988 Planning Grant

Planning Coalition Meeting

June 29, 2021

Members Present:
Wendy Bailey, DMH Executive Director
Katie Storr, DMH Chief of Staff
Suzanne Rabideau, Health Management Associates
Laquisha Grant, Health Management Associates
Cami McIntire, Health Management Associates
April McNair, DMH Special Projects Officer
Veronica Vaughn, DMH Director of Branch of Coordinated Care
Falisha Stewart, DMH Program Coordinator of Office of Consumer Support
Kristi Kindrex, DMH Special Projects Officer of Consumer Support
Nicole Bedsole, Housing Case Manager of Mental Health Association
Ann Rodio, Region 8 Director of Alcohol and Drug Services
Brenda Patterson, Executive Director of Contact Crisis Line
Katrina Sunivelle, Region 12 Executive Director of Contact Helpline
Teresa Mosley, Psychometrist/Adjunct Instructor of Mississippi College
Amy Mosley, Region 10 Director of Crisis Services
Andrew Day, Mississippi Division of Medicaid
Sitaniel Wimbley, Executive Director of Nami of Mississippi
Jonathan Grantham, Region 6 Clinical Director of LifeHelp
Kelly Breland, DMH Chief Financial Officer
Ja'Quila Newsome, DMH Director of Suicide Prevention
Molly Taylor, DMH Program Director of Outreach and Planning
Vickie Winslett, President of Mississippi Alliance to End Suicide
Marissa Nooner, Region 4 Mobile Crisis Team
Pamela Smith, Board Member of MS Chapter of American Foundation for Suicide Prevention

I. Welcome

- Katie Storr, Chief of Staff with the Department of Mental Health, welcomed team members to the 988 Planning Coalition meeting.

II. Approval of Minutes from June 8, 2021, and May 25, 2021

- Planning Coalition meeting minutes from June 8, 2021, were approved as submitted, with one change. Take out Section 3-Number 7, where it stated that Suzanne Rabideau, Health Management Associates, recommended that the Contact Helpline and the Contact TCL increase hiring paid staff employees, not just volunteers and replace with: Members discussed the possible benefits of utilizing additional paid staff, as well as volunteers, at Contact the Helpline and Contact the Crisis Line when determining how many staff will be needed in the future.

  Motion to accept minutes:

  1. Nicole Bedsole, Housing Case Manager of Mental Health Association
  2. Jonathan Grantham, Region 6 Clinical Director of LifeHelp
  3. All members were in favor

- Planning Coalition meeting minutes from May 25, 2021, were approved as submitted, with no changes.

  Motion to accept minutes:

  1. Nicole Bedsole, Housing Case Manager of Mental Health Association
  2. Jonathan Grantham, Region 6 Clinical Director of LifeHelp
  3. All members were in favor

III. Recap of Prior Discussions and Work Conducted

- Suzanne Rabideau, Health Management Associates, reviewed a recap of prior discussions and work concluded.
  1. Call volume projections and baseline call volume for 2020
  2. Funding projections, CMHC's reimbursed by Medicaid, and DMH Funding
  3. Legislation
  4. Draft outline of the 988 Plan-Health Management Associates is beginning to populate a draft plan using information and input provided during the Planning Coalition meetings.

IV. Operational, Clinical and Performance Standards for Centers Answering 988

- Laquisha Grant, Healthcare Management, discussed the operational, clinical and performance standards for centers answering 988 calls.

  1.Grant Requirement

  a. As set forth by SAMHSA, the Lifeline, and its national partners, in order to assure successful 9-8-8 implementation, state and territory agencies must comprehend and account for the operational, clinical and performance standards for all of the Lifeline member centers in their region. Technical assistance regarding Lifeline requirements in each of these areas will be provided.

  2. Lifeline Suicide Risk Assessment Standards (SRAS) (2007)

  a. Require three prompt questions

  * Are you thinking of suicide?
  * Have you thought about suicide in the last two months?
  * Have you ever attempted to kill yourself?

b. Full suicide risk assessment
    * Suicidal desire
    * Suicidal intent
    * Suicidal capability
    * Buffers and connectedness
c. Lifeline Imminent Risk Standards (IR) (2011)
    * Active Engagement
    * Active Rescue
    * Collaboration

3. Safety Assessment Focus
    a. Develop model based on hotline call flow
        * Focuses on safety at its core
        * Emphasizes safety and prevention over prediction
        * Provides improved direction for center staff
    b. Change name from Risk Assessment to Safety Assessment
    c. Maintain the Lifeline four core principles
        * Desire
        * Intent
        * Capability
        * Buffers, connectedness and clarify essential components
    d. Maintain prompt questions but reinforce importance of asking all questions
    e. Provide guidance on how to approach safety assessment, not just what to ask

4. Imminent Risk Policy Update
    a. Change the term “active rescue”
    b. Lifeline provide training and education
        * Potential physical dangers associated with law enforcement
        * Emotional and financial impacts of involuntary hospitalization
    c. Requirements for crisis centers
        * Maintain data on interventions
        * Review of all active rescues
        * Collect information on local resources
        * Engage first responders (e.g., law enforcement)
    d. Lifeline maintain quality monitoring
        * Collect imminent risk intervention data
        * Provide guidance for centers with high rates of involuntary intervention

5. Future Requirements (TBD)
    a. Minimum policy requirements
        * Safety Assessment and Imminent Risk Policy

b. Clinical training requirements (TBD)
    * Complete and pass Lifeline Core Clinical Training on suicide assessment and intervention
    * Complete 5-10 live role plays facilitated by center
    * Complete 10-20 hours observing an experienced crisis counselor
    * Complete 2 online simulated trainings on direct callers/third party
c. Ongoing center training options
    * Complete 8 hours of additional lifeline training per year

V. Follow-Up Services to 988

- Laquisha Grant, Healthcare Management, reviewed the follow-up services to 988.

1.Grant Requirement

a. State and territory shall ensure all centers in their region are able to provide follow-up services to 988 callers, texters, and chatters based on lifeline best practices and guidelines.

2. Follow-up Programs Defined

a. Follow-up care can involve home visits, phone calls, emails, or texts that are designed to check in with individuals who have recently experienced a suicide crisis to assess their well-being check in regarding their safety plan, and to support them as they access additional resources or services.
b. Follow-up is usually by telephone and typically occurs between 24-72 hours after the initial contact.
c. Phone calls are brief (10-20 minutes) and while they can be tailored to the individuals need, they are structured and focus on review of the safety plan care coordination.
d. Types of Follow-ups
    * Short-term: 2 contacts to increase or maintain safety
    * Long-term: Can last weeks or months to update safety plan as needed or connect to services
    * Community partnerships: MCT. LE, etc.

3. Follow-up Calls Enhance Safety

a. 79.6% of individuals reported that follow-up has stopped them from killing themselves
b. 90.6% reported that it kept them safe
c. As the number of follow-up calls increased, positive perceptions of care also increased

4. Current Follow-up Best Practices

a. Establish a safety plan and use it to structure follow-up calls
b. Fully integrate the follow-up plan into your center's objective
c. Consider a wide range of follow-up methods
d. Track and evaluate key outcomes
e. Establish policy to work with familiar/frequent callers and local law enforcement

5. Follow-up Requirements for 988
    a. 988 Follow-up program eligibility requirements
        * All callers, chatters, and texters that confirm current suicidal ideation during their interaction with the lifeline will be asked for consent to follow-up services
    b. Consent criteria
        *Callers, chatters and texters must consent to follow-up services
        *Lifeline has a recommended consent form, centers can adapt their own, but it should include all elements on the recommended form
    c. Modality for follow-up
        * Telephone for follow-up is the only current modality that can be offered through lifeline, but they are exploring other options that may offer some future technological aids, like outbound texting or messaging
    d. Time required for completing the follow-up contacts
        * First contact should typically occur with 24-72 hours after the original contact with the lifeline
        * Contacts needed sooner than 24 hours are often done as part of a safety check outreach and are particularly helpful for those who need additional support and do not want or need to go to the ER, people who receive safety check calls can also be asked for consent to participate in a follow-up program once the period of immediate safety is no longer a concern
    e. Required procedures
        * Individuals who have consented to follow-up typically receive a minimum of 2 follow-up contacts
        * At least 3 attempts should be made to make contact with the individual if the individual is not reached for a scheduled conversation
        * At a minimum in each follow-up contact, assess the individuals current well-being and suicide risk review and update safety plan as needed, coordinate care with other providers, and increase connection to needed services

6. Recommendations Regarding Community Partnerships
    a. Suicidal ideation increases after discharge from ED/Inpatient facilities, intervention is needed between discharge from ED/hospital and the first appointment with an outpatient provider
        *Greatest risk is one week post discharge and continues for months
        *Suicide rates post discharge are higher for individuals with a mental health diagnosis, not connected to a system of healthcare, and has been admitted for suicide related incident
    b. Partnerships with emergency departments and inpatient facilities
        * In an effort to address the high risk for suicide following discharge from an inpatient or emergency department setting

* Crisis centers have taking the lead on creating new partnerships to provide follow-up services with patients recently discharged

c. Other community partnerships to consider

*Mobile crisis services
* Law enforcement
* EMS/Paramedics
* Jail diversion programs
* 911 dispatch centers
*Domestic violence shelters
*Substance abuse service providers

VI. Technology

- Suzanne Rabideau, Health Management, discussed various technology that can be utilized for 988 and presented the video on Crisis Now-Transforming Crisis Services in Arizona.

1. National Call Center Best Practices from SAMHSA to Operate Regional Crisis Call Center
    a. Incorporate caller ID functioning
    b. Implement GPS-enabled technology in collaboration with partnering with crisis mobile teams to efficiently dispatch care to those in need
    c. Utilize real time regional bed registry technology to support efficient connection to needed resources
    d. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode

2. Current Technology Utilized in Mississippi
    a. Telecom-Avaya phone system
    b. Text/Chat-PureConnect with Vibrant
    c. Call center documentation system-iCarol

VI. Date and Time of Next Meeting

- THE NEXT MEETING WILL BE HELD ON TUESDAY JULY 13, 2021, at 10:00AM.