs** (throughout referral and discharge processes).

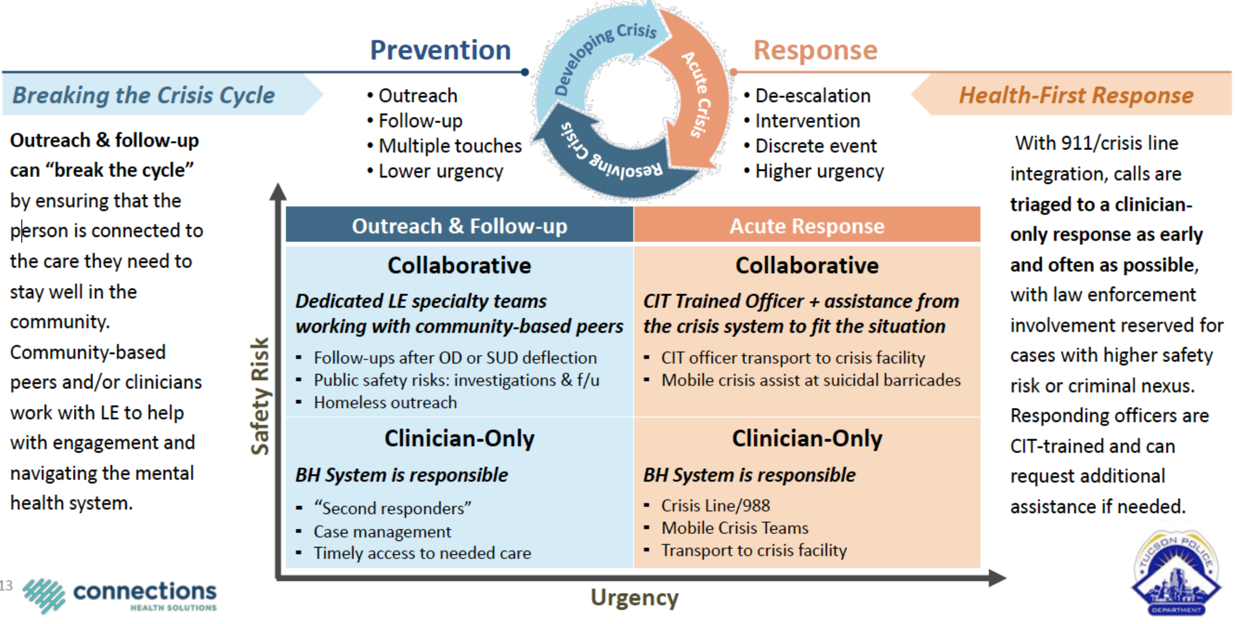
19. Ensure these workgroups and subcommittees continue to consider **multiple perspectives**: i.e., CSU/CRC providers (especially those who are not 988 call centers), individuals and families with lived experience of accessing crisis continuum services, law enforcment, managing entities, NAMI representatives.

20. Review **other state systems** who are doing crisis response/care well. E.g., look at Arizona crisis care system for ideas (example slides below).

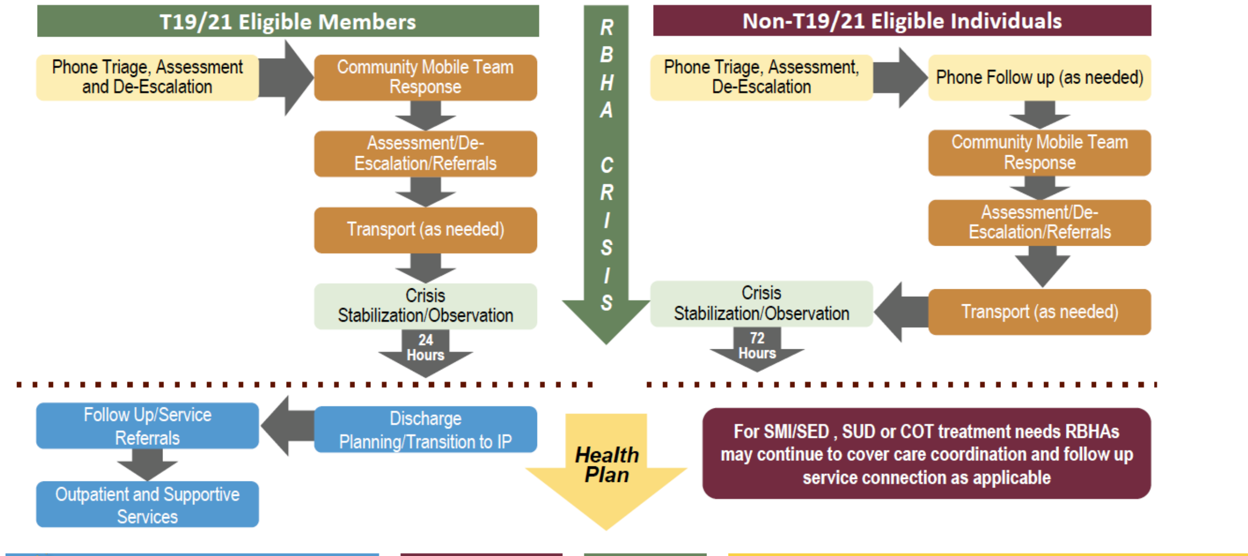
21. Enhancing and expanding the **FL Suicide Prevention annual conference** to help support all of the above.

From Arizona System presentation:





AZ RBHA Crisis Coverage vs. Health Plan of Enrollment



How 988 flows into the Arizona Crisis System of Care