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Improving Access to Behavioral Healthcare Services: The Georgia Crisis & Access Line

David W. Covington

Behavioral Health Link and Georgia Crisis & Access Line
Atlanta, Georgia

Editor's Note. *This is the second in a recurring series of bulletins, from individual clinicians' perspectives, on research-informed accounts of day-to-day practice in various clinical settings.*

David W. Covington is CEO with Behavioral Health Link (BHL) and director of the Georgia Crisis & Access Line. He has served as vice-chair of the SAMHSA National Suicide Prevention Lifeline Steering Committee since 2005 and is a member of the Board of Directors of NAMI Georgia and the Georgia CIT Advisory Board, a collaborative of law enforcement officials, mental health professionals and advocacy groups. Mr. Covington is also a licensed professional counselor and has an MBA. Prior to joining BHL in 2002, he served as director of Public Sector Quality Improvement at APS Healthcare, Inc.

When Skinner is fond of saying, "Treatment works if you can get it." Ms. Skinner is the director of behavioral health for the Georgia Department of Human Resources (DHR). In 2005, her leadership team was grappling with a system with long delays and little quantifiable information about ease and speed of access. They believed dramatic improvements could result from a standardized single point of contact rather than the 25 different points of entry available at the time.

Like many areas of the country, Georgia had anecdotal reports of waiting times for mental health intake that ranged from 3 weeks to 3 months. Individuals calling directly from the community often faced a maze to reach the right agency contact; busy signals and lengthy hold times were commonplace. In 2003, the President's New Freedom Commission on Mental Health targeted access as a key area for improvement in removing the barriers of a fragmented and complex system. In addition, stigma can make picking up the "400-pound phone" to seek help nearly impossible.

The situation became more complex in 2005 when Hurricane Katrina displaced 120,000 individuals to Georgia from the Gulf Coast. According to Director Skinner, "DHR was totally unprepared to deal with this [tens of thousands needing trauma care] and had to respond quickly to meet their needs as well as meet the needs of Georgia's citizens." This disaster placed even more pressure on the state's emergency rooms (ERs), law enforcement, and overcrowded publicly funded inpatient hospitals.

These barriers to access to routine behavioral health care services result in the most costly and intensive services being easily overwhelmed. Unnecessary expenses are incurred by the system, and inappropriate placements result. In 2002, Malcolm Hugo et al. (in the *Australian and New Zealand Journal of Psychiatry*) studied the differences between community-based crisis intervention and services based in an ER. They suggested that those who are not assessed until they reach the ER are three times as likely to be admitted to psychiatric inpatient units

In early 2006, Georgia DHR set out to purchase a statewide toll-free crisis

and access line that would provide telephonic crisis intervention. They also wanted real-time data and reporting for strategic planning. Behavioral Health Link (BHL) was selected in a competitively bid process, and the project was launched on July 1, 2006, with a tagline of "A Crisis Has No Schedule." Since that beginning, the program has logged nearly 600,000 incoming calls, representing all 159 counties of the state.

BHL is a Georgia company whose core business of integrated crisis intervention coordinates brief screening, triage/referral, mobile crisis, and disaster outreach. The company has provided public-sector crisis services since 1998 and relocated to Atlanta in 2002. Fulton County and the city of Atlanta have had a psychiatric crisis emergency line continuously since 1966. BHL is proud to continue that tradition with the new statewide Georgia Crisis & Access Line (GCAL) contract.

Fifty years ago, Edwin Shneidman established the professionally staffed Los Angeles Suicide Prevention Crisis Center. He formed the American Association of Suicidology (AAS) in 1968 and became one of the nation's leading suicide researchers. In 1961, he identified 5 core goals, including partnerships with key community stakeholders, law enforcement, and ERs and improved access to care for those in crisis. He also called for tracking and reporting important data to inform practice and policy.

Public-sector crisis services proliferated throughout the country. These services were often provided by volunteers without professional training. They offered much-needed help for thousands, but Shneidman's vision of community connectedness and data tracking went unrealized. In 1999, Surgeon General David Satcher declared suicide a "public health problem." The federal government initiated a national network with the hotline 1-800-SUICIDE, and \$3 million in funding was provided to

AAS to manage over 100 crisis centers nationwide.

In 2004, significant research about public-sector crisis call services revealed individuals with very severe needs were calling and being helped. However, these studies uncovered a lack of consistency and reliability. A call to action ensued for professional orientation, standards, and guidelines for the industry, which has dramatically improved credibility. Key changes have occurred in the last decade that have changed the landscape, and crisis lines are increasingly recognized as essential partners in providing behavioral health care access and continuity of care.

This new trend of increased attention and funding for suicide prevention and crisis lines has continued and accelerated. In 2005, the National Suicide Prevention Lifeline (NSPL), in partnership with the National Association of State Mental Health Program Directors (NASMHPD), won the Substance Abuse and Mental Health Service Administration (SAMHSA) grant to administer the 800-273-TALK network and introduced significant additional research and technical resources. Also that same year, Congress made an amazing \$82 million available for suicide prevention under the Garrett Lee Smith Memorial Act. States, tribes, and universities received 3-year grants for additional programming. Senator Gordon Smith of Oregon lobbied successfully for this funding after his 22-year-old son ended his life in his college dormitory.

Of course, suicide is a significant problem among returning veterans. Last November, Congress passed the Joshua Omvig Suicide Prevention Act, which mandated a comprehensive Veterans Administration program. The act was named for a 22-year-old Army reservist who killed himself after returning from Iraq.

The Georgia Model

Georgia DHR was aware of this changing landscape and the increased credibility and positive impact of a crisis center's coordinating access to care. They developed a broad vision to significantly improve Georgia's system with GCAL.

GCAL is increasingly viewed by the public-sector crisis industry as a new generation of crisis centers. Geor-

gia DHR and BHL have partnered to pioneer an innovative system that is the only crisis and access line to operate statewide, 24 hrs a day, 7 days a week. To ensure consumer choice, it is operated by an organization that does not provide direct services. During a single phone call, a GCAL staff member conducts accurate screening to quickly assess callers' needs and risks and then makes real-time linkage to connect callers to routine or crisis services (including mobile crisis). Callers can be scheduled with an appointment date and time at one of hundreds of sites across the state. Utilizing flexible software to triage calls, identify treatment options, and make real-time linkage to community mental health center providers, GCAL removes key barriers to service access with significant cost savings.

Equally innovative is GCAL's "high-touch, high-tech, high-volume" approach. Staff work to create a quality personal interaction, actively engaging callers through empathic connection, offering choices, and using the least invasive intervention possible. This personal contact is supported by an interactive flexible suite of call center software applications that provide real-time "actionable intelligence" for staff to use during calls. The software facilitates effective triage and prioritizes the best, closest, and fastest providers. Electronic call center boards provide staff with immediate performance feedback and help track open calls and pending referrals.

With these innovations, GCAL's high call volume (> 1,000 calls on most business days) can be effectively managed without compromising its personalized approach. GCAL's innovations create unprecedented benefits for the public-sector crisis industry and Georgians who need help.

Benefits can be categorized as follows:

Increased accessibility. GCAL callers have round-the-clock access to crisis services and provider appointments. The service also includes hard-to-reach groups (5% from homeless individuals).

Improved service quality. GCAL exceeds national service standards, including an average speed of answer for all calls of less than 30 s and an abandonment rate under 4%.

Improved accountability. GCAL

provides decision makers with reliable, useful information capturing tens of millions of data elements, including demographics; mental health, addiction, and medical history; and lethality risk. GCAL synthesizes these massive data sets into powerful, easy-to-read-and-understand dashboard tools.

Cost control. GCAL saved over \$34.5 million in costs in 2 years by diverting callers to community-based services rather than having them inappropriately use ERs and state hospitals. Georgia is saving \$1.2 million per year with GCAL compared with the previous 25-line system.

The innovative service has garnered a significant amount of positive national attention. In September 2007, SAMHSA convened its first-ever national conference for crisis centers in New Orleans, with more than 130 agencies in attendance. GCAL was awarded the Crisis Center Award for Community Engagement. In December 2007, NASMHPD featured GCAL in its "Brag & Steal" segment of its annual winter meeting in Arizona. In 2008, NASMHPD released a position paper on suicide prevention with specific focus on including crisis centers in state strategies. In February 2008, the Commission on Accreditation of Rehabilitation Facilities selected GCAL from among its 5,000+ accredited agencies and spotlighted the program in its inaugural "Promising Practice" newsletter for behavioral health care programs. Most recently, the Council of State Governments issued GCAL the 2008 Innovation and Transferability Award.

However, at its core, GCAL is not about technology or innovation. It is about crisis intervention, a human interaction to engage those who need support. GCAL's clinical professionals have a passion for what can be achieved in these moments. When a person gathers the courage to pick up the "400-pound phone" and call, the GCAL worker gives respect and offers a genuine human touch, asking first, "How can we help? How can we work together?"

GCAL breaks new ground through its use of technology, imperceptible to the individuals in crisis making the calls but empowering the crisis workers with rich information, communication, and coaching, all at their fingertips.