CYBHWG Youth & Young Adult Continuum of Care (YYACC) subgroup

Friday, September 10, 2021
2:00 – 3:30 p.m.

Agenda Items	Notes
Introductions/Agenda review	**Rep. Lauren Davis, Rep. Carolyn Eslick, Michelle Karnath** (parent)**, & Lillian Williamson** (youth/young adults) • Quad leads, following the model of the Family Youth System Provider Round Table (FYSPRT).
Overview: YYACC mission and scope	**Rep. Lauren Davis** • 2nd year that this committee has met. • Everything from prevention through recovery support services • Youth/young adults to age 25, and families

2021 recommendations & legislation	*See page 5 for recommendation/legislation crosswalk.*
	• Expand youth mobile crisis services statewide.
	  Budget funded $38 million to expand adult and youth mobile crisis units.
	• Youth and family peer access, support, and workforce
	• Support: HB 1349 establishing licensed peer specialists
	  Recognition that half of our youth and more adults cannot access peer services because they have private insurance and they do not include peers in covered providers. Also peers can only bill under Medicaid if they are agency affiliated. Doesn't include EDs and other settings. Rep. Cody – sent back to DOH for a 2nd sunrise review. The primary criterion is if there is a risk to the public if they are not licensed (not updated since 1982). Working with Rep Cody on other strategies: certified, registered, licensed. Working with commercial providers.
	• Support: Care transitions from inpatient behavioral health and juvenile justice (SB 6560 work group)
	• Respite care for youth with behavioral health challenges
	  Respite has been an ongoing topic for the FYSPRTs since 2017. Until 2012, respite services were funded. Provide respite within communities to avoid hospitalization, long-term inpatient care, incarceration.
	Discussion
	• Mobile crisis – access to care standards in Medicaid, not in commercial world – as a result, youth with commercial insurers are accessing crisis units more frequently; OIC has regulations around access to service – Rep. Davis working with commercial carriers.
	• Crisis training for peers is tied to the expansion of youth mobile crisis services and 988 implementation.
	• The entire BH is in crisis; peers are the only area where there is a large prospective workforce; there have not been jobs for them.
	• Philanthropists (Balmer Group) funded the following:

	- FT position at HCA to move forward peer positions across the continuum for adult, youth and family peers, including for individuals with commercial insurance - Subsidize fees for several years for licensure/certification for peer specialists, if passed by the Legislature.
HCA updates: Implementation of 2021 legislation	**Youth mobile crisis services**, Liz Venuto *See page 6 for the documents that will provide the basis for standards development.* - Positions (2) for this work have been posted and applications have been reviewed. - Foundamental components for both the adult and youth system; 1 component – a family member/caregiver or individual defines the crisis, not a clinician.2. delivered in person, 3. Delivered in home, school or community setting, 4. Available within 60 minutes of contact; and with telephone support until in-person arrives. - Youth-serving model- Mobile Response and Stabilization Services - Standards will be incorporated in BH-ASO contracts and will follow the best practices in SAMHSA's crisis toolkit and MRSS. - All crisis teams will be trained in trauma informed care, de-escalation techniques, harm reduction. - Youth mobile crisis teams will require specialized training and expertise in order to provide developmentally appropriate services. **Discussion/Q&A** - Integration of all 3 of these recommendations is a fantastic model. How do you see the other elements coming together with the mobile crisis system. *A key goal of the MRSS model is linking with natural community supports. As we build out the programmatic pieces, we can see more of what this will look like.* - Respite might not be going to stay somewhere else. It can be a cooling down period, connections to activities/natural supports outside of the home, etc. - CORES is 8-12 weeks in King County. - Bring stakeholders together so we can learn what's been working that people are already doing. - How long can those positions work with a youth or family? Is there a necessity to have a time limit, or can it be open? (Issues with prevention when it's time-limited, so individuals and families are jumping from crisis to crisis.) *Those are questions we want to hear in the months to come as this is developed. Would be great to have you be part of those conversations as we're building out these teams. Time limits usually relate to billing.* **Peer-related legislation**, Maureen Bailey - Emotional support network for peers (2 year project): Going out for bid now for competitive procurement - Recruitment for peers, with a focus on BIPOC: Going out for bid now for competitive procurement - Getting feedback from stakeholders. - Have parents in advisory group – have very few for youth peers – invite youth to join the group.

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	- COPE Project Center of Parent Excellence – developed as a result of this group. Contractor: A Common Voice – longest standing family-run organization in Washington state – will provide one-on-one support to parents/family members with children and youth with intensive behavioral health needs. 4 specialist positions will cover all 10 regions statewide (2 hired, recruiting for the other 2). - Also providing biweekly support groups within each region. - Support groups for family peers throughout the state. - Assistance to WISe family/child team on request. Track concerns and barriers and communicate to regional FYSPRT and HCA. Chat: - Patty King - https://www.hca.wa.gov/about-hca/behavioral-health-recovery/center-parent-excellence-cope-project - MRSS – Mobile Response Stabalization Service **Respite care for youth and families**, Enos Mbajah - Work with actuaries to explore what other waivers are in place in Washington, as well as how other states have provided respite care. - Next step will be to develop a range of options and recommendations for changes in the state plan. - Process will be informed by those in the FYSPRTs and (other group?). - Contract should be in place soon. - Have funded a couple pilots for respite – Seattle YMCA and Excelsior – to date, they have served 100 youth and families. Not just out of home placement. Looking creatively at options that help youth and families stay together. **Chat:** - Totally support "relationship based support/respite"
2022 priorities	**Proposals that have come to YYACC leads** - Neuropsych eval proposal (FYSPRT) - Behavioral health parent portal (Healthy Minds and Futures) **Members' priorities** - Survey (Google doc) – Members' priorities for 2022

Attendees

Mo Bailey, Health Care Authority (HCA)
Rachel Burke, HCA
David Callahan, University of Washington (UW)
Diana Cockrell, HCA
Becky Daughtry, HCA
Representative Carolyn Eslick, Washington State Legislature
Avreayl Jacobson, King County Behavioral Health and Recovery Division
Charlotte Janovyak, Legislative staff
Kim Justice, Office of Homeless Youth
Michelle Karnath, Clark County Juvenile Court, Statewide FYSPRT tri-lead, Parent
Patty King, Division Behavioral Health Recovery
Annette Klinefelter, AKI
Enos Mbajah, HCA

Cammie Perretta, HCA
Barb Putnam, Department of Children, Youth and Families (DCYF)
Whitney Queral, Office of Juvenile Justice
Wendy Skarra, DCYF
Janice Schutz, Washington State Community Connectors
Representative My Linh Thai, Washington State Legislature
Jim Theofelis, NorthStar Advocates
Megan Veith, Building Changes
Liz Venuto, HCA
Cindi Wiek, HCA
Lillian Williamson, Youth/Young adult

2021 YYACC Recommendations and passed legislation

Recommendation	Legislation
Expand youth mobile crisis services statewide and ensure existing teams can meet the significant increase in demand exacerbated by the pandemic.	SB 5092 (budget), Sec. 215 (65): Funding provided solely for increasing local behavioral health mobile crisis response team capacity and ensuring each region has at least one adult and one children and youth mobile crisis team that is able to respond to calls coming into the 988 crisis hotline. (a) In prioritizing this funding, the health care authority shall assure that a minimum of six new children and youth mobile crisis teams are created and that there is one children and youth mobile crisis team in each region by the end of fiscal year 2022. (b) In implementing funding for adult and youth mobile crisis response teams, the authority must establish standards in contracts with managed care organizations and behavioral health administrative services organizations for the services provided by these teams.
• Expand the availability of youth and family peer services across the continuum of care, • Remove barriers to entry and improve retention of peers in the workforce, • Enhance diversity in the peer workforce, and • Ensure peers are supported in their own recovery and the secondary trauma they experience on the job.	SB 5092 (budget), Sec. 215 (53) $1,762,000 GF-Federal for maintaining and increasing resources for peer support programs and for HCA to contract with an organization to assist with the recruitment of individuals to work as behavioral health peers with a specific focus on black, indigenous, and people of color communities. (54) $250,000GF-Federal for HCA to provide crisis response training to behavioral health peer specialists. HCA must contract for the development of a specialized 40 hour crisis response training curriculum for behavioral health peer specialists and conduct a minimum of one statewide training session during fiscal year 2022 and one statewide training session during fiscal year 2023. The training shall focus on preparing behavioral health peer specialists to work with individuals in crisis, including providing peer services to emergency departments, as co-responders with law enforcement, and as part of mobile crisis teams. The training sessions must be offered free of charge and may be offered virtually or in person. (48) $500,000 GF-Federal to establish an emotional support network program for individuals employed as peer specialists. HCA must contract for these services which shall include, but not be limited to, facilitating support groups for peer specialists, support for the recovery journeys of the peer specialists themselves, and targeted support for the secondary trauma inherent in peer work.
Respite care for youth with behavioral health challenges.	SB 5092 (budget), Sec. 215 (82) $150,000 GF-State for HCA to evaluate options for a Medicaid waiver to provide respite care for youth with behavioral health challenges while avoiding adverse impacts with respite waivers at the DSHS Developmental Disabilities Administration and DCYF.

National Association of State Mental Health Program Directors
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Assessment #9

Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm

August 2020

Alexandria, Virginia

Ninth in a Series of Ten Briefs Addressing—Beyond Beds: Crisis Services

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Improving the Child and Adolescent Crisis System:
Shifting from a 9-1-1 to a 9-8-8 Paradigm

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Perhaps the most potent element of all, in an effective crisis service system, is relationships.
To be human. To be compassionate.
We know from experience that immediate access to help, hope and healing saves lives.

- SAMHSA 2020,
National Guidelines for Behavioral Health Crisis Care
Best Practice Toolkit

Background

The lack of a comprehensive coordinated crisis response system for children and youth has resulted in inconsistent care, repeated emergency department (ED) visits and hospitalization, and arrests and detention for youth whose crises are responded to by law enforcement rather than behavioral health providers [1] [2] [3]. SAMSHA has recently emphasized the importance of crisis services that are available to **anyone, anywhere, and any time**, and which do not lead to delays, detainment, or denial of services, or create undue burdens on those afflicted, or on EDs, law enforcement, or the justice system [4]. This vision is perhaps most critical for our youngest citizens, whose behavioral health challenges can often be prevented or identified early, yet are often neglected, at a high cost to society and to the quality of life of many children and families.

Behavioral health disorders are described as serious changes in the way children typically learn, behave, or handle their emotions, leading to distress and problems getting through the day.[5] The prevalence of chronic behavioral health disorders continues to grow among youth, doubling in the past decade, and impacting 20–25 percent of school-aged youth [6] [7]. In children aged 3-17, the most commonly diagnosed behavioral health conditions in children are anxiety (7.1%), ADHD (9.4%), disruptive behavior disorders (7.4%), and depression (3.2%); these conditions often are comorbid, and are more common among children impacted by poverty and other social determinants of health [8] [9]. Suicide is currently the second most common cause of death in young people (ages 10-24) in the United States, and suicide rates in youth have increased 56% over the past decade, with the greatest increases occurring since 2014.[10] People younger than 25 years of age account for 45% of the global burden of disease from behavioral health conditions.[11]

With the rise in behavioral health disorders, we have seen a parallel increase in behavioral health crises among children and adolescents in the United States [1]. These crises are typically addressed by engagement with EDs, law enforcement, or psychiatric inpatient care [2][3]. Children in crisis are frequently boarded for long periods in EDs or receive short inpatient stays, often resulting in readmission. Many concerns that result in hospitalization may have been prevented or better served via community-based care models with appropriate wraparound supports.

Challenges with the Current Child and Adolescent Crisis System

Limited prevention, early identification and intervention

Emotional and behavioral health challenges in children can often be prevented or diminished with early, immediate identification and action, yet our care systems often do not reflect this reality. The benefits of prevention and early intervention for physical health are now well-recognized. Routine screenings and checkups, and awareness of signs and symptoms that allow early detection and intervention, are increasingly implemented in pediatrics. Such routine screening and behavioral health checkups have lagged in child behavioral health,[12] with those under age 25 experiencing the greatest delay to initial treatment after initial symptom onset.[13] Currently, less than half of children with a behavioral health condition receive any behavioral health treatment,[14] resulting in estimated costs of approximately $247 billion annually from this lack of behavioral health treatment.[15] A number of factors, including persisting stigma and lack of providers, have slowed the emphasis of behavioral health early intervention, leading to much more costly downstream or late intervention, when behavioral health crises necessitate urgent, dense, and often lengthy interventions.[16] The World Health Organization recognized that addressing childhood adversities, particularly those associated with maladaptive family functioning, such as parental mental illness, child abuse and neglect, would lead to a 30% reduction of any lifetime mental disorder, and a 39% reduction in child mental disorders.[17] Moreover, these childhood risk factors and adversities contribute to children having further recurrence of mental disorders later in life.[18] Promoting early detection of behavioral health symptoms and implementing prevention and early intervention strategies that enhance children's emotional and behavioral regulation slows and alters the progression and impacts of child mental illness.

Misuse of Emergency Departments (EDs)

Pediatric behavioral health ED visits nationwide have increased dramatically across the United States in recent years. EDs are typically the first point of contact for children having any type of crisis. Despite its frequency of use, the ED has become an unattractive option to manage behavioral health crises for multiple reasons.[19] First, EDs have become overburdened with non-emergent, inappropriate behavioral health referrals. The ED has become a prime route for patients after hours, once clinics close, and at least one-third of these referrals are not truly urgent. Similarly, about half of the students sent by schools to the ED for behavioral health conditions are inappropriate (i.e., low severity of presenting complaint, low harm potential, absent suicidality or psychosis, and/or no recommended behavioral health follow-up).[20] Second, children with limited resources are routed to the ED amidst an escalation or conflict, yet rarely does ongoing behavioral health care result; children with public health insurance or no health insurance are four times more likely to seek mental health treatment at the ED than children with private insurance.[21] Third, ED staff are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis, despite most behavioral health crises arising from aggressive

outbursts or escalations.[22] Fourth, despite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises.[23] [24] So behavioral health crises routed to the ED more often result in subsequent ED visits, more testing, longer stays, and boarding for hours to days until transfer from the ED to a suitable placement can occur.[25]

Law Enforcement Involvement in Child Behavioral health Crises
As first responders, police are frequently accessed for behavioral health crises in children and families. Police are usually poorly prepared for managing behavioral health crises, and feel time pressured to deescalate situations quickly or to then employ more familiar policing strategies, which too often lead to arrest and detention. An adult with a behavioral health condition is six times more likely to get arrested than someone without a serious mental illness,[26] and 16 times more likely to get injured or die during encounters with the police.[27] Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder,[28] 60% of children with an emotional disturbance will be arrested at least once within 4 years after leaving high school, and 39% report being on probation or parole.[29] Most police academies devote less than 1% of training to interactions with adolescents,[30] yet 20% to 40% of juvenile arrests are for "contempt of cop" offenses, such as questioning or "disrespecting" an officer.[31] Incarceration of adolescents fails to decrease recidivism and compounds the negative impacts on the 60-70% of youth in correctional facilities who have significant untreated behavioral health problems.[32] [33]

Racism and Inequity
Despite many emotional and behavioral crises in children and youth resulting from unmet behavioral health needs, crisis events are often responded to with disciplinary or legal action, disproportionately affecting Black and Latinx/Hispanic students compared to White youth[34]. System challenges contribute to a preference for disciplinary versus behavioral health response, including implicit bias and racism among educators and health providers, and fewer behavioral health resources and instead greater law enforcement presence in communities of color [35]. In schools, where most ED referrals for child and adolescent crises arise, educators are usually inadequately trained to identify and address behavioral health concerns [36]. Further, "zero tolerance" policies remain common, despite evidence that they are counterproductive and disproportionately negatively impact youth of color [37]. Ultimately, when youth of color experience emotional and behavioral health crises, they are often met with education and health systems that favor a discipline response over a behavioral health response. In addition, inequities in behavioral health care access, utilization, and quality persist for children and adolescents [38]. Disparities are often attributed to challenges such as stigma, cost, and transportation, but also result from the systemic racism within our behavioral healthcare institutions that lead to limited access and poor quality of care for youth and families of color [38].

A paradigm shift
The challenges outlined above illuminate the need to reconfigure the behavioral health crisis system to better provide coordinated, specialized and equitable crisis prevention and intervention for all children and youth. In 2020, SAMHSA introduced national guidelines for behavioral health crisis care, calling for system transformation toward a more proactive, compassionate, efficient and effective system for those experiencing crises [4]. Core principles of the guidelines include addressing recovery needs, engaging peers, utilizing a trauma-informed and zero suicide

approach, and collaborative partnerships with law enforcement, dispatch and emergency medical services (EMS). While many of the principles and practices apply across the lifespan, some additions and adjustments must be considered for application with children and adolescents and their families. Fortunately, the core principles of the new national guidelines align well with System of Care principles that have been adopted and adapted by many state and local systems for children and adolescents, including family- and youth-driven care, cultural and linguistic competence, preference for community-based services, and interagency collaboration [39].

Multiple current conditions uniquely position us to establish a comprehensive, high-quality child and adolescent crisis system: (1) the 2020 introduction of SAMHSA behavioral health crisis practice guidelines; (2) the recent Federal Communications Commission (FCC) approval of the 9-8-8 behavioral health crisis hotline (to expand our existing 9-1-1 emergency response); and (3) a multitude of lessons and innovations from the global COVID-19 pandemic to inform crisis system transformation. In this brief, we offer best practice considerations for achieving a paradigm shift in our child and adolescent crisis system, away from a reactive and fragmented approach toward a full continuum of supports and services, built on the collaboration of child-serving systems and leveraging current technology. We will first highlight opportunities to "work upstream"; that is, to prevent crises before they occur and diminish them when they do arise by leveraging the natural support systems already available to children and families, including schools, pediatric primary care and community partners. We then outline child-specific considerations to augment the SAMHSA Crisis Best Practice Toolkit, with an emphasis on developmental attunement, youth and family engagement, and cultural responsiveness and equity. Finally, we derive policies from lessons learned in the context of COVID-19, including ways to harness and expand technology to augment care quality and access.
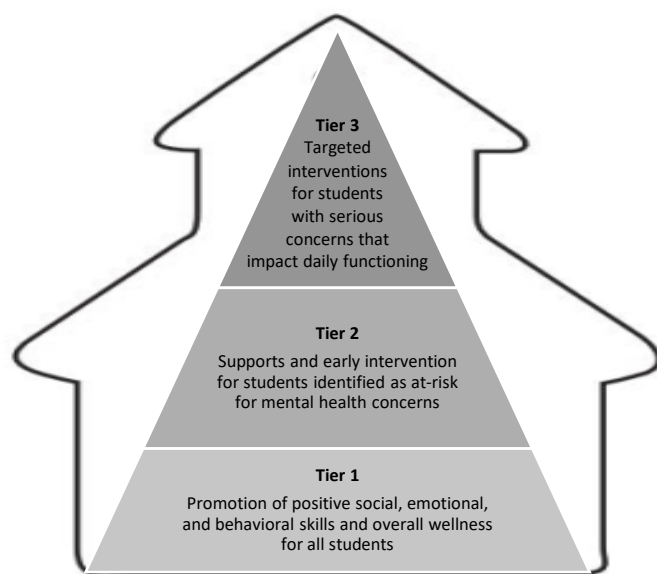
Working Upstream: Prevention and Early Intervention in Child and Adolescent Crisis

In a 2018 brief to the National Association of State Mental Health Program Directors (NASMHPD), states and communities were described as increasingly shifting delivery systems for children's behavioral health to an upstream approach that minimized unnecessary use of acute care settings, such as emergency departments, psychiatric hospitals, and residential treatment facilities.[40] The brief described the value of Mobile Crisis Response and Stabilization Services (MRSS) as an approach that identified problems early, before intensive psychiatric care (e.g., inpatient or residential treatment) were needed. Moving further upstream than the MRSS, other resources and interventions exist that may both prevent and intervene early to diminish children's emotional and behavioral health crises. Many mental illnesses that lead to behavioral health crises could have been identified and treated earlier in their trajectory, likely lessening the negative outcomes for children and families, including the experience of crises. Further, many of our youngest citizens, especially youth of color, experience disciplinary responses, such as juvenile services and incarceration, for behaviors that could have been prevented or best addressed with a behavioral health response [34][38]. This is a fundamental tenet in building a comprehensive behavioral health care system which cannot be overstated and should be a focus of every conversation regarding crisis response systems. Although we must address current failings in our current crisis response system for children, we should only do so while simultaneously building universal behavioral health promotion and early identification and intervention systems to minimize crises from occurring in the first place.

Schools

Increasingly, schools are installing *comprehensive school mental health systems (CSMHS)*, reflecting partnerships between education and behavioral health sectors to support a full continuum of behavioral health supports and services, from promotion to treatment [41]. CSMHS provide a full array of tiered services, often referred to as multi-tiered systems of support (MTSS; see Figure 1), including universal behavioral health promotion activities for all students, selective prevention activities for those most at risk to develop behavioral health conditions, and indicated early intervention services such as clinical assessment and treatment for those students who screen positive for behavioral health conditions. CSMHSs rely on meaningful partnerships between school systems and community programs so that children are supported by collaborative school-employed behavioral health professionals and community behavioral health providers.

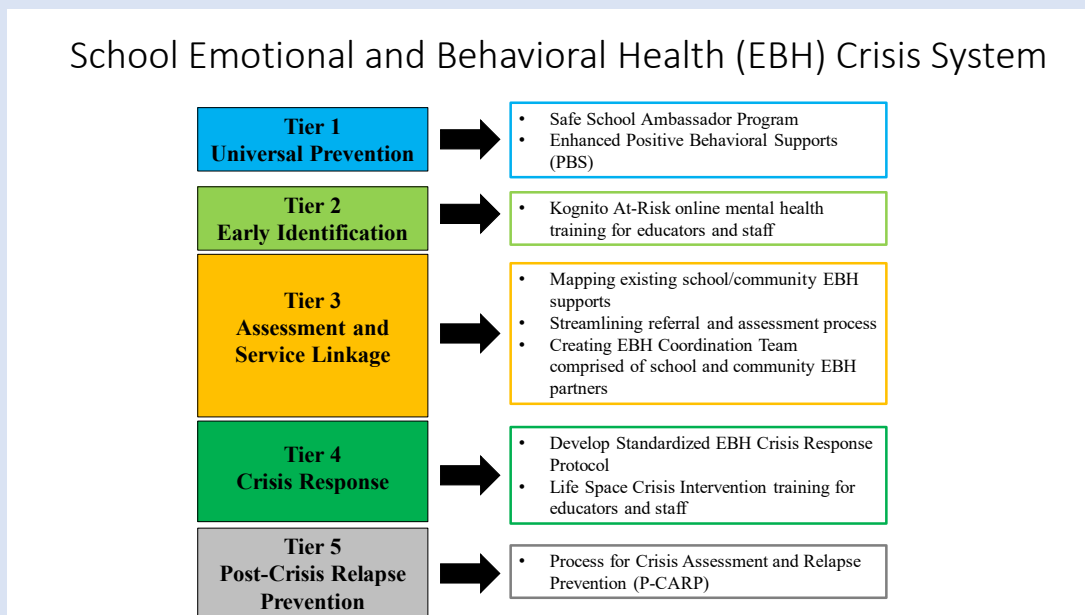**Figure 1. Multi-Tiered Systems of Support (MTSS) in Schools**

Tier 3
Targeted interventions for students with serious concerns that impact daily functioning

Tier 2
Supports and early intervention for students identified as at-risk for mental health concerns

Tier 1
Promotion of positive social, emotional, and behavioral skills and overall wellness for all students

When treatment is delivered in the school setting, youth are far more likely to be identified early, and to initiate and complete care [42] [43] [44]. Further, interventions delivered in schools have demonstrated positive impact on multiple of children's psychosocial outcomes. Schools across the nation are increasingly delivering universal programming, with students participating in social emotional learning (SEL) programs demonstrating significantly greater social-emotional skills (e.g., emotion regulation), prosocial behavior and positive self-image, and significantly fewer conduct problems, emotional distress and substance use problems than their peers who do not receive such programming [45] [46] [47] [48]. Behavioral health treatments delivered in schools have demonstrated success at reducing mental illness, including anxiety and depression [49] [50], post-traumatic stress [51] [52] [53], behavior disorders [54] [55], and substance use problems [56] [57].

An essential component of CSMHS is crisis prevention and response. The installation of a comprehensive MTSS has been demonstrated to reduce emotional and behavioral health crises [58]. Despite many emotional and behavioral crises in schools resulting from unmet behavioral health needs, crisis events too often lead to unnecessary disciplinary or legal action by schools, [59] which disproportionately affects Black and Latinx/Hispanic students compared to White students [60]. System challenges also contribute to disciplinary over behavioral health

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responses in schools, such as inadequate training of school staff to identify and address behavioral health concerns [61] [62], overburdened educators and inadequate student instructional support staffing, and limited response mechanisms to support behavioral health interventions relative to typically well-specified disciplinary procedures [63]. Successful school crisis prevention and response involves a comprehensive approach that installs a continuum of behavioral health supports and services, including universal focus on positive school climate and social emotional learning, behavioral health literacy for teachers and students, crisis preparedness for all school personnel, a focus on educator and school staff well-being, and availability of on-site school behavioral health providers, including both school- and community-employed professionals. Box

Box 1. The School Emotional and Behavioral Health (EBH) Crisis System was installed and studied as part of a randomized controlled trial (RCT) funded by the National Institute for Justice. As illustrated, at the universal level (Tier 1), the Safe Schools Ambassadors program offered peer training for students from various social groups in conflict management and bullying prevention. At Tier 2, an online virtual simulation technology trained teachers in how to support students experience psychological distress. In addition to creating clear referral, assessment and coordination of school and community behavioral health supports (Tier 3), all education staff received crisis response training using the Life Space Crisis Intervention program (Tier 4). Finally, a structured process was implemented for post-crisis response relapse prevention (Tier 5).

School Emotional and Behavioral Health (EBH) Crisis System

Tier	Components
Tier 1 **Universal Prevention**	• Safe School Ambassador Program • Enhanced Positive Behavioral Supports (PBS)
Tier 2 **Early Identification**	• Kognito At-Risk online mental health training for educators and staff
Tier 3 **Assessment and Service Linkage**	• Mapping existing school/community EBH supports • Streamlining referral and assessment process • Creating EBH Coordination Team comprised of school and community EBH partners
Tier 4 **Crisis Response**	• Develop Standardized EBH Crisis Response Protocol • Life Space Crisis Intervention training for educators and staff
Tier 5 **Post-Crisis Relapse Prevention**	• Process for Crisis Assessment and Relapse Prevention (P-CARP)

The system is now established as a "Promising Program," with the initial RCT demonstrating increases in school staff knowledge and preparedness to address emotional and behavioral health issues and increases in student actions and behaviors to prevent mistreatment and improve school climate. Intervention schools also had 56% fewer suspensions, 75% fewer office referrals, and more on-site crisis response and threat assessments as opposed to off-site referrals to EDs or law enforcement. For more information: https://www.crimesolutions.gov/ProgramDetails.aspx?ID=677&utm_source=govdelivery&utm_medium=email&utm_campaign=csreleases

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1 illustrates a comprehensive school-based crisis prevention and intervention initiative recently studied as part of the National Institute of Justice Comprehensive School Safety Program.

Pediatric Primary Care

Pediatricians remain a trusted and frequently accessed avenue for children and families to obtain behavioral health support. Over 70% of children and adolescents under age 18 see a primary care provider annually,[64] and parents and youth report feeling comfortable discussing behavioral health issues with their primary care providers.[65] [66] Pediatricians may be particularly helpful in apprising families of a 9-8-8 system as that emerges, and in providing families de-escalation approaches and behavioral health checkups during routine physical checkups. For more complex issues, collaboration and behavioral health support for pediatricians by behavioral health providers has emerged as an effective approach, with improved behavioral health outcomes for youth compared to usual care.[67] The elements most effective for collaborative care include population-based care (systematic efforts to screen or track all patients for a condition and track outcomes), measurement-based care (using validated tools to identify and monitor responses to treatment of particular behavioral health conditions), and evidence-based behavioral health services (specific psychological interventions such as motivational interviewing, problem-solving, psychotropic prescribing, psychoeducation).[68] A guide for initiating collaborative behavioral health care within pediatric primary care has been devised by the American Academy of Child and Adolescent Psychiatry and is freely available on their website (https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf).

Multiple approaches have improved infusion of behavioral health promotion and early intervention into contemporary pediatric care. First, *child psychiatry access programs* (CPAPs) are a "facilitated referral model," (coordinated care model) where pediatricians have rapid (within an hour) access to behavioral health providers located off-site, and who consult to pediatricians about mental conditions, including crises, but do not absorb the direct care of these patients. CPAPs have now been implemented in over 30 states in the past decade. The initial Massachusetts Child Psychiatry Access Program (MCPAP) has remained the model most states now emulate. Initial calls from the pediatrician are immediately triaged by a MCPAP care coordinator who either (a) provides the pediatrician viable behavioral health resources (e.g., a counselor appropriate for the child's condition, who is geographically feasible, and who takes the family's insurance), or (b) connects the pediatrician, within 60 minutes, to a MCPAP child psychiatrist, psychologist, or social worker to discuss the case and plan treatment. While the MCPAP behavioral health provider does not assume care of the child/family, they remain a consultation support for the pediatrician to manage the case, or until care is transitioned, if necessary, to a local behavioral health provider for ongoing treatment. Over 95% of Massachusetts pediatricians participate in the program, and satisfaction with services has remained high since creation of the program.[69] [70] There is now an existing national infrastructure, the National Network of Child Psychiatry Access Programs (NNCPAP) of now 30+ state programs, to support pediatric primary care physicians as they manage psychiatric issues of their patients.[71] These programs initially relied on remote calling centers, but now many include face to face evaluations patients with unclear diagnoses, and also telepsychiatry meetings with patients. In addition, most of these CPAP programs maintain active websites (e.g., www.mcpap.org, www.dcmap.org) with efforts to provide pediatricians effective screening tools for both general and specific behavioral health monitoring, and provide ongoing guides and

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recommendations to address common behavioral health concerns. These CPAP programs provide an alternative rapid route for children and families experiencing urgent behavioral health needs, and also an opportunity for mass distribution of relevant mental information (e.g., 9-8-8 information, de-escalation approaches for families) through the NNCPAP network that allows relevant information to be applied to specific regions or States.

Second, co-located models, in which behavioral health clinicians are housed in primary care settings to provide direct care and consultation provide another model where families can be more easily seen by a behavioral health clinician on-site (or virtually by telehealth) familiar and more easily accessible to the pediatrician. Data are promising for on-site co-located behavioral health providers, with reports that 85% of patients follow through to attend their first appointment, and 84% of patients report showing improvement over a 6-month interval.[72] Co-located providers appear effective in diverting patients from visits to the ED; over a six month period, embedded predoctoral psychology interns in one pediatric clinic were able to provide 184 "warm handoffs," 250 same-day behavioral health consultations, 223 follow-up appointments, and to manage onsite 21/23 (91%) patients who reported suicidal/homicidal ideation (and who otherwise would have been referred to the ED for further evaluation).[73]

Community Partners
Schools and primary care providers are parts of most communities and can serve a critical role in crisis prevention and response. Additional important partners for addressing behavioral health care are local community organizations, sometimes unique to the area. Identifying those community organizations that have aligned goals and interests is important for configuring a collaborative behavioral health system, including crisis prevention and response. Multiple types of organizations may enhance the collaborative care system for a community, such as:

- Mentorship programs (e.g., Big Brother/Big Sister)
- After school programs
- Recreation and parks programs
- Youth sports leagues
- Youth and family advocacy organizations
- Faith organizations, youth groups

To create a behavioral health crisis management system for children and adolescents, mapping the local resources to identify important partners can significantly expand local, familiar, trusted supports for both children and families who have experienced behavioral health crises.

Best Practice Considerations for Child and Adolescent Crisis Systems
Consistent with the premise described by SAMHSA that crisis services must be available to **anyone, anywhere, and anytime**, best practices indicate that a child and adolescent crisis continuum should be available 24/7 to all children, regardless of payer[74]. A comprehensive crisis continuum includes screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination. These components, articulated in the 2018 NASMHPD *Making the Case for a Comprehensive Children's Continuum of Care*, align with the 2020 SAMHSA practice guidelines for crisis behavioral health. The guidelines specify

three organizing categories of support that must be embedded in any comprehensive crisis system:

1) Regional Crisis Call Hub Services (*Someone to Talk To*)
2) Mobile Crisis Team Services (*Someone to Respond*)
3) Crisis Receiving and Stabilization Services (*A Place to Go*)

We will describe each component briefly, followed by considerations for how to best fit these to the child and adolescent system context.

Regional Crisis Call Hub Services (*Someone to Talk To*)
Regional crisis call services allow for real-time access to a live person 24/7/365 to support those experiencing behavioral health crises. As of July 2020, the FCC approved a national 9-8-8 behavioral health crisis number, to be fully installed by July 2022, that will increase access to immediate crisis support via this one easily recognized and remembered number. Minimally, regional crisis lines are staffed by clinicians with expertise in behavioral health crises and suicide risk assessment, and who are equipped to triage callers to appropriate mobile teams or facility-based care, as warranted. Best practices call for regional crisis services to have Caller ID functionality, utilize GPS-enabled technology to dispatch mobile care when needed, utilize real-time bed registry data to connect to facility-based care, and schedule community-based follow-up care akin to a warm handoff following the crisis episode.

To meet the needs of children and families in crisis, regional crisis call hub services should consider the following:

- **Expand technology options for callers**, including the use of texting, telephone and telehealth. Children and adolescents may prefer to seek crisis support via texting or videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing.
- Akin to how we begin teaching children about 9-1-1 in preschool, **educate children in preschool and throughout K-12 schooling about how to access regional crisis call services** (e.g., OK2SAY program, https://www.michigan.gov/ok2say/), preferably as part of behavioral health literacy education in the curriculum. Education should emphasize help-seeking efficacy and destigmatizing of mental illness and seeking support.
- All regional center calls pertaining to child and adolescent concerns should be staffed by individuals with **specialized training in child and adolescent development and behavioral health and illness**. This would include an understanding of typical developmental milestones, how to promote positive behavioral health, and how to distinguish typical challenging behaviors of childhood and adolescents from behaviors that reflect a more serious concern. They should be familiar with child behavioral health and developmental disorders and behaviors or symptoms that differ from those experienced by adults, including autism, sensory processing disorders, developmental delays, separation anxiety, and Attention Deficit Hyperactivity Disorder. See Table 1 for examples of common behavioral health concerns among children and adolescents and how they might be presented during a crisis call.

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- Call center staff should have **skills to navigate family systems** during crisis call, including how to diminish conflict and increase safety, engage additional support people, and determine whether speaking with the child or adolescent in crisis will be useful for information gathering and de-escalation. These skills would include how to best engage families as co-supporters and experts about their child, when possible, and addressing any parent/guardian concerns about child safety, including family concerns about being reported to protective services or law enforcement if they seek help.
- Call centers should have **developmentally attuned guidance for de-escalating children and adolescents** and their family members, as needed. This may include how to support family and school personnel in managing conflict and behavior dysregulation, and how to separate, support, and/or distract a child experiencing a crisis.
- All calls should be delivered in a **culturally responsive manner**, with call center staff receiving ongoing training on racism and bias, and the unique strengths and needs of Black, Indigenous and People of Color (BIPOC) youth and families, and how those intersect with behavioral health crises. Interpretation services should be made available to the extent possible (see Pinals, Edwards, 2020)[75].
- Call center staff should have training in **adolescent reactivity to peer rejection or romantic breakups**, both predictors of suicidality and risk behavior.
- Given the high risk for suicide, bullying, substance use and other behavioral health concerns among **LGBTQ+ children and adolescents**, call center staff need to be versed in supports responsive to this population.
- Call center staff need to be **familiar with school-specific concerns** such as chronic absenteeism or school refusal, aggression and bullying (including cyberbullying) in schools, and emotional and behavior dysregulation that disrupts the school environment, and how these may best be managed in the school setting.
- Call center staff should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Developmental Differences Manifest Differently in Youth
Approximately 75% of behavioral health conditions begin before adulthood. Crisis responders need to be aware of how youth may describe symptoms compared to adults. For example, young children rarely describe being "anxious" or "depressed," but may instead complain of physical ailments, often week after week, as they may only notice that they feel badly rather than understand why. Youth with depression are often more likely to report feeling angry or irritable than to report feeling depressed or sad, and may stop doing previously enjoyable activities (e.g., riding a bike, playing a sport, etc.) when they become depressed.

In addition, some behavioral health symptoms more commonly occur in youth, and result in crises, such that crisis responders require specific child behavioral health training to be prepared to recognize underlying conditions that may result in a behavioral health crisis. Table 1 describes how parents/guardians may describe a current crisis to a 9-8-8 phone responder.

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Table 1: Behavioral health Symptoms Presenting as a Crisis in Youth

Behavioral health Category	How This May Present as a Crisis Call to a 9-8-8 Phone Responder "My Child:"
Autism	"doesn't speak or look at me or seem to want to engage." "won't listen or respond to me." "freaks out if we don't do our usual schedule or change our plans" "doesn't play or show any interest in other children." "freaks out over normal noises." "does weird stuff with toys instead of playing with them." "just wants to swing or rock for hours and won't stop."
Anxiety	"won't go outside, worries about everything." "won't be apart from me, wants to know where I am." "describes having bad dreams every night and comes to my room."
Attention Deficit Hyperactivity	"doesn't think before doing dangerous, foolish things." "refuses to listen to me and do what I ask." "runs into the street or jumps off high places."
Communication Disorders	"is making stuttering sounds." "got into another fight with a peer today because of misunderstanding."
Conduct	"is stealing/shoplifting/vandalizing, assaulting others." "is lying and I can't take it anymore." "is staying out late, disobeying my rules." "is hiding guns/knives/bullets in room." "hurt our family pet/set a fire for no reason."
Disruptive Mood Dysregulation	"is having horrible meltdowns over nothing every other day." "is in a bad mood all the time and can't calm down for hours."
Elimination Disorders	"is peeing all over the place; keeps wetting the bed after told not to." "is leaving poop under the couch; won't clean self after pooping."
Feeding and Eating Disorders	"will only eat a few things." "eats weird stuff—like dirt or hair" "refuses to eat because they'll get too fat." "will eat but then do things so they'll throw up."
Intellectual Disability	"isn't doing or keeping up with schoolwork." "isn't doing what other kids their age."
Learning Disorder	"hates school and refuses to do math/reading/writing assignments."
Movement Disorder	"is making weird movements with arms/legs/mouth/head." "is suddenly now blinking all the time/making weird noises uncontrollably."
Obsessive-Compulsive Disorders	"does this long ritual before they will leave home and freaks out if interrupted." "has pulled all their hair out over the weekend." "has hoarded all kinds of food into a closet, and it's all rotting now."
Somatic Disorder	"keeps saying they have a stomach/headache, refuses to walk." "is very sick, eyes rolling back in their head, and no one believes me."
Traumatic Disorder	"won't stay with a sibling alone at night in a room." "keeps avoiding my relative, who they used to like." "has bad dreams often and will scream or come to my room."

Mobile Crisis Team Services (*Someone to Respond*)

To respond to crises as they occur, mobile crisis teams that offer community-based interventions must be available to support individuals in crisis wherever they are, including home, school, or any other community location. Two-person teams are preferred, with diversion from emergency department or the justice system preferred. Minimally, mobile crisis team services must include a licensed and/or credentialed clinician who can respond wherever and whenever a crisis occurs. This can include home, stores, schools, offices, streets, and even juvenile courts outside of a locked facility in some states. The team will conduct warm hand-offs to facility-based care as needed and coordinate transportation if the situation warrants location transition. Best practices call for peer support (i.e., those with direct experience with the behavioral health system and who are trained to support individuals in crisis) as part of the mobile crisis team to decrease engagement of law enforcement. As above, mobile crisis teams should partner with the regional crisis call center to utilize GPS-enabled technology.

To meet the needs of children and families in crisis, mobile crisis team services should consider the following:

- **Expand technology options for crisis response teams, including the use of telehealth**. Children and adolescents may prefer to engage in crisis support via videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing. In addition, telehealth may allow for broader access and improved response time and efficiency.
- For all crises pertaining to child and adolescent concerns, mobile crisis team members should be staffed by individuals with **specialized training** (as outlined above for call responders) including training in:
  - child and adolescent development and behavioral health and illness, including manifestations of child traumatic stress (e.g., difficulties at school, withdrawal);
  - skills to navigate family systems, including how to diminish conflict and increase safety, engage additional support people, and how to best engage child and family in a developmentally appropriate manner to gather information and de-escalate crisis;
  - the escalation cycle across the developmental spectrum, and developmentally attuned de-escalation skills, including approaches like collaborative problem solving and specific strategies (e.g., validate feelings but not actions; see Box 2 for specific child-specific de-escalation strategies from The Crisis Prevention Institute, https://www.crisisprevention.com/).
  - culturally responsive crisis management, including skills in supporting the unique strengths and needs of BIPOC and LGBTQ+ youth and families;
  - assessing for child abuse, neglect and family violence and supporting families if a report to child protective services is warranted;
  - assessing parent readiness and ability to implement recommendations and interventions, with consideration for parental behavioral health, cognitive ability, social supports and stressors and economic resources.
- Mobile crisis team members responding to child and adolescent crises should be **familiar with school-specific concerns and school procedures to support students with emotional and behavioral needs.** Team members should be versed in the special

education process, including how families can access and advocate for special education programming (e.g., 504 Plans and Individualized Education Programs).

- Mobile crisis team members should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Box 2. 18 De-escalation Strategies for Children and Adolescents
1. Don't yell to be heard over a screaming child
2. Avoid making demands
3. Validate their feelings, not actions
4. Don't try to reason
5. Be aware of your body language
6. Respect personal space
7. Get on child's level
8. Use a distraction
9. Acknowledge child's right for refusal
10. Reflective listening
11. Silence
12. Be non-judgmental
13. Answer questions and ignore verbal aggression
14. Movement break
15. Avoid the word "no"
16. Decrease stimulation
17. Deep breathing exercises
18. Calming visuals

Crisis Receiving and Stabilization Services (*A Place to Go*)

During a crisis, it is essential that individuals have a place to go that will accept, support and stabilize them regardless of age or clinical condition. Crisis receiving and stabilization services act as a "no wrong door" mechanism for those in crisis to receive immediate behavioral health support and offer our de-facto crisis responders (i.e., law enforcement, emergency departments) a more appropriate alternative to address crisis. Minimally, crisis receiving and stabilization services accept all referrals (including walk-in and first responder drop-offs), do not require medical clearance prior to admission (but offer medical support, as needed), design services to address mental health and substance use needs, offer 24/7/265 multidisciplinary staffing capable of meeting all levels of crisis and screening for suicide and violence risk, when clinically indicated. Best practices dictate functioning for a 24 hour or less facility with a dedicated first responder drop-off area, incorporation of intensive support beds (including those within the real-time bed registry system), and coordinate connection to ongoing care.

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To meet the needs of children and families in crisis, crisis receiving and stabilization services should consider the following:

- Children and adolescents should have **a separate area from adults** to be received and supported during crisis. It can be distressing and frightening to young people to witness adults in crisis, increasing the likelihood that the child's crisis will escalate rather than diminish. The climate of receiving and stabilization needs to be calming, positive, welcoming and compassionate.
- **Receiving spaces should be developmentally attuned**, with places to play and move safely, especially for younger children. For adolescents, who may be particularly concerned about the stigma of seeking help, spaces that allow privacy are optimal. The environment should be calming aesthetically and include art and signage that is appealing and friendly to youth, and not overstimulating.
- **Telehealth should be available for care provision and engagement of supportive others.** Children and adolescents in crisis may prefer to see providers via videoconferencing, also expanding the capacity for access to limited child behavioral health specialists. Telehealth technologies can be used to integrate other support important in the care process, including school personnel, family members, peers, or primary care providers.
- For all crises pertaining to child and adolescent concerns, crisis receiving and stabilization services should be staffed by individuals with **specialized training** in child and adolescent development and behavioral health (as outlined above for call responders and mobile crisis teams).
- **Medical staff must have training in child and adolescent health** to ensure developmentally appropriate, high-quality medical care, as needed. If pediatric or child psychiatric providers cannot be available on-site, telehealth may be utilized as a mechanism to ensure 24/7/265 pediatrician and child psychiatry consultation.
- Crisis receiving and stabilization services must have **spaces for family support and gathering**, both to immediately support the child in crisis and to provide a space for separation and parental/guardian support, as needed. Families should be offered comfortable places to stay with children, including places for rest for young children, access to snacks and developmentally attuned activities.

Three vignettes are provided in **Appendix A** that describe example circumstances with varied system responses during child and adolescent crisis situations. These represent a small sampling of the crisis situations that present during childhood and adolescence but are illustrative of the unique considerations that arise during each stage of crisis response, from call to stabilization.

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Examples and Outcomes of Child and Adolescent Crisis Response Systems
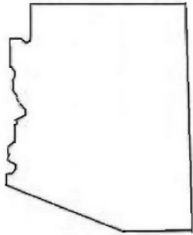
Arizona: Crisis Response Center (CRC)

In 2006, county bond funds supported the development of the Banner-University Medicine Crisis Response Center (CRC), serving adults and children in Pima County, Arizona. The CRC was initiated to provide support to those in need of urgent psychiatric care and to reduce the number of individuals with behavioral health needs in emergency departments or the criminal justice system. In addition to a 24/7 Behavioral Health Crisis Line that can dispatch GPS-tracked mobile crisis teams and manages an electronic bed placement board, the CRC offers a peer-operated warm-line staffed by trained peers who, as described on their website, "provide a friendly voice, support and help to alleviate loneliness and isolation."[76] They also offer a Tribal warm line, supported by the American Indian Support Service. The CRC serves approximately 12,000 adults and 2,200 children annually, with 45% brought directly by law enforcement via a secure gated sally-port and 10% are transported from emergency departments. Adults and children are served in distinct, separately licensed areas of the facility. The CRC is connected to a Level II trauma emergency room, a 66-bed Behavioral Health Pavilion, and the mental health court. Between 2015-2019, the CRC had an 8% increase in adult visits and a 24% increase in youth visits. Increasing numbers may reflect growing awareness of the service, including among law enforcement who now have a more sophisticated option than waiting hours in an emergency department, and may also reflect the limited options to prevent crises before they occur.

Connecticut: Mobile Crisis Intervention Services

Connecticut's Mobile Crisis Intervention Services (formerly called EMPS) is available at no cost to all youth in the state under age 18. A single statewide call center, currently accessed by dialing 2-1-1, deploys providers to the crisis location. The providers are comprised of 160 trained behavioral health professionals from 14 different sites, allowing for on-site response within 45 minutes of when a child experiencing a behavioral health need or crisis. Mobile Crisis provides ongoing care to youth and families for up to 45 days to offer stabilization and linkages to ongoing behavioral health support.
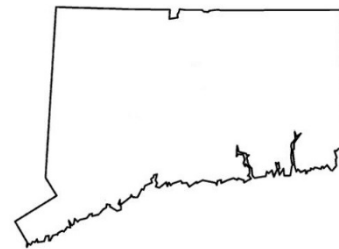
Since data collection began in 2011, the number of Mobile Crisis response episodes of care increased by 54%, with 14,585 episodes in 2018 alone. For two consecutive years, schools have provided the greatest proportion of referrals to Mobile Crisis (44.3% in 2018). Schools often use Mobile Crisis as an alternative to transporting a child to the Emergency Department or contacting law enforcement. A recent study demonstrated that over a period of 18 months, youth using Mobile Crisis had 25% lower emergency department use than a comparable group[77]. Most (88%) of parents or guardians report satisfaction with Mobile Crisis and 2018 data demonstrate significant decrease in problem severity and increase in functioning among youth who received Mobile Crisis[78]. Evaluation of Mobile Crisis has demonstrated significant cost savings, with the

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average cost of an inpatient stay for Medicaid-enrolled children and youth being $13,320, while the cost of Mobile Crisis was $1,000, saving $12,320 per youth[79].
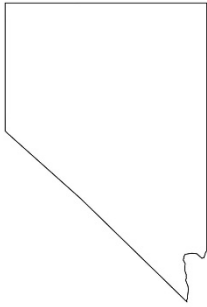
Nevada: Children's Mobile Crisis Response System Rural Team
In November 2016, the Rural Mobile Crisis Response (RMCRT) team of Nevada began taking calls. By September 2017, the RMCRT had served 243 youth and families across Rural Nevada; 86 percent of youth were successfully diverted from the hospital. Initially funded for three years through the State's Division of Child and Family Services, the Department of Public and Behavioral Health Rural Clinics received a budget enhancement during the 2019 legislative session to grant continued funding through Fund for a Healthy Nevada (allocated from tobacco settlement monies to help with services that address the health and well-being of all Nevadans). Call volume has increased in recent years, and in 2017, the RMCRT reported a Hospital Diversion Rate of 86%. The rural team intends to expand coverage using telehealth and has already equipped many of its rural schools, hospitals and Juvenile Detention Centers with the telehealth program the RMCRT uses for interventions, allowing for more efficient crisis response.

Crisis Lessons and Innovations from COVID-19

COVID-19 has disrupted the delivery of behavioral health care across the globe. Data also points to an anticipated surge in behavioral health care needs related to the pandemic, including for children and adolescents who are suffering the burdens of family financial insecurity, caregiving load, and social isolation during a time of limited access to supports [80] [81]. Past pandemics, such as the Influenza of 1918, 2009 H1N1 flu, and the 2014 Ebola virus all were associated with increases in depression, anxiety, stigma, and shaming.[82] Longitudinal negative impacts of other large-scale community crises (e.g., natural disasters) on children's behavioral health and academic functioning have also been well documented [83] [84]. These tragic events, though, also led to significant transformations in behavioral health care.[85] There are many lessons and innovations from the global response to COVID-19 that can guide us as we reconstruct our children's crisis system.

1. **COVID-19 has further illuminated disparate inequities in our health, education and economic systems and the resulting toll on youth behavioral health.** COVID-19 has disproportionately impacted non-White racial and ethnic groups [86] [87] [88]. Social determinants of health, including systemic racism, poverty, and inequitable access and quality of healthcare and education, have historically prevented BIPOC individuals from having equal economic, physical and behavioral health. Children suffer the same disparities, which during and following crises are compounded by their limited ability to independently mobilize resources and supports to buffer the negative impacts [89]. COVID-19 is expected to worsen the inequities in health outcomes for those living in poverty and in resource-poor rural communities across the United States [90].The disparate increases in unemployment and economic burden from COVID-19 in poor regions and in communities of color alone will be detrimental to children's mental health. Golberstein and colleagues found a striking 35% to 50% increase in "clinically meaningful childhood mental-health problems" during a 5-percent-age-point increase in national unemployment

during the Great Recession (2007 to 2009) [91]. Given unemployment rates of over 11% in August 2020 compared to less than 4% in January 2020, and that the increase is in the context of a health crisis and school closures, the mental health impact on children is likely to be even more severe than past trends, particularly in communities that are harder hit. In addition to greater density of family and community members inflicted with COVID-19 in communities of color, resulting in greater behavioral health consequences, youth of color are much less likely to have access to behavioral health support and at greater odds of receiving poor quality behavioral health care [92]. Children living in rural areas are also more likely to have more negative COVID-19-related health outcomes and limited accessibility, availability and acceptability of behavioral health services [90] [93].

The profound inequities highlighted during COVID-19 have implications for how we build crisis response systems for children. Namely, children's behavioral health crises must be viewed within the context of the child's family and neighborhood/community and influenced by social and environmental factors. As such, these factors must be both assessed and addressed during crisis response, rather than simply focusing on the individual child or attributing crisis behaviors to individual psychopathology that can be treated at the child level [94]. In addition to assessing for and addressing social determinants of health during crisis response with children and families, our systems must act as "health strategists," addressing the social determinants that contribute to the development of behavioral health crises in the first place [95]. Recognizing the anticipated long-lasting impacts of COVID-19 on marginalized communities, Shah and colleagues (2020) called for our public health departments to think beyond individual interventions and to foster cross-system partnerships, with public health departments in the lead, to develop broad social supports (e.g., financial assistance, microloan programs) to assist those most vulnerable [90]. So too must our children's behavioral health systems consider the broader interventions that may prevent and address crises by integrating supports for accessible and culturally responsive healthcare, food, housing and educational support.

2. **EDs are not suited for youth mental health or substance use crises, and broad community awareness campaigns and education can route children and families to more appropriate avenues for support .** Many families with children experiencing significant psychological deterioration in the context of COVID fear increased exposure risk by going to the ED. This has further highlighted the need for creating more appropriate places for children in crisis to go and has resulted in public awareness efforts to triage families to other community-based settings, including telehealth options. This type of re-routing of families from the default of the ED as the first point of entry during a crisis can be facilitated by the establishment of the 9-8-8 crisis line. However, the 9-8-8 system alone will not be sufficient to alter families' patterns of service utilization. Awareness campaigns can direct youth and families to trusted internet and social media sites as escalating events and crises do arise, providing de-escalation and help-seeking information and encouraging more appropriate pathways to support and care. During COVID-19, the Centers for Disease Control, the World Health Organization, and other health organizations regularly provide updates and guidance across multiple social media platforms, and these platforms similarly reciprocate by routing those seeking new, more specific information to the CDC and WHO sites,[96] and this similarly should be

envisioned and configured with appropriate behavioral health crises sites. In addition, public health information to address behavioral health crises (e.g, the 9-8-8 number, noticing if others are struggling, de-escalation techniques) can be added to existing user platforms, including through banners, pop-ups, and other such tools to directly message users about preferred approaches for managing behavioral health difficulties. This may include chatbots for basic psychological first aid and geotargeted sites for crisis services based on one's location.[97]

3. **The rise in risk coupled by a decrease in reporting of child abuse and neglect during COVID-19 highlighted the need for accessible mechanisms for youth and families to directly access crisis support.** Many children during COVID-19 are at increased risk of abuse, neglect and exposure to family violence.[98] Calls to protective services have decreased during stay-at-home orders, likely due to schools being closed and traditional monitoring systems not being intact [99]. By providing children and families with an accessible way to get help when they are in distress (e.g., by educating them about 9-8-8 and supports that are youth- and family-centered), exposure to adverse childhood experiences may be reduced or prevented. Further, youth and families will benefit from behavioral health literacy efforts that educate them about how to obtain and sustain positive mental health, recognize and seek help for mental health problems, and identify and support others experiencing mental distress. Recognizing the tremendous burden on families during COVID and the increased risk of child abuse and neglect, many organizations have mobilized to provide education and support to families to reduce risk. For example, the Child Mind Institute (https://childmind.org/coping-during-covid-19-resources-for-parents/), a national nonprofit, offers online learning, outreach, and resource support to families including tips for parent self-care, strategies for remote learning and discipline, skills for responding to children's mental health needs. Even prior to COVID-19, behavioral health literacy efforts for children and adolescents were increasingly implemented via school curricula, with several states (e.g., Florida, New York, Virginia) recently mandating the inclusion of mental health literacy in schools. For example, New York schools are required to integrate four key mental health literacy components into students' education [100]: 1) Understanding how to obtain and maintain good mental health; 2) Decreasing stigma related to mental health; 3) Enhancing help-seeking efficacy (knowing when, where, and how to obtain good health with skills to promote self-care); and 4) Understanding mental disorders (*i.e.,* anxiety and depression) and treatments.

4. **Telehealth services are needed, feasible, and often preferred by youth and families.** The paradigm shift in children's behavioral health crisis systems calls for significant expansion of telehealth technology. During COVID-19, behavioral health systems witnessed a dramatic increase in the utilization of telehealth to support the behavioral health needs of children and families. This occurred with federal, state and local infrastructure support, policy adjustments to ease use, and technical assistance and training to providers and consumers [101] [102]. A transformation of our children's crisis system toward robust telehealth capacity will require continued infrastructure improvements (e.g., enhanced broadband systems, up-to-date telehealth delivery equipment, internet connectivity services for providers and consumers); policy expansion

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(e.g., reimbursement parity for telehealth, expanded access of Medicaid and Children's Health Insurance telehealth programs); and ongoing guidance and support to providers and families to increase adoption and facility of telehealth services [80] [103]. Policy must move toward parity such that state parity laws guarantee comparable payment for telehealth at the same rate as in-person services (i.e., reimbursement parity). Prior to COVID-19, only five states had implemented telehealth parity laws, and while 21 states expanded telehealth services during COVID-19, only 13 required parity. We must continue to evolve in this area and consider how to best integrate telehealth at all levels of the crisis system. As demonstrated during rapid adoption of telemental health during COVID-19, funding must be dedicated to both clinician and user training and to improving the infrastructure (e.g., hardware, software, internet access) necessary for successful telemental health practices [103].

During COVID-19 and beyond, child and adolescent mental health services traditionally provided in-person, including crisis services, may be shifted to telehealth, allowing youth and families to access support while minimizing health risks and other burdens of in-person care. As illustrated in Box 3, telehealth has already improved crisis response efficiency and outcomes for children and youth [104]. It is important to recognize that rapid shifts to telehealth may inadvertently increase health disparities, as people with less income may not have consistent access to the internet or devices. Increasing access to the internet, ensuring that resources are accessible to individuals with disabilities, and providing free or low-cost devices may help to address this problem. Further, given that so many children and families access behavioral health services through schools, it will be essential for school-based behavioral health providers to become facile with and be supported to use telehealth services

> **Box 3.** To address the absence of child and adolescent behavioral health specialists in EDs, the Children's Hospital of Colorado used telepsychiatry to link the specialists at its central academic medical center to pediatric EDs and urgent care centers in the Denver area. The goal was to improve care and decrease patient transfers to the main campus. Children and youth who received the telehealth consultations, when compared with those receiving usual care, had ED lengths of stay that were 2.8 hours shorter, patient charges for care that were more than 40% lower, and higher satisfaction with services among ED providers and the patients' caregivers.

5. **COVID-19 has illuminated the need for flexibility and innovation to provide effective care amidst different public health parameters.** Across all tiers of support, from universal mental health promotion to treatment for mental illness, behavioral health supports have been adapted to meeting the changing landscape of mental health needs resulting from the pandemic and its sequalae and to conform to the necessary adjustments in service delivery. The innovations in behavioral healthcare during COVID-19 point to the importance of a nimble system during community crises, and to the importance of crisis systems being similarly equipped to adjust as needed to changing public health parameters. For example, at the universal (Tier 1) level, addressing prolonged loneliness

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experienced during COVID-19, a risk factor for multiple behavioral health conditions, requires that not only everyone retain some contact virtually with others (e.g., school, peer activity networks), but also that teachers, coaches, mentors, and other supportive adults directly reach out to young people weekly, as employers are now being encouraged to do with each worker. [105] Video and voice interactions will be needed, particularly for children often too young to shift to a more written or texting type intervention. At the selective intervention (Tier 2) level, the lack of direct contact and access will require modifications in screening and responding to early signs of distress. Nontraditional groups (e.g., parenting groups, teachers/school staff, community organization members) may be provided familiarity with a simplified version of psychological first aid and specific questions or approaches to check in with children, which historically may have been done with a more standardized program designed for more highly trained clinicians (but now insufficient or inaccessible) At the intensive intervention (Tier 3) level, different counseling models will be better suited to evolving public health circumstances; for example, written counseling has been described as effective to address needs for those who may not have access to telehealth equipment or resources[106]. Novel approaches mindful of new public health constraints (e.g., changes in shaking hands/greetings, going to an office) should be monitored for applicability to crisis management as well.

6. Finally, even with brick and mortar schools closed, **schools remain a hub for a full continuum of behavioral health supports for students and their families**. Of children in the United States who receive any behavioral health care, over half receive care at school, and this is even greater for youth of color or living in poverty. [107] During COVID-19, schools mobilized to continue supporting students' nutritional, educational and behavioral health needs. While rates of community behavioral health access dipped during COVID-19, school support personnel and school-based mental health clinicians continued to provide needed behavioral health support, often via telemental health. Our children's behavioral health system should leverage schools as a place to support social emotional health, and to practice early identification and intervention, including crisis response. Parallels from Hurricane Katrina to COVID-19 also illuminate the need to ensure that beyond the supports for students and families, our behavioral health and education systems must attend to the ongoing needs of educators and other school staff as they work to support students' behavioral health.[108] Guidance from the Centers for Medicare and Medicaid Services and SAMHSA offers states ideas and examples for how state Medicaid programs can increase and improve school mental health service delivery and several states and local communities have leveraged school-community partnerships to improve children's behavioral health systems. [109] [41]

Conclusion
The stage is set to reimagine the child and youth crisis prevention and response system given the limitations of the existing system, burgeoning innovations in youth mental health, and lessons learned amidst the current global pandemic and increased attention to longstanding social injustices. As community behavioral health crisis policies and practices are established, the unique needs of children and families must be considered across the developmental spectrum and across communities and cultures, always addressing issues of equity and racism. The vision must include promotion, prevention, early identification and intervention available through natural

supports like schools, primary care, and other community partners (e.g., afterschool programming, faith organizations) and through expanded technologies, including telehealth. The opportunity to shift the paradigm for how we build and implement children's crisis response systems is within our reach and will require thoughtful leadership and advocacy, significant policy and financing support, and active engagement of youth and families to shape the supports they will receive.

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Appendix A: Vignettes

The roles of the (a) Call Responder, (b) Mobile Crisis Team, and (c) Receiving and Stabilization Services are described below, and then applied to each vignette:

Call Responder: (1) **clarify safety**: is this new/unusual (possible poison ingestion), or abuse/trauma reaction; (2) **identify impacts** across multiple spheres of life: does the child do this everywhere, or only at home, around certain people (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **offer parent support/appropriate de-escalation strategies** (see Box 2); clarify if parent receptive to speaking with a behavioral health provider, if telehealth visit acceptable.

Mobile Crisis Team: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, both (a conflict between them), and/or other (e.g., school staff, peers); (2) **observe/speak** with the child to clarify potential behavioral health conditions that best explain behaviors; (3) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; and (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance, further evaluation (medical or behavioral health))

Receiving and Stabilization Services: (1) **seek to understand this unique family and youth's perspectives and their goals** to manage this event; (2) Clarify if **ongoing parent/child/family support services** are needed (e.g., speech therapy for social pragmatics, autism program at school); and (3) **identify where these services might best be provided** (considering feasibility and accessibility for family).

Angel is a 4yo, whose parent calls 9-8-8 reporting "my child refused to eat dinner tonight and started screaming uncontrollably. My child isn't like other kids and I'm scared; doesn't talk to anyone, just sits in a corner, no facial expression, and freaks out if touched or asked to eat anything other than uncooked macaroni. I think something is really wrong and I don't know what to do."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by distinguishing whether this circumstance is a new-onset, sudden deterioration (suggestive of poison intoxication, traumatic events, or an underlying medical condition) vs. an ongoing, worsening pattern (suggestive of autism spectrum or chronic trauma). The **CR** might further (2) **clarify impacts**, such as if these behaviors occur everywhere, all the time, with peers, family, and at preschool (suggestive of autism spectrum or general developmental or social skill delays) vs. only in certain settings and times, such as when visiting particular relatives (suggestive of trauma). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, which might be that the child is being treated differently than other children, that relatives have expressed concerns, or that the parent may be doing something to contribute to these behaviors; inquiry about the child may reveal whether the child is distressed by any of these behaviors, or instead preferring to be apart from others to do preferred activities. The **CR** may (4) **provide some immediate de-escalation** to this event by reviewing the history of these behaviors ("these are not new, but are now more concerning, so it seems you want someone more familiar with this to

partner with as you decide your next steps") and inquiring whether the family would like to speak with someone immediately about the behaviors Angel is displaying, including offering videoconferencing as an option for communication.

In Angel's crisis, the **Mobile Crisis Team (MCT)** uses telehealth technology to connect via videoconference (which the family preferred over an in-person visit) to (1) **elicit descriptions** from the parent about the evolution of these behaviors, who in the family seems most distressed or impacted by them; (2) **observe/speak** with the child to clarify potential behavioral health conditions (e.g., trauma, autism spectrum, anxiety and selective mutism) that best explain this child's unique constellation of behaviors; (3) **understand this unique family's perspectives and their goals** (parents might ask " Is this because we did something wrong?" "We don't know who can evaluate these symptoms to help us figure out what to do at home," or "Does Angel need a special school?" "What should we do right now about Angel only eating macaroni?") and (4) **clarify interventions needed now** to improve/resolve this crisis (e.g., parent support and guidance about trying some different types of food, engaging around activities/play to see if that increases interaction and communication, and partnering around the process to obtain further evaluation, medical or behavioral health, including potential fears (parents might ask "Will I get turned in to Child Protective Services or will Angel be taken away if we talk with someone?") or perceived obstacles ("I don't know what to do, or if I can do it; I don't have insurance to do any further evaluations, and they'll just blame me for all this…like they did before")). In this case, the **MCT** used videoconferencing to engage a pediatric specialist who could discuss some of the family's concerns and better assess Angel's behaviors. Angel and her family were routed by the **MCT** to a community-based assessment and intervention program with a pediatrician to clarify the diagnosis, to partner with the school to provide evaluation for additional needs (such as speech, occupational therapy, etc.) and to create a plan to be delivered through the preschool to address behaviors.

If Angel's behaviors continued to escalate or the family requested respite and immediate in-person support, the **MCT** may have referred them to **Crisis Receiving and Stabilization Services (CRSS)**. In this case, **CRSS** providers, including specialists in child development, might (1) **seek to understand this unique family and youth's perspectives and their goals** (parents might describe fears that Angel will escalate to doing harm to self or others, or that others in the family are frustrated and likely to lash out aggressively toward Angel, such that safety becomes an issue; e.g., "My other children, and I, are freaking out—we're afraid Angel may try to hurt herself while we're sleeping"); (2) clarify if **ongoing parent/child/family support services** are needed (e.g., family education and respite, parent peer support, child diagnosis and intervention), and (3) **identify where these services might best be provided** (e.g., other family members to stay with if the family is currently overwhelmed or concerns of traumatic conditions are present, local family support chapter for autism, pediatrician specializing in autism and developmental disorders).

Lin is a 7yo, whose parent texts 9-8-8, distraught that the child would not get out of the car to go into the school since the beginning of this school year; usually the child will scream and cry when approaching the school; when brought to the school other times, the child will describe physical symptoms so that the parent will be called and come get the child; today the child was cursing and biting at the teacher who was trying to walk the child into the school; the school

threatened to report the child as habitually truant if the parent cannot get the child to come and stay at school.

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by addressing whether Lin is actually trying to harm others (e.g., the teacher(s)), describes plans or obtains "weapons" to harm anyone, has specific people at home, at school, or elsewhere that frighten Lin such that Lin seeks the protection of family and to avoid a perhaps past traumatic situation (suggestive of posttraumatic stress), or if there are consistent physical symptoms that may suggest an underlying, perhaps new, medical condition, or if Lin has consistently each year avoided separating from family to attend school or other seemingly safe, desirable places (suggestive of separation anxiety), The **CR** might further (2) **identify impacts** across multiple spheres of life, such as how often these events occur, whether parents are able to transition Lin to school most days or to separate to be with others, and which people (e.g., parents, caregivers, certain school staff) are most engaged in this situation, and how long these episodes involve these other people, and how Lin is progressing academically and socially at school. The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as threats that the police or child services may be called if Lin does not transition into school, that the parent doesn't know what else to do and thus seeks help and support, the family fears school reporting may result in all children being removed and thus want Lin out of the home now, etc. The **CR** might (4) **offer parent support/appropriate de-escalation strategies** by helping the family preview separations to go to school, provide distracting options for Lin such as listening to music while driving to school, etc.), and to offer consultation or teleconferencing with a **Mobile Crisis Team (MCT)** to help devise alternative strategies (e.g., helping Lin transition to familiar others (staff and possibly peers) when Lin arrives at school to make these transitions less stressful) as well support the family as they address their fears about school reporting them.

In Lin's crisis, the **MCT** might initially have a phone call to demonstrate support for parent and address fears of reporting to the police/child services, and then as trust is created engage in a videoconference to (1) **elicit descriptions** from the parent about what Lin seems to "gain" by these episodes (e.g., get to go back home to be with a parent, avoid some person or activity disliked at school), how these episodes impact the parent(s) (Parent may say "yes, I have to stay home now to care for Lin, which isn't so bad since I hated my job anyway," or "I've had many problems with the school staff there---they have reported me multiple times with multiple of my children over the years, so this is just another way they try to get us to move."): (2) **observe/speak** with the child to discern if this sounds new and acute to suggest a traumatic origin, or if this seems more like ongoing separation anxiety (even if a repetition of what has occurred at the beginning of new school years), or some other behavioral circumstance (Lin might say "I need to be home with my Mother as she's sick" ("or needs my help taking care of my Grampa," etc.): (3) **understand this unique family's perspectives and their goals** (parents), which might include parental fears of being turned in, the police arriving and scaring other family members, fears of betrayal and distrust given past experiences with the school, and parental aspirations to get the school to be more understanding and partnered with the parents around these events or alternatively to compel the school to place Lin in a different school); and (4) **clarify interventions now needed** to improve/resolve this crisis, such as collaboration with the school to understand the school's experiences or concerns so that a different, more collaborative plan between home and school can be initiated to ease transitions, school options

for gradually getting Lin to transition fully (all day) into school (which might include some interval of virtual school so that Lin becomes more comfortable with new teachers and peers)..

If Lin continues to be threatening to others at school or at home, or the parents fear that others in the family may get angry or aggressive toward Lin, then **Crisis Receiving and Stabilization Services (CRSS)** may be needed to (1) **better understand this unique family and youth's perspectives and their goals** to manage Lin's behaviors and eliminate aggression during school transitions, which might include family interviewing and then supportive or focused counseling (e.g., parent previewing, calm management of Lin's escalations, problem-solving techniques and practice with family to prepare for transitions, and anxiety reduction techniques for Lin) at the CRSS site; (2) clarify if **ongoing parent/child/family support services** are needed (e.g., school-based behavioral health services to target the source of transition behaviors via skill development and/or trauma treatment); and (3) **identify where these services might best be provided** (e.g., feasible practices for the family to do differently, the possibility of implementing promptly a school program with preferred school staff or peers to improve the magnetism of school for Lin and to simultaneously make home more "boring," so that Lin is more motivated to transition to school).

Devon is a 14yo, whose parent contacts 9-8-8 after finding a bag of "weed" in Devon's room and confronting Devon; Devon became livid, asked why the parent was "in my stuff," and ran out the door, breaking a lamp on the way out, saying "I don't want to live like this anymore."

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by asking family if this is a new/unusual explosive event, or recurrent ("has Devon had other episodes or signs of substance use, has Devon made threats, tried to harm self/others before" and directly address Devon's comment by exploring "what did "I don't want to live like this anymore" seems to suggest today?" to parents, or others present or who may have heard similar comments from Devon before, and which may have included descriptions of self-harm plans/acts, or preparations to gather weapons, write suicide notes, etc.). The **CR** might (2) **identify impacts** across multiple spheres of life: the CR might inquire about whether Devon explodes or "takes off" everywhere, or only today at home? and how Devon's functioning with school, peers, and parents has changed in recent months). The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as parental fears that Devon's substance abuse is now problematic, fears that others involved with substances may come to their home, and fears that any discussion of this with others may lead to police searching their home. The **CR** may (4) **offer parent support/appropriate de-escalation strategies**, such as ensuring that Devon is now in a safe place with trusted others, and plans by parents for addressing this situation (parents may say "we want him to return but he has to get rid of the weed and not bring it into our home again," or "we want Devon to go away now for treatment---this has been going on for too long—he cannot come back right now"), and clarify if parents are receptive to speaking with a behavioral health provider, including by teleconference, to identify next steps to locate/find Devon, and determine appropriate next steps.

In Devon's crisis, the **Mobile Crisis Team (MCT)** might speak with family to: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, or both (a

conflict between them), The **MCT** might then text or phone Devon to (2) **observe/speak** with Devon to clarify potential behavioral health conditions that best explain the episode at home (from depression to substance use ("I don't want to live like this anymore" could refer to some ongoing situation or stressor, from bullying to gender or sexual identity concerns, to ongoing substance or legal problems, etc.). From both family/others and Devon, the **MCT** may be able to (3) **understand this unique family's perspectives and their goals**, which might include parental fears of Devon harming/stealing from parents, police involvement and fear of arrests, family fears of Devon being unable to control substance use and significant deteriorations observed, as well as Devon's fears of being misunderstood, overreactions to rare marijuana use that has not been associated with deteriorations in functioning, etc. Based on information from both family and Devon, the **MCT** would speak with parents and/or Devon to (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance to reach and deescalate conflict with Devon, steps to address Devon's substance use vs. Devon's underlying distress recently leading to substance use).

If this crisis results in Devon or parents unable to work out this situation so that he can return home safely, then **Crisis Receiving and Stabilization Services (CRSS)** may be required to: (1) **better understand this unique family and youth's perspectives and their goals**, which might include discussing options with parents and Devon together to navigate an acceptable resolution, identifying underlying fears family members have regarding Devon, as well as stressors that may be influencing Devon's recent behaviors, and both the family and Devon's perceptions of law enforcement as well as social support agencies in partnering with families like them; (2) **clarify if ongoing parent/child/family support services are needed** (e.g., crisis team members clarify whether Devon will be able to safely return home by the next day or whether other options for Devon may need to be explored now, are Devon and family able to work with a provider to agree to terms of returning, is the home environment likely to work or does it remain too volatile between child and parent such that immediate return may put Devon or family members at jeopardy for harm, etc.); and (3) **identify where these services might best be provided** (e.g., does Devon require further evaluation to clarify underlying substance use disorders/withdrawal/intoxication symptoms, specialized referral for other issues, substance abuse treatment, depression, etc.).

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MOBILE RESPONSE AND STABILIZATION SERVICES (MRSS)
BEST PRACTICES FOR YOUTH & FAMILIES

- The crisis should be defined by the parent/caregiver and/or youth themselves.
- The mobile response is in-person and delivered in home or community-settings and available within 60 minutes of contact, with telephonic support until in-person response arrives.
- The stabilization service must include both the youth's ability to manage daily activities and establish clear connections for the youth and family, as needed, to community supports, not just clinical interventions. The stabilization service can be provided for up to 8 weeks.
- MRSS goals should include:
    o Support and maintain youth in their current living situation and community environment, reducing the need for out-of-home placements and placement changes.
    o Promote and support safe behavior in homes, school, and community
    o Reduce admission to Emergency Departments, inpatient psychiatric units, detention centers and residential treatment centers due to a behavioral health crisis
    o Assist youth and families in accessing and linking to ongoing support and services, including intensive clinical and in-home services.
- There is a distinction between the Response Service component (up to 72 hours) and the Stabilization Service component (up to 8 weeks) but they must be connected.
- Initial Response requires an identified Crisis Assessment, Crisis Needs Assessment and Safety Planning tools to be implemented.
- Training, supervision and mentoring should be clear, consistent and in line with systems of care or wraparound services.
- Mobile response teams should connect to both informal and formal community supports and connections should be made to higher intensity of services, if needed.
- Outcomes should be collected to demonstrate the reach, benefits and impact of the MRSS intervention and support provided.

Webinar

The Institute for Innovation and Implementation at University of Maryland, School of Social Work hosted a webinar, via the statewide Mobile Response and Stabilization Services (MRSS) Collaborative, to share best practices in Oklahoma, Nevada and New Jersey to effectively design and implement a mobile response system specific to the needs of children and families. The webinar was held on February 13, 2019.

- To access the recording , please use the following link:
    https://theinstitute.adobeconnect.com/perwr6ps1evg/
- To access the PowerPoint presentation, please use the link below:
    https://www.dropbox.com/s/wpqlc3hb8virvrv/2.13.19%20MRSS%20Webinar.FINAL.pdf?dl=0

National Guidelines for Behavioral Health Crisis Care

Best Practice Toolkit

SAMHSA
Substance Abuse and Mental Health
Services Administration

Acknowledgments

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The *National Guidelines for Crisis Care – A Best Practice Toolkit* advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs. This toolkit includes distinct sections for:

- ✓ Defining national guidelines in crisis care;
- ✓ Tips for implementing care that aligns with national guidelines; *and*
- ✓ Tools to evaluate alignment of systems to national guidelines.

In preparing this information, we could think of no one better to advise you than people who have worked successfully with crisis systems of care. Therefore, we based the information in this toolkit on the experience of veteran crisis system leaders and administrators as well as the individuals and families who have relied on these supports on their worst days. The interviews in this report's addendum showcase the diversity and richness of this expertise and experience.

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Forward

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the U.S. Department of Health and Human Services agency that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

This *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* (*National Guidelines for Crisis Care*) responds to SAMHSA's mission by providing science-based, real-world tested best-practice guidance to the behavioral health field. The Toolkit reflects careful consideration of all relevant clinical and health service research, review of top national program practices and replicable approaches that support best practice implementation. Select nonfederal clinical researchers, service providers, program administrators and patient advocates offered input on specific topics in their areas of expertise to reach consensus on the best practices chosen to be included in this Toolkit. The evolution of this *National Guidelines for Crisis Care* benefited from the 15 year catalog of work of the SAMHSA-funded National Suicide Prevention Lifeline, the National Action Alliance for Suicide Prevention's Crisis Services Task Force that produced *Crisis Now* recommendations in 2016, the Interdepartmental Seriously Mentally Ill Coordinating Committee (ISMICC) report to Congress in 2017 and feedback from exceptional crisis providers and administrators from around the nation. Field reviewers then assessed draft content prior to publication.

The talent, dedication, and hard work that the Toolkit contributors and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field. This report finally offers our communities true *National Guidelines for Crisis Care* within a user-friendly Best Practice Toolkit. You will also find innovative data-informed crisis system capacity modeling tools that can estimate the likely crisis service needs of your community and optimal resource allocations to meet those needs within a few key variables. Together, we can and will make a difference!

Elinore F. McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and Substance Use SAMHSA

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Introduction

Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While an individual crisis cannot be fully predicted, we can plan how we structure services and organize approaches to best meet the needs of those individuals who experience a mental health crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as no-wrong-door safety net services, we must start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime**. Examples of crisis level safety net services seen in communities around the country include (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance personnel dispatched to wherever the need is in the community *and* (3) hospital emergency departments serving everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

Similarly, crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This toolkit will delineate how to estimate the crisis system resource needs of a community, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care and the community-changing impact that can be seen when services are delivered in a manner that aligns with this *Best Practice Toolkit*. Readers will also learn how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices.

Perhaps the most potent element of all, in an effective crisis service system, is relationships. To be human. To be compassionate. We know from experience that immediate access to help, hope and healing saves lives.

Overview

Crisis mental health care in the United States is inconsistent and inadequate when it falls short of aligning with the best practice. This is tragic in that good crisis care is widely recognized as:

1. An effective strategy for suicide prevention;
2. An approach that better aligns care to the unique needs of the individual;
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis;
4. A key element to reduce psychiatric hospital bed overuse;
5. An essential resource to eliminate psychiatric boarding in emergency departments;
6. A viable solution to the drains on law enforcement resources in the community; *and*
7. Crucial to reducing the fragmentation of mental health care.

Short-term, inadequate crisis care is shortsighted. Imagine establishing emergency services in a town by purchasing a 40-year-old fire engine and turning the town's old service shop into the fire station. It will work until there is a crisis. True no-wrong-door crisis care is needed and anything short of full implementation will fall short of meeting the needs of the community.

Our country's approach to crisis mental health care must be transformed. Addressing crisis is the most basic element of mental health care because it immediately and unconditionally accepts everyone seeking care. It represents real-time access to services that align with the needs of the person when the person needs it most. In many states and communities, crisis care is nonexistent, limited or simply an afterthought viewed as an additional expense that was not included in the local budget. We cannot afford to pay the exorbitant price of not offering crisis care; including:

- The human cost of emotional pain of families struggling to access care;
- The opportunity cost of lost community contribution as mental illness represents our nation's largest source of disability;
- The costs of law enforcement and the justice system teams dedicating a disproportionate amount of resources to address issues that result from a person's untreated crisis; *and*
- The ever-escalating cost of inpatient healthcare for individuals who are unable to access needed community-based services in a timely manner.

In many communities, the current crisis services model depends primarily upon after-hours work by on-call therapists or in space set aside within a crowded emergency department (ED). These limited and fragmented approaches are akin to plugging a hole in a dike with a finger.

This toolkit is designed to bridge the unacceptable gap that currently exists in our continuum of care by solidifying national best practice guidelines that reflects SAMHSA's view of the standard of care we must expect in our communities. Core elements of a crisis system must include:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; *and*
4. Essential crisis care principles and practices.

These elements are discussed in more detail later in this toolkit. Effective crisis care that saves lives and dollars requires a systemic approach, and these key elements must be in place. In this report, we will review the proven key components of good crisis care and demonstrate that piecemeal solutions are unacceptable.

Many communities across the United States have limited or no access to true "no wrong door" crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. The available alternatives represent systemic failures in responding to those in need; including incarceration for misdemeanor offences or drop-off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis. Unacceptable outcomes of this healthcare gap are (1) high rates of incarceration for individuals with mental health challenges, (2) crowding of emergency departments that experience lost opportunity costs with their beds and (3) higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available. For many others in crisis, individuals simply fail to get the care they need; contributing to mental illness's designation as the most prevalent disability in the United States and one of the greatest causes of lost economic opportunity in communities throughout the nation.

The purpose of this publication is to establish a solitary set of national guidelines for crisis care and offer a toolkit that supports program design, development, implementation and continuous quality improvement in systems of care throughout the nation.

Core Services and Best Practices

In this section, we define essential elements of effective, modern, and comprehensive crisis care along with the actions needed to bring those services to communities across the United States. The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

1. **Regional Crisis Call Center**: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time;

2. **Crisis Mobile Team Response**: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*

3. **Crisis Receiving and Stabilization Facilities**: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Although there are many other services that will be incorporated into the continuum of a comprehensive system of care, these three programmatic components represent the three true crisis service elements when delivered to the fidelity of the *Crisis Service Best Practice* guidelines defined in this toolkit. However, crisis systems must not operate in isolation; instead striving to fully incorporate within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed need of the individual.

A good way of looking at crisis system flow is to examine on the stratification of assessed need of individuals in crisis. The Level of Care Utilization System (LOCUS) is a tool designed to assess level of care needs of individuals experiencing psychiatric and addiction challenges for over a decade with broad utilization in many states around the country. Developed by the American Association of Community Psychiatrists, LOCUS provides a single easy-to-use instrument that can be used in a multitude of settings to clarify an individual's needs and identify services appropriate to address those needs.

An analysis of over a decade of Level of Care Utilization System (LOCUS) data in Georgia from individuals who were engaged by a face-to-face crisis response service by facility-based or mobile team providers was recently completed; offering insight into what service types would best align with the needs of a community in a fully efficient crisis and acute care system. The statewide crisis line data set used in the analysis included a total of 1.2 million records, 431,690 of which met the criteria described above. This review resulted in the following breakdown that can be used to inform optimal initial referral paths within a system of care that includes a continuum of crisis services:

- 14% (59,269 of 431,690) LOCUS Level 6 – Direct Referral to Acute Hospital;
- 54% (234,170 of 431,690) LOCUS Level 5 – Referral to Crisis Receiving and Stabilization Facility; *and*
- 32% (138,251 of 431,690) LOCUS Levels 4-1 – Evaluation by Crisis Mobile Team with Referral to Care as Needed.

Crisis mobile teams are projected to serve a broader range of individuals in less acute crisis situations. A survey of higher-performing mobile crisis teams shows that approximately 70% of those engagements result in community stabilization. The remaining 30% should be connected to facility-based care that aligns with their assessed needs; including referrals, when indicated, to crisis receiving and stabilization facilities, respite or residential treatment programs. Crisis service providers should be prepared to support all individuals seeking their care and then connect them to care in a manner that truly aligns with the needs of the person.

Crisis systems must work within the larger system of care to address the needs of community members. The true test of whether there is adequate capacity to meet the needs of the community is whether individuals are able to access needed services in a timely manner. Psychiatric boarding in emergency departments and an over-representation of people with mental health and substance use challenges within the justice systems would suggest insufficient capacity within that community; warranting further analysis of flow within that system.

> **The true test of whether there is adequate capacity to meet the needs of the community is by assessing whether individuals are able to access needed services in a timely manner.**

In addition to the essential structural or programmatic elements of a crisis system, we have established a list of the following essential qualities that must be "baked into" comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. "Suicide safer" care;
3. Safety and security for staff and those in crisis; *and*
4. Law enforcement and emergency medical services collaboration.

The subsections of this *Core Services and Guidelines for Care* chapter that follow contain the information the user of this Toolkit will need to align service delivery with the *Crisis Service Best Practice* guidelines.

Core Elements of a Crisis System

The good news is that there are really only three core elements to a crisis system. Unfortunately, few communities have them and even fewer have them operating in a manner consistent with the *Crisis Services Best Practice* guidelines defined in this Toolkit. The three-core structural or programmatic elements of a crisis system defined in this section are:

(1) Regional Crisis Call Center,
(2) Crisis Mobile Team Response *and*
(3) Crisis Receiving and Stabilization Facilities.

Regional Crisis Call Hub Services – *Someone To Talk To*

Regional crisis call services offer real-time access to a live person every moment of every day for individuals in crisis. Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Analogous to a 911 call for most emergencies, mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

At the time of this publication, Congress is considering a national 988 behavioral health crisis number to serve as a dedicated crisis call center line in a manner that generates better access to care through a more broadly recognized and remembered number than the local options that exist at this time.

Minimum Expectations to Operate a Regional Crisis Call Service
Regional, 24/7, clinically staffed call hub/crisis call centers must:

1. Operate every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
5. Coordinate connections to crisis mobile team services in the region; *and*
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.

Best Practices to Operate Regional Crisis Call Center
To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Incorporate Caller ID functioning;
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

Implementation of the *National Suicide Lifeline Policy for Helping Callers at Imminent Risk of Suicide* is an expectation as these regional crisis line providers partner in Zero Suicide efforts around the country. **Direct crisis center staff are expected to:**

1. *Practice **active engagement** with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;*
2. *Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;*
3. *Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;*
4. *Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;*
5. *Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;*
6. *Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; and*
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

Regional Crisis Call Center Technology

The incorporation of advanced technologies is essential to efficiently operating a regional crisis call center hub. We see the nation's air traffic control system (ATC) as one we can learn from as we work towards seamless connections to care in a mental health and substance use crisis system.

Air Traffic Control (ATC) Capabilities with Crisis Line Expertise

Virginia State Senator Creigh Deeds was stabbed by his son, Gus, who then took his own life by suicide. Shortly before this horrific outcome, Gus had been assessed at a local hospital and a magistrate had ordered an involuntary commitment. However, no beds were available at any nearby inpatient psychiatric hospitals so Gus was sent home. Sadly, it is far too common for individuals in mental health crisis to receive an initial assessment but then "fall through the cracks" due to a failure to make a connection to care that aligns with the unique needs of the individual. The cracks occur because of interminable delays in access to services based on an absence of:

1. Real-time coordination of crisis and outgoing services; *and*
2. Linked, flexible services specific to crisis response, namely mobile crisis teams and crisis stabilization facilities.

Because of these gaps, individuals walk out of a hospital emergency department (ED), often "against medical advice," and disappear until the next crisis occurs.

The nation's approach to crisis call centers received a significant upgrade starting in 2004 with creation of the National Suicide Prevention Lifeline (NSPL). Over time, the NSPL has demonstrated its effectiveness and raised the performance bar for crisis call centers. Recent SAMHSA initiatives include efforts to solidify real-time bed registries that can be used to more

efficiently connect individuals to care during their times of greatest need. Air traffic control (ATC) systems provide a primary example of how access to real-time data and consistent standards lead to remarkable efficiency in complex systems. Adopting an ATC model for crisis services can significantly reduce the incidence of tragic and unacceptable outcomes for individuals in crisis.

Learning from Air Traffic Control (ATC) Safety

Air Traffic Control (ATC) works to ensure the safety of nearly 30,000 U.S. commercial flights per day. In the United States, this occurs with a very high success rate; making air travel remarkably safe today. Unfortunately, we have been less successful at supporting individuals who are navigating a mental health crisis.

The advancements in ATC that have helped transform aviation safety are two vitally important objectives and, without them, it is nearly impossible to avoid tragedy:

- Objective #1: Always know where the aircraft is (in time and space) and never lose contact; *and*
- Objective #2: Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

These objectives easily translate to behavioral health and our evolving crisis systems of care. Always knowing where an individual in crisis is and verifying that the hand-off has occurred to the next service provider seem like relatively easy objectives to fulfill. However, they are missing from most U.S. behavioral health and crisis systems despite the existence of technology that is working in some regions. Individuals and families attempting to navigate the behavioral health system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that ATC provides.

The Air Traffic Control (ATC) Model for Crisis Services and Functional Targets

Air traffic control (ATC)-type technology is being applied by some crisis call center hubs in the country; offering real-time connection to GPS-enabled mobile teams, true system-wide access to available beds and outpatient appointment scheduling through the integrated crisis call center. These exceptional practice centers serve as a true hub for whole, integrated crisis system of care.

Status Disposition for Intensive Referrals

In an effective ATC-based model for crisis services, there must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels; including requirements for service approval and transport, shared protocols for medical clearance algorithms and data on speed of accessibility (average minutes until disposition). An effective program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. For example, some systems display names on a pending linkage status board that highlight names in green, white, yellow, or red to reflect how long an individual has been waiting for connection to care.

24/7 Outpatient Scheduling

Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the region while providing data on speed of accessibility (average business days until appointment) by provider/program.

Crisis Bed Registry

An intensive services bed census is required; showing the availability of beds in crisis stabilization programs and 23-hour observation chairs, as well as beds in private psychiatric hospitals, with interactive two-way exchange (such as through an individual referral editor and inventory / through-put status board).

High-Tech, GPS-enabled Mobile Crisis Dispatch

Mobile crisis teams should use GPS-enabled tablets or smart phones to support quick and efficient call hub determination of the closest available teams, track response times, and ensure clinician safety (*e.g.,* time at site, real-time communication, safe driving, etc.).

Real-Time Performance Outcomes Dashboards

Effective crisis service models utilize outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency created through these reports provides an extra layer of urgency and accountability.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. Emergency medical services (EMS) should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services
Mobile crisis team services must:

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

Best Practices to Operate Mobile Crisis Team Services
To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's- or Bachelor's-level clinician may be paired with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians who are on-call as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

SAMHSA's 2014 *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* report stated:

> *The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional*

objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.

In summary, mobile crisis care:

1. Helps individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible;
2. Meets individuals in an environment where they are comfortable; *and*
3. Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

The same report confirmed previous evidence on the effectiveness of mobile crisis service:

Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.

The cost-effectiveness of mobile crisis services is noted as well:

Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.

SAMHSA asserts that mobile crisis team care is one of three essential elements of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center. Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;

- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Triage/Screening

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and assess the most appropriate response to meet the need. In discussing the situation with the caller, the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available or the nature of the crisis indicates that EMS or police are most appropriate.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, legal factors and substance use;
- Safety and risk for the individual and others involved; including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
- Medications prescribed as well as information on the individual's compliance with the medication regimen; *and*
- Medical history as it may relate to the crisis.

De-Escalation and Resolution

Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

Peer Support

SAMHSA's 2009 report (p.8) asserts that mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers

can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis" (see Significant Role for Peers in Section 4).

For community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services

Community-based mobile crisis programs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA's essential elements of responding to mental health crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*" (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support professional should engage the individual in a crisis planning process; resulting in the creation or update of a range of planning tools including a safety plan.

When indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs. This activity is typically completed through telephonic outreach but there may be times when further face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone.

Crisis Mobile Service Summary

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations.

Crisis Receiving and Stabilization Services – *A Place to Go*

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. As we will discuss later in this toolkit, it is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred

> One of the phrases we have seen applied to programs around the country is *"Thank you. Can I have another?"* in reference to law enforcement bringing individuals to the program.

to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements and not shift responsibility to the initial referral source (family, first responder or mobile team). Law enforcement is not expected to do the triage or assessment for the crisis system and it is important that those lines never become blurred.

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

Crisis receiving and stabilization services must:

1. Accept all referrals;
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
3. Design their services to address mental health and substance use crisis issues;
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed;
5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
   a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
   b. Nurses
   c. Licensed and/or credentialed clinicians capable of completing assessments in the region; *and*
   d. Peers with lived experience similar to the experience of the population served.
6. Offer walk-in and first responder drop-off options;
7. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders;

8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*

9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
5. Coordinate connection to ongoing care.

Many individuals in crisis brought to hospital EDs for stabilization report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who have little experience with psychiatric crisis care. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals; an experience they did not have at the hospital. In such an alternative setting, psychiatric crises can be de-escalated.

In the 2014 *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* report, SAMHSA defined crisis stabilization as:

> *A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services." (p. 9).*

Data suggests that a high proportion of people in crisis who are evaluated for hospitalization (LOCUS levels 5 and 6) can be safely cared for in a crisis facility and that the outcomes for these individuals are at least as good as hospital care while the cost of crisis care is substantially less than the costs of inpatient care and accompanying emergency department "medical clearance" charges.

The Role of the Psychiatrist/Psychiatric Nurse Practitioner

Psychiatrists and Psychiatric Nurse Practitioners serve as clinical leaders of the multi-disciplinary crisis team. Essential functions include ensuring clinical soundness of crisis services through evaluation of need, continued monitoring of care and crisis service discharge planning.

The role of the psychiatrist/psychiatric nurse practitioner during the evaluation is to:

- Clarify diagnosis and information within any existing psychiatric advance directive (PAD);
- Evaluate and define a course of care for substance use, mental & physical health needs;
- Collaborate with the team to assess risk and level of care needs;
- Participate in establishing patient-centered treatment goals and plans with the team;
- Educate about medications and care options; *and*
- Partner with the team to engage with the person's support system.

The role of the psychiatrist/psychiatric nurse practitioner in continued treatment is to:

- Monitor patient-centered needs and risk while adjusting treatment as needed;
- Collaborate to support movement towards recovery goals in a patient-centered fashion;
- Participate in the delivery of family education as applicable;
- Educate, train and model best practice care to team members during treatment; *and*
- Provide overall clinical leadership and oversight of patient-centered care.

The role of the psychiatrist/psychiatric nurse practitioner during the discharge process is to:

- Collaborate with the team and those served to develop PAD and discharge plan;
- Prescribe medication to bridge until the person's follow-up appointment; *and*
- Support persons served with education about discharge medications and any follow-up needs or recommendations for monitoring side effects.

Additional Elements of a System of Care

As noted previously, essential crisis system elements are limited to (1) the crisis call center hub, (2) crisis mobile response and (3) crisis receiving and stabilization services. A multitude of other resources that support a comprehensive system of care exist; including facility-based resources such as short-term residential facilities and peer respite programs that offer step down options for individuals following a crisis episode.

Short-Term Residential Facilities
Small, home-like short-term residential facilities can be seen as a strong step-down option to support individuals who do not require inpatient care after their crisis episode. In many communities, these are called crisis residential facilities. SAMHSA cautions that these are not actual crisis facilities given the criteria that a crisis facility must accept all referrals. However, they are an important part of a continuum that can be used to address the needs of individuals experiencing LOCUS assessed needs of 4 and 5 in a cost-effective manner. As such, staffing for these programs is far less intensive than a crisis receiving and stabilization facility. Short-term crisis residential programs should minimally have a licensed and/or credentialed clinician on location for several hours each day and on-call for other hours.

To maximize their usefulness, short-term residential facilities should function as part of an integrated regional system of care. Access to these programs should be facilitated through the air traffic control (ATC)-capable call center hub of the region to maximize system efficiency. This approach also centralizes data regarding program occupancy, lengths of stay, percentage of

referrals accepted and time to make decisions on referral acceptance; offer valuable data on how each participate in the system of care is supporting the needs of the community.

Peer-Operated Respite

Another model of short-term facility-based care is a peer-operated respite program. These programs do not typically incorporate licensed staff members on site although some may be involved to support assessments. They provide peer-staffed, restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. Peer-respite offers a low-cost, supportive step-down environment for individuals coming out of or working to avoid the occurrence of a crisis episode. Program activities should focus on issues that have contributed to the escalation in challenges facing the individual and/or their support system and the skills needed to succeed in the community.

Crisis System Coordination

Crisis services should not be viewed as stand-alone resources operating independent of the local community mental health and hospital systems but rather an integrated part of a coordinated continuum of care. Services needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. This is not easily achieved given the complex dynamics that are in play in many communities throughout the country that have complex health ecosystems influencing the care delivery system. Given the understanding that pieces of a continuum of care will not typically align and partner fully without a purposeful intent, regular communication between crisis services, local hospital and outpatient service leaderships must be coordinated in a thoughtful manner that focuses on the needs of the community served.

Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch and outpatient appointment setting through the call center hub. A modification of the Milbank collaboration continuum may be used to assess the degree to which crisis systems are meeting the expectation of community coordination and collaboration (*shown in Table 2 below*).

Table 1 - Continuum to Evaluate Crisis Systems and Collaboration

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM→				
Level 1 **MINIMAL**	*Level 2* **BASIC**	*Level 3* **BASIC**	*Level 4* **CLOSE**	*Level 5* **CLOSE**
Agency Relationships	*Shared MOU Protocols*	*Formal Partnerships*	*Data Sharing (Not 24/7 or Real-Time)*	*"ATC Connectivity"*

In this model, the highest level of care requires shared protocols for coordination and care management that are supported in real time by electronic processes. For a crisis service system to provide Level 5 close and fully integrated care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update and monitor available resources in the network of provider agencies.

Psychiatric Advance Directives

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PAD creates a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities and listings of visitors.

Essential Principles for Modern Crisis Care Systems

A crisis provider's approach to care must include the incorporation of a philosophy that removes barriers to accessing care. Regional 24/7 clinically staffed crisis call centers must be equipped to triage and provide telephonic support to any caller, mobile teams must go to wherever the person in need is at the time of their crisis and crisis stabilization centers must accept all referrals that walk through their door or are brought in by first responders. To execute on this bold approach to care, a crisis provider must be staffed to meet these expectations. First responders and other community partners must know that they are able to connect every individual to care in a timely manner. Approaches that result in the rejection of even a small percentage of referrals translate into questioning whether crisis is really a viable alternative to emergency department and jail options that do not reject referrals.

There are many other levels of care that contribute to a comprehensive system of care and most of those will implement some form of admission criteria that restricts who is admitted to the program. This is appropriate for a vast majority of non-crisis programs but cannot be part of a crisis provider's practice. Much like 911, fire, police and emergency departments, the expectation is that crisis programs will respond to emergent appeals for support; never responding with an unwillingness to engage in addressing the emergent issue.

Core Principles

Best practice crisis care incorporates a set of core principles throughout the entire crisis service delivery system; offering elements that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that are defined as essential for modern crisis systems. These essential principles and practices are:

1. Addressing Recovery Needs,
2. Significant Role for Peers,
3. Trauma-Informed Care,
4. *Zero Suicide*/Suicide Safer Care,
5. Safety/Security for Staff and People in Crisis *and*
6. Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services (EMS).

Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) Crisis Now Summit, consumer Misha Kessler ended his description of his direct experiences with crisis services, "Mental illness is [just] one part of my tapestry."

Recovery is possible and should not be viewed within the narrow definition of an absence of symptoms. In fact, many individuals develop meaning and purpose in life despite the continuation of symptoms. The report of the President's New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is elevated for individuals in crisis and, thus, for crisis settings. In an outmoded, traditional model, crises reflect "something wrong" with the individual. Risk is seen as something to be contained; often through involuntary commitment to an inpatient setting. In worst-case situations, this obsolete approach interacts with inadequate care alternatives; resulting in people restrained on emergency room gurneys or transferred to jails because of their behavior.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises. A recovery-oriented approach to crisis care is integral to transforming a broken system. Not only must we expand crisis care, but we must forge a better approach to crisis care by ensuring implementation of fidelity to these best practice guidelines.

Implementation Guidance

1. *Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options and offer materials regarding the process in writing in the individual's preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align actions to those preferences.*
5. *Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.*

6. *Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible.

Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11% to 50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following ED referral (Kessler et al., 2005). Peers can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement while reducing distress.

The role of peers—specifically survivors of suicide attempts as well as survivors of suicide loss—was bolstered when the National Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*
2. *Develop support and supervision that aligns with the needs of your program's team members.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. The adverse effects of childhood trauma may present well into adulthood; increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance abuse, and poor medical health (Finkelhor et al., 2005). Persons with history of

trauma or trauma exposure are more likely to engage in self-harm and suicide attempts and their trauma experiences make them very sensitive to how care is provided.

Mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, we find that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA set the following guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; *and*
6. Ensuring cultural, historical and gender considerations inform the care provided.

These principles should inform treatment and recovery services. If such principles and their practice are evident in the experiences of staff as well as consumers, the program's culture is trauma-informed and will screen for trauma exposure in all clients served, as well as examine the impact of trauma on mental and physical well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility of further trauma or crisis.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57).

Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care
Crisis intervention programs have *always* focused on suicide prevention. This stands in contrast to other health care and even mental health services, where suicide prevention was not always positioned as a core responsibility. Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2)

commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC). The following seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of Zero Suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL), which has established suicide risk assessment standards, guidelines for callers at imminent risk, and protocols for follow-up contact after the crisis encounter. Zero Suicide also promotes collaborative safety planning, reducing access to lethal means, and incorporating, into the service provided, the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis intervention systems are the most urgently important clinical service for suicide prevention and most parts of the country do not have adequate crisis care, we find a national and state-level commitment to implementing comprehensive crisis services to be foundational to suicide prevention; leading to an expectation that best practices in suicide care be required by health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare).

Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members.*
2. *Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services.*
3. *Incorporate suicide risk screening, assessment and planning into the crisis provider's practices.*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider.*
5. *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

Safety/Security for Staff and People in Crisis

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised.

People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. The Department of Health and Human Services' (DHHS's) Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation and stabilization.

Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical

Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of individuals under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to themselves or others (DHHS, 2006).

In some crisis facilities licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as punishment, an alternative to appropriate staffing of crisis programs, a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment while assessing risk for violence to collaboratively develop de-escalation and safety plans for individuals served by the program. Staff and individuals involved in those interventions should be debriefed after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability of future use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the mental health division of the state's Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals.

According to SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device;
- Mental health workers dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness on the client they are visiting.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the *perception of safety* is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly "Job One" in all crisis settings.

Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. As first responders, they are often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis.

Police officers are critical to mobile crisis services as well; either (1) providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995) when the need is assessed or (2) as a referral source delivering warm hand-offs to crisis mobile teams. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of "repeat players"; *and*
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call often escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between mental health and law enforcement, found the alliance

between first responders and mental health professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to mental health crisis included police-based specialized police response, police-based specialized mental health response, and mental health-based specialized mental health response. These forms of collaboration share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker *et al*., 2008). Lord *et al*. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and mental health programs that includes the availability of a crisis setting where police can drop off people experiencing a mental health crisis. CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006). Crisis programs should engage in ongoing dialog with local law enforcement agencies to support continuous quality improvement and collaborative problem-solving. Top crisis systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care justice system diversion and the elimination of psychiatric boarding in emergency departments. The absence of comprehensive crisis systems has been the major "front line" cause of the criminalization of mental illness and a root cause of shootings and other incidents that have left people with mental illness and officers dead. Collaboration is the key to reversing these inacceptable trends.

Implementation Guidance

1. *Have local crisis providers actively participate in CIT training or related mental health crisis management training sessions.*
2. *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
3. *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

Unique Challenges of Rural and Frontier Communities

Rural and frontier communities face unique workforce and geographic challenges that make it more difficult to deliver high quality crisis services that meet the needs of the region. System leaders should evaluate opportunities to leverage technology and existing program capacity to deliver care to maximize access to timely services. Approaches should include:

1. Learning how other first responder services like law enforcement, fire and emergency medical services operate in the area.

2. Leveraging existing first responder transportation systems to offer access to care in a manner that aligns with emergency medical services in the area.

3. Incorporating technology such as telehealth to offer greater access to limited licensed professional resources.

4. Developing crisis response teams with members who serve multiple roles in communities with limited demand for crisis care to advance round the clock support when called-upon.

5. Establishing rural reimbursement rates for services that support the development of adequate crisis care in the area.

6. Creating crisis service response time expectations that consider the geography of the region while still supporting timely access to care.

Residents of rural and frontier communities are at risk of experiencing mental health and substance use crisis. When this occurs, these individuals must have access to care that meets their needs in a timely manner much like their counterparts in urban communities. Limited resources may make this aspiration challenging. However, approaches are available to narrow the difference between these rural communities and those with higher population densities.

Funding Crisis Care

Approaches to fund mental health and substance use crisis services vary widely from state to state. In many cases, funding is cobbled together, inconsistently supported and inadequate when not aligned with best practices. One of the greatest factors contributing to these funding challenges is the inconsistent expectations around crisis provider service delivery; allowing providers who staff and operate in very different ways to utilize the same crisis stabilization service coding.

Consider the nature of crisis care in systems with multiple payers. If a provider commits to fully align their practices to the *National Guidelines for Crisis Care* contained in this toolkit, then that provider is poorly positioned to negotiate reimbursement with each of those multiple funders in a region simply because the funder knows the provider will accept all referrals and serve them even if they do not reimburse in a manner that covers the cost of care. In these cases, it is often local jurisdictions who are paying part of the bill for legally or contractually responsible payer health plans that fall short in reimbursement. The solution is to create rate reimbursement structures that sustain delivery of services that align with best practice guidelines and secure capacity funding for community members who otherwise do not have insurance to cover critical care. This is not a new concept given the funding streams that exist in support of 911, fire, ambulance and emergency department services but it is one that must be extended for mental health and substance use crisis care for parity to be realized.

In a November 13, 2018 letter from the Centers for Medicare & Medicaid Services to State Medicaid Directors, a path to receive a waiver on the payment exclusion for Institutions of Mental Disease (IMD) was offered:

"CMS will consider a state's commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Furthermore, CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, **particularly crisis stabilization services.***"*

The letter clarifies that "*states may receive federal matching funds for Medicaid-coverable services provided to individuals residing in psychiatric hospitals and residential treatment settings that are not ordinarily matchable because these facilities qualify as IMDs"* under an approved demonstration project. This represents an opportunity leverage the additional federal funding in lieu of state payment for these IMD services; freeing up state funding to support local crisis care.

The Firehouse Model: Crisis Care Funding vs. Emergency Care Funding
It is revealing to compare mental health crisis care to other first responder systems like firefighting or emergency medical services (EMS). There are striking similarities:

- The service is essential and may be needed by anyone in the community;

- The need for it is predictable over time but the timing of individual crises events is not; *and*
- Effective crisis response is lifesaving and much less expensive than the consequences of inadequate care.

One might measure the effectiveness of emergency medical services (EMS) in lives saved because of timely intervention for individuals with acute heart disease. For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief respite stays that might cost $300 per day versus inpatient rates of $1,000 per day. This approach better connects the individual to his or her community while minimizing disruption in the person's community connections.

It is also useful to think about the financing of core crisis services. It would be unthinkable for any community, except frontier or very small ones, to go without their own fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are simply made available. Sometimes users may pay a fee for service calls but the station and the equipment are available to anyone in need regardless of ability to pay. In most communities, mental health crisis services take a different approach or are not offered at all due to the lack of coverage or reimbursement for this level of care. Health coverage (e.g., Medicaid) will pay for professional fees as if services were delivered as part of a routine office visit but few entities pay for the infrastructure of a crisis system with rates that reflect the "firehouse model" expenses involved in being available for the next call or referral.

For those who have ever experienced a medical emergency and contacted 911 for help, they probably know how this plays out. Fire departments and/or an ambulance respond quickly to deliver emergent care. If they assess a need for further support, they may transport to the emergency department for care. What follows in the subsequent weeks, following care, is the delivery of bills or invoices for the ambulance care and transportation followed by any services received within the emergency department. These bills or invoices total thousands of dollars in most cases; expenses that represent the higher cost of offering emergent care that is accessible to **anyone, anywhere and anytime**. Unfortunately, crisis care reimbursement is often a fraction of that of its physical health counterparts and is, therefore, delivered in a model that falls short of best practice expectations or is simply not offered because there is no mechanism to adequately reimburse the cost of the level of care.

A Potential Solution

Funding crisis care through a firehouse model may be the best approach for some of these services while other viable options are also evolving with the implementation of parity. A leading solution to the crisis care funding puzzle is to model reimbursement after the physical health service counterparts already in place. Subsequent efforts to enforce parity laws in a manner that removes much of the burden on local communities by shifting the expense to the person's health insurance plan that, by law or contract, is actually responsible for covering this care will position crisis care to have sustainable funding streams in support of best practice care; leading to care that can truly lower health care costs while dramatically improving the experience of people in crisis and the health of communities through justice system and ED diversion.

Multiple Payer Systems

The approach proposed supports reimbursement within multiple payer systems when responsible payers (health plans) each pay for services at rates that support operations. Therefore, it is recommended that states, counties or local jurisdictions establish rates for their communities that can be applied to all payers. Otherwise, local jurisdictions will be forced to cover the shortfall in funding from the legally or contractually responsible payers who offer lower reimbursement for care that is always made available to all community members. In essence, the lead of local government to establish reasonable reimbursement rates for best practice crisis services amongst all responsible payers offers a sustainable model that reduces the demand on communities to cover health care expenses that should be covered by an insurer; supporting the existing of the safety net service that is accessible in real-time when called-upon.

Regional 24/7 Crisis Call Center Hub

This service is really meant to serve entire regions in a manner similar to 911 call responses with SAMHSA delivering some funding to support this valuable resource currently. Although there is some ability to verify certain information identifying the caller, reimbursing for care using the Behavioral Health Hotline code, call center funding might be best served through a population-based funding stream that comes from an assessment on cell phone and/or land line utilization. This approach would more cleanly sustain nationwide funding for this safety net service and implementation of advanced air traffic control-type technology in all parts of the country.

Crisis Mobile Response Services

Crisis mobile response services are analogous to fire and ambulance responses for emergent physical health issues. As such, funding mechanisms should align so that adequate capacity can be in place to serve communities. Given that demand is not completely predictable, there will be some down time for these teams and reimbursement rates must be set so that the health plan still realizes value in the service (largely value realized by avoiding ambulance and emergency department bills) while community members get better access to care. If commercial and Medicaid plans pay at this reasonable rate for quality care, the state, county or city funding of contributions will be relatively low; particularly in states with low uninsured rates.

Crisis Receiving and Stabilization Facility Services

Crisis receiving and stabilization services are analogous to emergency department services but typically fall under a crisis stabilization coding approach that offers hourly and per diem reimbursement. Facilities are likely licensed outpatient programs that offer flexibility to deliver care to a larger number of people in smaller spaces; necessitating that service duration be limited to under 24 hours (often referred to as 23 hour programs). Professional fees are usually billed in addition to the crisis stabilization service but can be bundled if that approach is preferred. The benefit to separate billing of professional services is that practically all payers currently reimburse for these services while few outside of Medicaid recognize crisis stabilization for reimbursement at this time. Getting some of the expense covered by these payers (pending a better enforcement of the parity law) is better than none when it comes to minimizing the financial cost to the community served.

Crisis Service Coding

Establishing a common definition for "crisis services" is essential to this coding process given the ever-expanding use of the term "crisis" by entities describing offerings that do not truly function as no-wrong-door safety net services accepting all referrals. Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**. This crisis service coding discussion focuses solely and exclusively on the three essential crisis services. Any other service may offer value within the continuum of care but should not use "crisis service" coding.

Crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system. The table below provides a look at similarities between crisis services and their physical health counterparts; offering a framework that can be used to model reimbursement for these similar services in a manner consistent with public expectations of parity.

Table 2 – Emergency and Crisis Service Analogies

Services for Responding to a Health Crisis		
	Physical Health	**Mental Health & Substance Use**
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance / Fire	Mobile Crisis Line
Emergent Facility Care	Emergency Dept.	Crisis Receiving & Stabilization Facility

Healthcare Coding of Crisis Services

Coding of crisis services must be standardized to support reimbursement for these important services. Additionally, coding for mobile and facility-based crisis services has a clear to path to reimbursement much like what currently exists for ambulance and emergency department service providers. Although a bit different than the analogous 911 service that largely focuses on dispatching support, crisis line services represent an essential element of improving access to care that includes the delivery of telehealth services. Here's a brief description of these services and a straightforward strategy for healthcare coding in each case:

1. **Crisis Call Center:** This service represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a mental health crisis to needed care; including telehealth support services delivered by the crisis line itself. Recognizing the provider's limited ability to verify insurance and identification over the phone, these services may be best funded as a safety net resource but reimbursement for services delivered is an

option. The most straight-forward option is to bill for services delivered to eligible individuals using the Healthcare Common Procedure Coding System *(HCPCS) code of H0030 - Behavioral Health Hotline Service*.

The limitation of the direct billing approach is that it can be very difficult to acquire the information adequate to verify healthcare coverage and the identity of the service recipient during the phone interaction. However, some level of direct billing for care could be used to augment the funding received by regional and state government entities to support operations. Crisis line providers do indeed deliver telehealth support to insured callers every day. Data elements such as member phone numbers of Medicaid-enrolled or privately insured individuals can be combined with Caller ID technology to support billing efforts.

2. **Mobile Crisis:** Mobile crisis services represent community-based support where people in crisis are; either at home or a location in the community. Services should be billed using the nationally recognized *HCPCS code of H2011 Crisis Intervention Service per 15 Minutes*. Limiting the use of this code to only community-based mobile crisis team services positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much as it does for a fire department or ambulance service reimbursement rate. When applicable, transportation services should be billed separately.

3. **Crisis Receiving and Stabilization Facility:** Crisis receiving and stabilization facility services that meet minimum expectations described in this paper are delivered by a 24/7 staffed multidisciplinary team that includes prescribers (psychiatrists and/or psychiatric nurse practitioners), nurses, clinicians and peers. Nationally recognized HCPCS codes of *S9484 Crisis Intervention Mental Health Services per Hour* and *S9485 Crisis Intervention Mental Health Services per Diem* can be used to reimburse for services delivered. Medications, radiology, laboratory, CPT codes and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates.

Table 3 – Crisis Service Coding

Service	Recommended Coding Option Approach
Crisis Line	**H0030** – Behavioral Health Hotline Service and contract as a safety net resource to augment funding
Mobile Crisis Response	**H2011** - Crisis Intervention Service per 15 minutes *Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if codes are used for multiple crisis delivery modalities.*
Crisis Stabilization Facility (non-hospital)	**S9484** - Crisis Intervention Mental Health Services per Hour **S9485** - Crisis Intervention Mental Health Services per Diem *Note: The TG modifier can be utilized to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities*

A Call for Parity

Establishing universally recognized and accepting coding for crisis services is an essential step towards delivering on our nation's promise of parity; moving mental healthcare out of the shadows and into mainstream care of the whole person. Parity should be the expectation. Individuals experiencing a mental health or substance use crisis must have access to timely and effective care, based on the person's needs, that aligns with access to care for a person with a physical health emergency.

Anyone!

Anywhere!

Any Time!

Unfortunately, access to effective care during a mental health crisis is widely known to be deficient in healthcare settings across the country. "8 in 10 ED Doctors Say Mental Health System Is Not Working for Patients" according to a survey by the American College of Emergency Physicians (ACEP). Thousands of Americans are dying from suicide every month and many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain. Individuals with limited options are getting the wrong care in the wrong place with jails, EDs and inpatient care substituting for mental health crisis services and law enforcement is functioning as defacto mobile crisis units.

According to the 2019 Treatment Advocacy Center published *Road Runner* study, more than $17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated to law enforcement agencies nationwide, this number is approximately $918 million or 10% of law enforcement's annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is ripe to solidify better access to crisis care and change these unacceptable outcomes that are adversely impacting communities, filling jails and crowding emergency departments. A nationally recognized framework for delivering a full continuum of crisis care has been established by the National Action Alliance for Suicide Prevention Crisis Services Task Force with resources found on the National Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and healthcare coding, as defined in this document, is available to support reimbursement for that care

Assessing Adequacy of System Capacity

Care for All Populations Throughout Lifespan

Crisis services are meant to address the acute mental health, substance use and suicide prevention needs of a community. This can only be achieved by designing services that meet the unique needs of all members of that community. Therefore, crisis services must offer the capacity to address the needs of rural and urban communities that may be experiencing mental health, substance use, intellectual, developmental disability and co-occurring medical problems by accepting all at the front door. This also means offering crisis services for children, adolescents, adults and an aging population that each have their own unique set of needs in each community.

Crisis Resource Need Calculator

To lower the cost of care, enhance community health and improve the experience of residents needing emergent mental health and substance use services, a full continuum of care must be developed that includes adequate psychiatric bed capacity and community-based alternatives to care. The innovative *Crisis Resource Need Calculator* offers an estimate of optimal crisis system resource allocations to meet the needs of a community as well as the impact on healthcare costs associated with incorporation of those resources. The calculator analyzes a multitude of factors that includes population size, average lengths of stay in various system beds or chairs, escalation rates into higher levels of care, readmission rates, bed occupancy rates and local costs for those resources. In communities in which these resources do not currently exist, figures from like communities can be used to support planning purposes.

The calculations are based on data gathered from several states. The *Crisis Now* Business Case video that explains the rationale behind the model can be seen on the National Association of State Mental Health Program Directors (NASMHPD's) www.crisisnow.com website. Quality and availability of outpatient services also influences demand on a crisis system so the *Crisis Resource Need Calculator* should be viewed as a guide in the design process. True assessment of system adequacy must include a look at overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in emergency departments and incarceration for misdemeanor offenses when connection to care is the preferred intervention.

The table on page 44 shows the very real cost savings that can be realized by implementing mobile crisis and facility-based crisis services in your community. In this table, the population of the community is set at 1,000,000 and if this community was working to address the acute mental health needs of individuals experiencing a crisis solely through inpatient care, the data indicates that those with LOCUS levels 5 and 6 (68%) would be referred to inpatient care. This would require 500 beds if the average length of stay was 10.06 days; which aligns with the Treatment Advocacy Center's published consensus estimate of needing 50 beds for every 100,000 members of the population. The table that follows (*next page*) includes a per diem inpatient rate of $900 which would result in an inpatient cost of $164,179,200. After applying an ED cost of $1,233 per person to those referred to an inpatient bed (medical clearance and assessment), total estimated costs rise to $184,301,760.

For the 32% of individuals with LOCUS levels 1-4, no cost or service is included in the calculations although it seems unlikely no actual cost would be incurred. When mobile team and facility-based crisis services are included in optimal ratios (*last column of table that follows*), total cost drops by 52% in these projections despite engaging all of these individuals. This means that 32% more individuals are served with programs that align better to the unique level of clinical need while costs are reduced by 52%. Additionally, alignment of clinical level need to the service delivered improves from 14% to as high as 100% (*please see LOCUS analysis from Georgia earlier in this toolkit*) in a *Crisis Now* system that aligns with this *National Guidelines for Crisis Care*.

Indicators of Insufficient Capacity

The *Crisis Resource Need Calculator* offers an estimate of community resource need to help guide development of crisis capacity for communities. However, this is only meant to estimate need while true evaluation of capacity must be based on the availability of services to meet the actual demand of the specific community or region. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in emergency departments, incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention and misalignment of service intensity to the actual need of the individual served. Misalignment and the absence of a continuum of care often results in a defaulting to placement in more restrictive environments or minimal connection to outpatient care.

Figure 1 – Crisis Resource Need Calculator

Crisis Now Crisis System Calculator Projections - Pop. 1,000,000		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	24,000	24,000
# Initially Served by Acute Inpatient	16,320	3,360
# Referred to Acute Inpatient From Crisis Facility	-	1,336
Total # of Episodes in Acute Inpatient	16,320	4,696
# of Acute Inpatient Beds Needed	**500**	**144**
Total Cost of Acute Inpatient Beds	**$ 164,179,200**	**$ 47,237,736**
# Referred to Short-Term Bed From Stabilization Chair	-	5,342
# of Crisis Beds Needed	**-**	**41**
Total Cost of Short-Term Sub-Acute Beds	**$ -**	**$ 13,356,000**
# Initially Served by Crisis Stabilization Facility	-	12,960
# Referred to Crisis Facility by Mobile Team	-	2,304
Total # of Episodes in Crisis Facility	-	15,264
# of Crisis Stabilization Chairs Needed	**-**	**48**
Total Cost of Crisis Stabilizartion Chairs	**$ -**	**$ 18,840,137**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**7**
Total # of Episodes with Mobile Team	-	7,680
Total Cost of Mobile Teams	**$ -**	**$ 2,761,644**
# of Unique Individuals Served	**16,320**	**24,000**
TOTAL Inpatient and Crisis Cost	**$ 164,179,200**	**$ 82,195,517**
ED Costs ($1,233 Per Acute Admit)	**$ 20,122,560**	**$ 5,789,675**
TOTAL Cost	**$ 184,301,760**	**$ 87,985,192**
TOTAL Change in Cost		**-52%**

Tips for System Implementation

Workforce Development

Communities across the nation are challenged by a limited workforce to meet the needs of individuals with mental health and substance use needs. On the surface, the creation of no-wrong-door crisis care services would seem to create greater demand for this already strained workforce. However, implementation of crisis care that aligns with these best practice guidelines actually reduces that demand by more efficiently deploying resources, connecting to care in real time in a manner that minimizes the time for symptoms to escalate and the broader inclusion of peers as a vital workforce resource with the potential to grow more quickly than others employed in behavioral health care delivery.

Crisis call center operations that incorporate air traffic control-type functioning dramatically increase the efficiency of the overall system. Offerings such as GPS-enabled mobile team dispatch, real-time bed registry with coordination into care and outpatient appointment scheduling all decrease the volume of mobile teams and beds needed to meet the needs of the community. Crisis receiving and stabilization centers that efficiently assess the needs of the individual and stabilize crisis episodes in less than half the time of traditional inpatient settings further decrease the demand on beds that must be staffed.

In the *Crisis Resource Need Calculator* example, implementation of a comprehensive crisis system with the addition of seven mobile teams decreases the projected bed need from 500 to 233 (beds and chairs) for the hypothetical community of 1,000,000 residents. This translates into a reduction in workforce demand and it should be noted that staffing patterns that align with these best practice guidelines will employee peers into approximately 1/3rd of the projected positions.

Mobile Team Staffing

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's or Bachelor's-level clinician may be paired with a peer support specialist with backup by psychiatrists or other master's-level clinicians who are typically accessed for on-call support as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

In this model, almost half of the mobile team system workforce would be filled by peers who are more broadly available to fill roles that their licensed and/or credentialed clinician team partners may not be available to fill.

Crisis Receiving and Stabilization Facility Staffing

Crisis receiving and stabilization facilities must be staffed every hour of every day without exception so they will be equipped to accept any referral that comes to the program. To fulfill

this commitment, programs must be staffed by a multidisciplinary team with expertise in mental health and substance use care that includes the following:

1. Psychiatrists or psychiatric nurse practitioners (telehealth may be used);
2. Nurses;
3. Licensed and/or credentialed clinicians capable of completing assessments; *and*
4. Peers with lived experience similar to those of the population served.

The innovative *Crisis Receiving and Stabilization Facility Staffing Calculator* (*example below*) can be used to project optimum staffing for one of these programs based on a number of variables that include:

1. Percentage served under involuntary commitment;
2. Percentage served via law enforcement drop-off;
3. Number of admissions per day;
4. Average length of stay;
5. Average number of seclusion and restraints per day;
6. Average program census; *and*
7. Number of one-on-one assignments in the program.

Figure 2 – Crisis Receiving and Stabilization Facility Staffing Calculator

Training Crisis Team Members

Many members of the crisis services delivery team are licensed mental health and substance use professionals operating within the scope of their license and training with supervision delivered in a manner consistent with professional expectations of the licensing board. Licensed

professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program; including the incorporation of ongoing supervision with licensed professionals available on site at all times. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives and role-specific tasks.

Training crisis team members must include training on the *National Guidelines for Crisis Care Best Practice Toolkit* with a strong emphasis on the essential structural elements of a crisis system and the crisis care principles and practices that follow:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; *and*
4. Essential crisis care principles and practices that include:
   - Addressing recovery needs,
   - Significant role for peers,
   - Trauma-informed care,
   - Suicide safer care,
   - Safety/security for staff and consumers *and*
   - Crisis response partnerships with law enforcement.

All of these must be presented and learned within the context of embracing the crisis system's responsibility to serve as a no-wrong-door path to accessing care for all community members in need of immediate access to mental health and substance use care. Let the message of "Thank you, can I have another?" remain at the forefront of every team members' minds as they engage in activities that support true emergency department and justice system diversion by offering care that aligns with the needs of the individual engaged by the team. Providers must ensure that non-licensed individuals deliver services within the scope of their allowed practice with supervision that supports best practice care.

Technology in Crisis Care

Technology such as GPS-enabled mobile team dispatch, real-time bed registry and coordination, centralized outpatient appointment scheduling and performance dashboards that support air-traffic control-type functioning in the crisis system play an important role in solidifying crisis care. Additionally, telehealth is becoming increasingly important within the context of increasing access to limited mental health and substance use resources; particularly licensed and/or credentialed clinicians as well as psychiatrists and psychiatric nurse practitioners. Although this mode of service delivery is more prominently applied in rural and frontier communities, there is

also an opportunity to use this approach to establish greater efficiencies when offering 24/7 access that may not have a consistent or high-volume flow during specific times throughout any given day. Application of telehealth services must align with local regulations and should continue to involve other members of the multi-disciplinary crisis team in face-to-face support as these advanced technologies are incorporated in crisis care practices.

System Evaluation Tools

As communities work to implement true crisis systems of care that meet the needs of their residents, SAMHSA wants to ensure resources to support advancement of best practice care be made accessible to all. Innovative community and staffing analytic calculators and videos around program structure have been made available on the National Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and are also published as part of this evidence-based practice resource page. Additionally, we have created a *Crisis Service Best Practice Review Tool* with a listing of evaluated elements included in this section of the toolkit. You will see that the tool is designed to evaluate the degree of implementation of essential element implementation tips that have been defined throughout this *Toolkit*. The elements are summarized here:

1. Regional or statewide crisis call centers coordinating in real time:
    a. Operate every moment of every day (24/7/365);
    b. Staff with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
    c. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
    d. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
    e. Coordinate connections to crisis mobile team services in the region;
    f. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed;
    g. Incorporate Caller ID functioning;
    h. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
    i. Implement real-time regional bed registry technology to support efficient connection to needed resources; *and*
    j. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.
2. Centrally deployed, 24/7 mobile crisis systems:
    a. Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
    b. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or to particular days/times;
    c. Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed;
    d. Incorporate peers within the mobile crisis team;
    e. Respond without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion;
    f. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*

    g. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.

3. 23-hour crisis receiving and stabilization programs:

    a. Accept all referrals;

    b. Do not require medical clearance prior to admission but will assess for and support medical stability while in the program;

    c. Design their services to address mental health and substance use crisis issues;

    d. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges:

    e. Staff at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:

        i. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)

        ii. Nurses

        iii. Licensed and/or credential clinicians capable of completing assessments in the region; and

        iv. Peers with lived experience similar to those of the population served.

    f. Offer walk-in and first responder drop-off options;

    g. Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no-rejection policy for first responders;

    h. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;

    i. Function as a 24 hour or less crisis receiving and stabilization facility;

    j. Offer a dedicated first responder drop-off area;

    k. Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support timely transitions to secure placement for individuals who need additional support;

    l. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*

    m. Coordinate connection to ongoing care.

4. Essential crisis care principles and practices:

    a. Addressing recovery needs,

    b. Significant role for peers,

    c. Trauma-informed care,

    d. *Zero Suicide*/suicide safer care,

    e. Safety/security for staff and consumers *and*

    f. Crisis response partnerships with law enforcement.

Monitoring System and Provider Performance

In addition to monitoring fidelity to the *National Guidelines of Crisis Care*, funders, system administrators and crisis service providers should continuously evaluate performance through the use of shared data systems. System transparency and regularly monitoring of key performance indicators supports continuous quality improvement efforts. It is highly

recommended that systems connect data in a manner that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches focused on value. Performance metrics should include the following:

- Crisis Call Center Services:
  - Call volume,
  - Average speed of answer,
  - Average delay,
  - Average length of call,
  - Call abandonment rate,
  - Percentage of calls resolved by phone,
  - Number of mobile teams dispatched,
  - Number of individuals connected to a crisis or hospital bed, *and*
  - Number of first responder-initiated calls connected to care.

- Crisis Mobile Services:
  - Number served per 8-hour shift,
  - Average response time,
  - Percentage of calls responded to within 1 hour… 2 hours,
  - Longest response time, *and*
  - Percentage of mobile crisis responses resolved in the community.

- Crisis Receiving and Stabilization Services:
  - Number served (could be a measure of individuals served per chair daily),
  - Percentage of referrals accepted,
  - Percentage of referrals from law enforcement (hospital and jail diversion),
  - Law enforcement drop-off time,
  - Percentage of referrals from all first responders,
  - Average length of stay,
  - Percentage discharge to the community,
  - Percentage of involuntary commitment referrals converted to voluntary,
  - Percentage not referred to emergency department for medical care,
  - Readmission rate,
  - Percentage completing an outpatient follow-up visit after discharge,
  - Total cost of care for crisis episode,
  - Guest service satisfaction, *and*
  - Percentage of individuals reporting improvement in ability to manage future crisis.

Marketing and Communication Efforts

The evolution of true crisis care services is essential to improving the health of our communities. Comprehensive crisis systems that align with these best practice guidelines offer universal real-time access to the most appropriate services, supports and resources to decrease the utilization of 911, emergency departments and jail for individuals experiencing mental health and substance use emergencies. Critical to the success of these services is an effective marketing strategy and campaign to inform communities of their existence and educate how to access the services when needed.

To evolve marketing and communication plans that effectively meet the community education objectives, communities are encourage to engage broad stakeholder groups that should minimally include law enforcement, hospitals with emergency departments, fire departments, ambulance providers, mental health advocacy agencies, community health providers, faith-based communities, schools, health plans, local Medicaid team members, those engaged in the service delivery system and their families.

The goal of these dialogs is to create public information materials and educational marketing campaign strategies that translate into regional and statewide crisis system resource access educational efforts with specific details on how the three core elements of the crisis system (crisis line, crisis mobile and crisis receiving and stabilization facilities) offer immediate access to care for anyone in the community through a no-wrong-door safety net system.

Minimum elements of a successful plan marketing and communication plan include:

1. Evaluation of educational and marketing services for various age groups and other targeted populations;

2. Key metrics that can be used to assess the impact of marketing strategies along with an evaluation plan to determine the effectiveness of the statewide and regional marketing strategies;

3. Distribution of materials based on the collaboratively developed marketing and communication plan;

4. Assessment of effectiveness of the plan and adjustment of the approach as needed; *and*

5. Ongoing meetings with key stakeholders, including first responders, local hospitals and health plans, to support appropriate diversion from emergency departments and justice systems.

Conclusion

Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care – A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

For crisis services to work effectively, the handoff from law enforcement must be quick, with assessment occurring after—and not before—the handoff takes place. There must be a full partnership with the community and an understanding by community partners, particularly law enforcement, of how crisis services can most effectively work to divert individuals from hospitalization and longer-term engagement with the criminal justice system.

Once the individual is engaged, treatment must be trauma and recovery-informed and engage peers with lived experience who can serve as mentors and models. Zero Suicide and safer-suicide must be a central focus.

But an effective crisis services program must be sustainable and sustainability requires a sustainable funding mechanism, supported by formal funding codes, that is not wholly dependent on the innovative braiding of small streams of revenue. Commitment by the community and state and local governments is essential for crisis services to remain an important element of the continuum of care for individuals in behavioral health crisis. And of course, any continuous funding stream requires continuous quality improvement of the system to ensure that it is effective and cost-effective, using current best evidence to produce positive outcomes that ensure clients will find their way to recovery.

Continuous Quality Improvement & Innovation

Case Study #1

In 2014, Connections Health Solutions began operating the crisis stabilization programs inside the Crisis Response Center in Tucson, Arizona. It seems self-evident that crisis services should offer timely, high quality care to people experiencing a psychiatric emergency. The response must match the need. Remember the opening theme to the long running NBC hit ER: everyone is running because lives depend on it.

Dr. Margie Balfour found the reality of crisis services was often the exact opposite. It can take hours or even days in an emergency department to be "medically cleared" before entrance is granted to many of the nation's "crisis stabilization" programs. Law enforcement and first responders are expected to take the person in crisis to the hospital first, not the crisis unit. It should be noted that these programs do not represent crisis receiving and stabilization facilities as defined in this *Crisis Service Best Practice Toolkit*.

The experience of the more than 13,000 individuals that utilized the services of the Crisis Response Center each year had been uneven. There were often long delays in the clinical triage area while the patient awaited a decision on whether he or she would be admitted or discharged. Frustration abounded. The result was a decrease in safety that manifested as increases in injuries and assaults. Individuals in crisis were sometimes left unattended for long periods of time and staff were spread areas amongst multiple program areas. Security was frequently involved.

Lean Six Sigma in Action

There was a significant need to improve and speed the triage process but there was a lack of agreement on the mission of the facility. Dr. Balfour and the Connections Health Solutions team met with the leadership and front-line staff in a series of town-hall meetings, conducted rounds in the facility to interview patients and staff, and worked shifts to view the experience up close and personal. The result of this process was a singular mission: **Meet the immediate needs of those in behavioral health crisis in a safe and supportive environment.**

In order to re-engineer the Crisis Response Center for this new mission, Dr. Balfour and the team incorporated a Lean Six Sigma approach to quality improvement. Motorola and Toyota both revolutionized process improvement by eliminating waste and improving the flow of manufacturing and by building upon the pioneering work of Edwards Deming in the 1950s (think Plan-Do-Study-Act). Healthcare has been slow to catch the vision and crisis care for behavioral health has been characterized by "crisis programs" that do not actually operate as emergency or crisis service options that serve all in need. These programs that do not align with best practice guidelines are characterized by waiting for care and clearance or screening to initiate an often-lengthy process.

The team began by establishing some assumptions. They would achieve gains with the existing resources and staff by standardizing the process and eliminating the waste of inefficient practices. They also introduced a number of interventions that include improved dashboard

tracking tools. Next, they analyzed wasted time and function. What were the tasks that added value? What were the tasks that added little value but were nevertheless required (by licensure, contract, etc.)? And finally, what were the tasks that were unnecessary and simply represented waste?

The value analysis found that the old process required almost 11 hours to connect to needed care and that nearly 40% of this process was simply unnecessary and non-value added. Wasted time for individuals and family members dealing with a behavioral health crisis. Idly sitting in the waiting room comprised a significant portion of this time but there were also inefficiencies in some of the tasks of the crisis provider.

The Results

The Connections Health Solutions team reduced the "door to door dwell times." The average time spent in the triage clinic decreased from seven hours to two hours and the time in the 23-hour unit decreased by 30%; improving not only the patient experience but also the capacity of the facility to serve the community by more efficiently serving those in need.

Even if you haven't been in a psychiatric crisis, most everyone has been to the emergency room and the key metric we all remember from the experience remains with us… how long did it take us to see the doctor? Dr. Balfour's team reduced the waiting time by nearly 80%. These significant gains had other cascading benefits. For example, the facility dramatically reduced the time it spent on diversion from referrals due to operating at full capacity so that it could better serve the needs of those in crisis in the greater Tucson area. Assaults to staff and calls to security were also dramatically reduced and the changes in process yielded additional space availability. The building was remodeled to take advantage of these improvements and the capacity of the temporary observation unit was increased by 36% to further increase capacity in a manner that supports their commitment to accept all referrals.

Dr. Balfour believes there were several key ingredients in their Tucson Arizona success. They engaged everyone from top leadership to the line staff. They kept compliance and quality functions separate and obtained Lean Six Sigma green belt certification for quality staff while building the IT and data system necessary to track and report accurately.

The metric that brings all this into focus is the law enforcement drop-off turnaround time. First responders do not take people in crisis to the emergency room first. They drive straight to crisis facilities in Phoenix or Tucson where they spend less than 10 minutes before returning to their patrol. Connections Health Services measures performance and progress through the levels below.

Levels of Accomplishment

Level 1	Everyone in the organization/department knows what the unit's core processes are.
Level 2	Each core process is fundamentally documented.
Level 3	The primary customer requirements of each process are documented and conformance to spec is tracked.
Level 4	The primary control factors that drive desired performance for each process are documented and tracked.

| Level 5 | Each process can be documented to be behaving as intended (e.g., is "in control"). |
| Level 6 | Each process is completely standardized, in control, and has an on-going continuous improvement plan. |

*Dr. Margie Balfour's article **"Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs,"** Community Mental Health Journal, 2015 ([download here](#)), includes the outcomes model below.*

Figure 3 – Crisis Reliability Indicators Supporting Emergency Services Framework
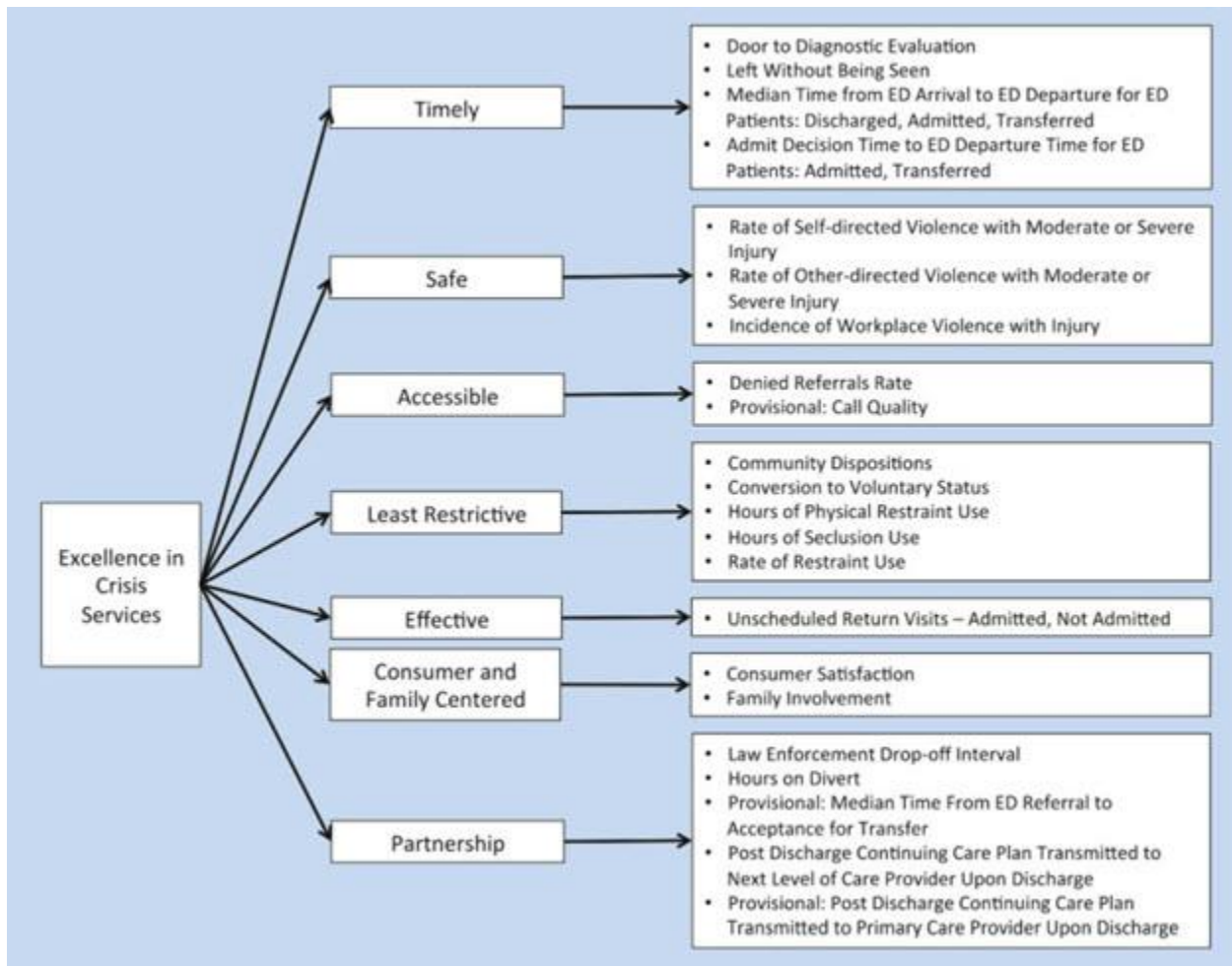
Case Study #2

In 1996, Recovery Innovations, Inc. (dba RI International) created its first Crisis Recovery Center just outside Phoenix, Arizona in the west valley city of Peoria. Like many similar Crisis Stabilization Programs across the country, it offered an alternative to acute inpatient, jail and emergency departments (EDs), a place where a mental health crisis could be handled by professionals as immediately as possible.

This program was an improvement, but it still had some of the issues that plague crisis care in EDs. It focused too much on procedures and diagnoses and too little on engagement and collaboration, which are vitally important for the individual in a mental health crisis. The hospital model was designed to treat disease and injury and RI set out to develop a new and unique approach that would handle the needs of those in debilitating emotional pain.

In 2002, RI began its evolution of the Crisis Recovery Center with the development of the Living Room model. It featured a strong focus on good contact with the person in distress and introduced new staff types as well. Certified Peer Specialists brought their own experience in mental health crisis and recovery and empathic and trauma-informed care into the interdisciplinary team.

The facility transformed from a colder, more sterile, traditional medical setting to have a warm inviting feel. Individuals were referred to as guests and not consumers. The teams began quality improvement efforts to reduce the prevalence of seclusion and restraint. And, overall, the Living Room felt more like home than an institution.

Still, there was the potential to make real community impact, since most acute cases were being diverted to traditional crisis facilities, i.e., hospitals and jails. In 2014, the leadership at Mercy Care, the health plan tasked by the Arizona Healthcare Cost Containment System (AHCCCS, the Arizona Medicaid authority), challenged RI to adopt the never-reject approach to law enforcement drop-offs.

At that time, RI was receiving 100 to 150 law enforcement drop-offs per month, but they were also diverting individuals that were deemed inappropriate. If there was concern about a medical challenge, primary substance use problem, history of aggressive behaviors, etc., law enforcement was instructed to take the person to a different facility. This approach required law enforcement to wait around while decisions were made (an approach leaders in LAPD have coined "wall time") and then transport them after evaluation.

RI determined to fully adopt the new approach. The facility already had a special law enforcement drop-off admission room that was attached directly to the 23-hour temporary observation and treatment unit. A lighted sign directed the officer to park directly adjacent to the unit where they could easily walk the individual in crisis a few short steps to immediate access.

The new approach meant that the officer would never be asked to wait for an evaluation. A peer leader would greet the individual and introductions would be made. The law enforcement officer would share any paperwork, if available, and exit to return to the work of public safety within three to five minutes.

RI leadership was concerned about the potential loss of the Living Room culture and experience but also fully grasped the stronger community impact of a true no-wrong-door approach. And, the Fusion Model was born, combining the direct and safe access of a hospital ED with the recovery-oriented approach of the Living Room.

Figure 4 – Peoria, Arizona Crisis Recovery Center Law Enforcement Drop-Offs
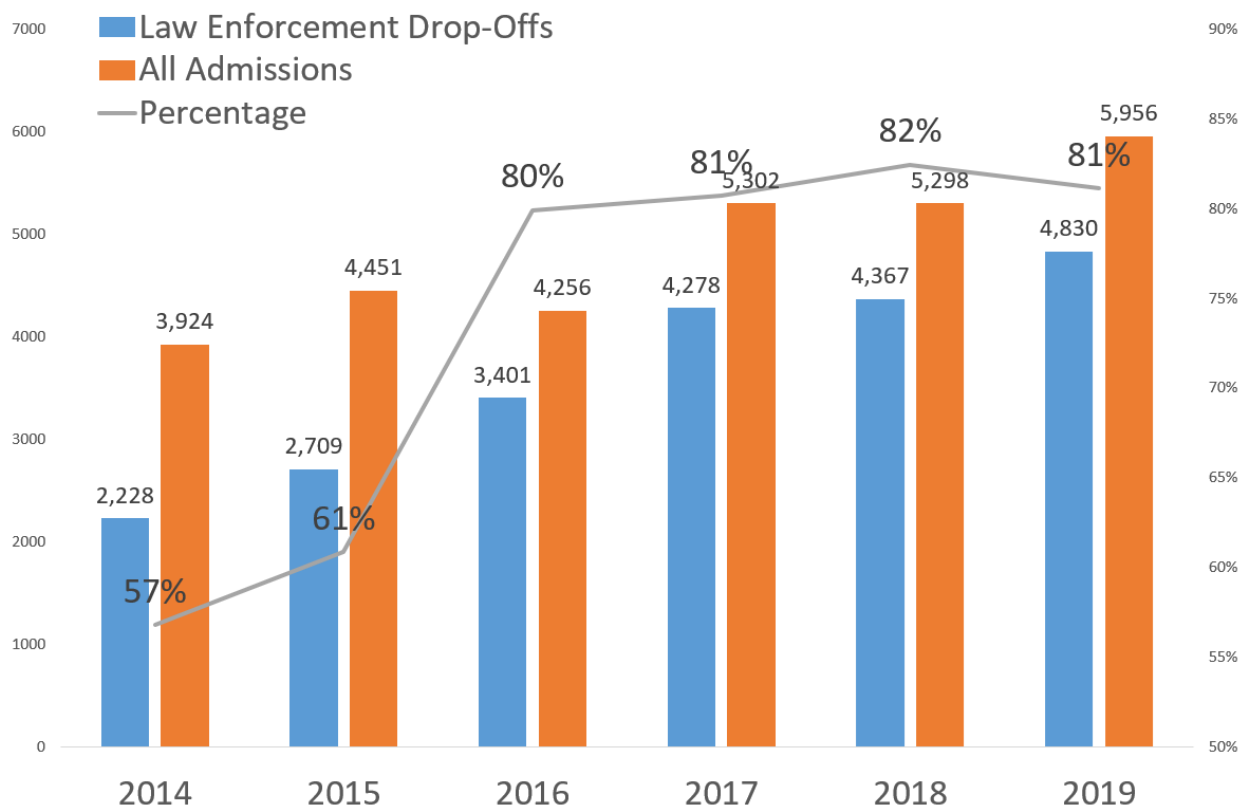
In late 2019, RI will admit the 20,000th consecutive guest who is dropped off by law enforcement, without a single rejection for any reason. While there have occasionally been guests who had a medical complication that was not obvious to the law enforcement officer, and that required more intensive hospital attention, additional treatment was organized by the Crisis Recovery Center, including transportation where appropriate. None of this was delegated to law enforcement, which has been immediately released to return to duty following a referral.

The graphic on the previous page demonstrates the increase in the total number of individuals in a crisis served by the program and law enforcement referral activity over the time period that this model was adopted. With 32 licensed chairs in the 23-hour observation and treatment program and 16 beds in the sub-acute crisis program, the law enforcement drop-off number doubled over the time-frame. Always accepting law enforcement referrals increases officer trust that making a drive to the facility is preferable to other traditional options, i.e., jail, hospital, relocation, etc.

Today, 80% of all guests received by the program are referred by law enforcement, and none of them first visited a hospital ED for medical clearance. The program has literally not refused a single police referral in the past five years, despite over half being involuntary. But unlike entering a hospital or jail, these individuals in crisis are immediately greeted by a peer staff who orients them to the care they will receive. There is active engagement and collaboration throughout their stay, and they become active participants.

In the Fusion Model, crisis becomes an event to be resolved and stabilized, versus a diagnosis to be treated. And, since law enforcement engages in zero wall time by by-passing the ER completely and is back on the street in less than five minutes, the burden on police is eased and the experience for the person in crisis is improved.

Figure 5 - Crisis Recovery Centers implementing the Fusion Model Across Several States

Addendum

Interview 1 – *Wesley Sowers, MD*

Ahead of the Curve: LOCUS Is as Relevant Today as It Was in the Nineties

In the mid-1990s, Wesley Sowers, MD, was the medical director for St. Francis Medical Center in Pittsburgh, the largest addiction treatment center in Pennsylvania at the time. A tug-of-war was brewing between clinicians and managed care plans over who got to determine what was best for clients. Dr. Sowers, who is now the director for the Center for Public Service Psychiatry at the University of Pittsburgh, says clinicians showed considerable variability in decision-making, which didn't always include judicious use of resources and often resulted in more extensive hospital stays than people needed.

"There wasn't much thought about how we could use resources most effectively." This began to manifest in burgeoning costs of care and was one of the reasons state and local governments, as well as private insurers, started to examine ways to control costs. The behavioral health community understandably feared that these limitations would harm treatment quality, and clinicians worried that managed care would eliminate their autonomy. "Both had a rationale behind what they were doing and why they were doing it. While managed care reforms were needed, many went too far." Dr. Sowers, who had long been interested in systems, believed there was a sweet spot where balance could be achieved, and so he began to develop a mechanism that would determine best outcomes for people and systems of care: a win-win in facilitating person-centered care and cost-effective resource use.

Examining how to optimize treatment quality and manage costs, Dr. Sowers attempted to develop an integrated medical necessity tool to help match patient need with the appropriate service intensity. He also wanted to create a structure that was as effective for people with addictive disorders as those with mental health issues, closing a divide perpetuated in behavioral health. "I was interested in co-occurring disorders and wanted to consider the interaction of mental illness, addiction, and physical issues that might affect people's treatment response." Dr. Sowers' answer was to design a comprehensive system that focused on seven assessment dimensions: risk of harm; functional status; medical, addictive and psychiatric comorbidity; recovery environment (this dimension has two subscales: level of stress and level of support); treatment and recovery history; and engagement and recovery status. These became the core of the Level of Care Utilization System known as LOCUS. With input and support from the American Association of Community Psychiatrists (AACP), Dr. Sowers developed an algorithm in 1996 that makes it simple for clinicians to provide best-fit recommendations for care intensity. A rating in each dimension ranges from lowest to highest need: from 1 to 5, respectively. The clinician then adds the numbers for each dimension together, resulting in a composite score that indicates a person's degree of need and the corresponding level of care required. Scores range from 7 as the lowest possible level of need and 35 as the highest.

Once LOCUS identifies the correct level of care in the continuum, providers can select from a menu of services tailored to a person's particular needs. Menu items include clinical services, supportive services or crisis resolution and prevention services and describe the conditions of the care environment. Dr. Sowers says that, on average, a person with a lower composite score wouldn't have the same need-intensity as a person with a higher one, but that isn't always the case. He says the first three dimensions—risk of harm, functional status, and comorbidity—include overriding concerns. If a person scores high in these critical areas, the algorithm will alter recommendations accordingly, pairing the person with an increased level of service. "There is a composite score and treatment grid that gives clinicians the correct placement. It's easy to use."

Dr. Sowers never anticipated it would work so well and has been pleasantly surprised at how widespread adoption has been; not just when it was developed it in the 1990s but in the decades since. Unlike most innovations, LOCUS is a tool that is as applicable today as when it began. Since their inception, LOCUS and CALOCUS (the Child and Adolescent counterpart) have gone through revisions to improve accessibility and clarity. "Along the way, we have asked people to tell us what doesn't work and what could be improved." Interestingly, he says that over the years, there hasn't been much need to change the rating system, but there have been minor adjustments to service intensity and level of care descriptions. "It has been a 20-plus-year process, and LOCUS is continually picking up momentum." Part of the reason, he says, is that while many clinicians still use paper and pencil, the automated version is increasingly used and preferred, particularly as hospitals and treatment centers move toward electronic medical records.

Though the use of LOCUS is widespread, Dr. Sowers isn't sure how comprehensively clinicians are using it. He built the system to span the service array and care continuum. The clinical structure translates from one level of care to the next and easily lends itself to a person-centered care and recovery paradigm. Dr. Sowers says there should be ongoing, continuous assessment throughout a person's treatment experience. "Using surveys, we have tried to determine whether there is full LOCUS use, but it hasn't yielded much information. Anecdotally, we can tell that many organizations only use it in a crisis setting, in some residential facilities, or in inpatient settings instead of along the entire continuum of care."

Using LOCUS in limited settings doesn't maximize its potential. Unlike alternative tools, the assessment takes into consideration prior responses to treatment and social and interpersonal determinants of functional impairment. Dr. Sowers says he and the AACP designed the system to guide continuous treatment planning, giving clinicians an indication of what needs to be improved upon to move a person down to a lower, less restrictive level of care. The objective is to follow the person as he or she moves through different care levels, tracking not only individual progress but also the entire system of clinical management. "It clarifies and unifies what we do in clinical settings, allowing us to identify the correct level of care for a person and the most cost-effective measures that ensure the best outcomes."

Interview 2 – *Sandra Schneider, MD, FACEP*

Emergency Mental Health is a Throwback of the 1950s Emergency Department

Sandra Schneider, MD, FACEP, a past President of the American College of Emergency Physicians (ACEP), says current day emergency mental health is reminiscent of the 1950s Emergency Department. It is a throwback, she says, in dire need of an upgrade.

What we know of today as the Emergency Department, shortened to ED by those in the field, began to take shape immediately after World War II. The climate in the United States at the time held lingering remnants of recent conflict and economic depression. At the same time, the innovation of the interstate highway made opportunity boundless, offering Americans a fresh start and quickly changing the face of medicine. Specialists who used large equipment they couldn't transport replaced family doctors and their small, black bags. These doctors had office hours and didn't make house calls. If an emergency arose, people went to the hospital. The ED started as a room in a hospital basement called 'The Pit.' It was overcrowded and run by some of the least experienced physicians who were treating the most dangerous situations, often resulting in grave consequences. [1] Dr. Schneider says that since then emergency medicine has made remarkable strides in every specialty area except mental health. The reasons for stagnancy, she says, are vague diagnostic criteria, challenges in case follow-up, lack of warm handoffs, and unlike all other specialties, emergency medicine physicians and psychiatrists have not had decades of collaboration.

Partnerships and the Golden Period of Intervention

While the direst situations were brought to the ED in the 1950s, specialists often failed to give patients timely care because they were on call for their practices. In 1961, Dr. James D. Mills realized that emergency medicine needed to be a specialization in and of itself. He convinced three of his coworkers to leave private practice to develop an ED alongside him in Alexandria, Virginia, becoming full-time emergency physicians working 12-hour shifts 5-day a week. Simultaneously, a group of 23 doctors in Pontiac, Michigan, did the same, working part-time to staff the ED at Pontiac General Hospital 24-hours a day.

Dr. Mills and his colleagues were the first to do this full time and say," Hey, this works for patients and us." Dr. Mills would call in a surgeon to do surgery or a pediatrician if the patient was young, fostering a partnership between ED physicians and specialists. Patients spent about the first 30 minutes with the ED physician and the next half-hour with a specialist, allowing emergency medicine physicians to learn: first through observation, then by consulting with specialists on the phone until finally, they could generally handle the cases themselves. Today, Emergency Department (ED) physicians often do procedures and no longer need specialists to come in and perform them. For example, says Dr. Schneider, ED physicians do far more intubations than many physicians in internal medicine or even anesthesiologists who predominantly do outpatient work. No such leaps have happened in psychiatric emergency medicine. She says the result is that ED staff often don't identify and fail to treat mental health crises during critical intervention periods. Emergency medicine physicians believe the first 30 minutes to an hour to be the most critical for outcomes, calling it the golden hour of intervention. For example, if a person has a stroke, ED

staff have about three hours to get the clot-busting drug tPA (tissue Plasminogen Activator) into the patient. "If that doesn't happen, the person is out-of-luck." In the case of a heart attack, doctors have a 90-minute window to intervene. Partnerships with specialists have allowed ED physicians to fully utilize the golden hour of intervention, improving outcomes and mortality and allowing patients a far better chance of leading normal lives.

Dr. Schneider says that in mental health, she and her colleagues understand that the longer a person is in psychosis, the more challenging it is to reverse. "It may not be a golden hour but more like golden days or even a week, but there is a critical window for intervention, especially in high acuity suicidality and psychosis."

Pattern Recognition and Follow-up

Emergency medicine physicians have learned through patterns, and, with the help of specialists, what is best to do during the golden hour of intervention. The field has developed through partnership, follow-up, and pattern recognition. That is not the case for psychiatry, which Dr. Schneider says is the least rote specialty. She can look at an EKG and see that the patient is experiencing a heart attack, or, if a patient comes in and cannot lift his arm and is not using his leg, he might have a seven on the Stroke Scale. Or if the person's blood count is low, he may need a blood transfusion. Through pattern recognition, training, and established intervention, Dr. Schneider can determine a person's critical needs.

Psychiatry is not as transparent. "I may have a patient who isn't making sense or is depressed, but there is no serum delirium or depression score for me to determine the level of acuity. We've not been trained and, as a result, never figured out the pattern recognition like we have in all other specialties. For many of us, our background is the month we spent on psychiatry in residency, so we feel out of our comfort zone." She says this is compounded by vague psychiatric diagnostic criteria, the components of which most emergency medicine physicians do not understand and minimal, if any, feedback after a handoff. Pattern recognition, says Dr. Schneider, is not just developed by working alongside specialists but also through follow-up. Dr. Schneider says that doesn't happen with psychiatric patients. If a patient has a rash that the ED physician suspects is a melanoma, she can follow-up and find out if she was correct, which helps to improve pattern recognition. On the other hand, if she wants to know whether she was right about the acuity of a patient's suicidality, that information is not accessible. "The result is we don't gain critical follow-up knowledge on psychiatric crisis."

No Warm Handoff

One challenge, says Dr. Schneider, is that while it is impossible to see the level of acuity in mental health, ED physicians realize that lack of bleeding does not mean it is not a high acuity case. The result is ED physicians often default to an assumption of high acuity, triggering numerous challenges for patients, including hospitalization and the corresponding trauma of institutionalization, stigma, and the detrimental impact on the patient's employment, finances, and personal life.

Part of the reason for defaulting to high acuity is the result of an 'it's-better-to-be-safe-than-sorry' mentality, but it is also because ED physicians are not always confident that the patient will get the care she needs if discharged. Dr. Schneider says that more than any other specialty, there is a disconnect on what comes next for the patient. For example, if a patient comes in with appendicitis, the ED physician can call a surgeon. In the case of a rash, the ED has a roster of dermatologists and clinics, and in many cases, the physician can even make an appointment for the patient. These partnerships create confidence in the system and an appeals process if the ED doctor doesn't agree with the specialist: the emergency medicine physician and specialist can get on the phone and discuss the case.

Dr. Schneider says this communication does not exist between most EDs and the mental health system, making navigating it incredibly difficult for ED staff. She says if she has a patient with depression who is feeling suicidal and needs mental health care in the next couple of days, she has no idea how to get them what they need.

The same is true for substance abuse. "Let's say a person with an opioid use disorder comes in and has managed to withdraw but needs help for his addiction. All most ED physicians can do is hand him a list of addiction centers to start calling in the morning. Can you imagine if we did that with any other medical issue? If someone comes in with chest pain, I can get them set up with a stress test the next day, regardless if she has insurance. Why is it with mental health it's okay to give patients a list and say, 'Good luck'?" Emergency medicine physicians need to be able to do a handoff and have confidence in that handoff. "If there is someone to evaluate the patient, but I don't know the person and whether he or she has made the right decision for the patient, that's not a warm handoff."

Dr. Schneider says now is the time to improve the relationship between the ED and psychiatry because she believes emergency medicine physicians will soon be playing an increasingly critical role. The approved use of intervention medications, such as Ketamine and Brexanolone, for depression and postpartum depression, means that ED physicians will be able to decrease acuity with medication so that patients can go home and seek care within a week or so. She says it is similar to how the ED addresses patients with atrial fibrillation (A Fib) or a blood clot. Physicians diagnose, stop, and often reverse the emergency, before sending the patient to primary care. "We would acutely treat them and do a warm handoff."

Replicating the Poison Center Model in Emergency Mental Health

Dr. Schneider recommends that mental health mirror the poison control center. Each center has a medical director and pharmacists, physicians, nurses, and toxicologists that answers the phone 24/7. If a physician is unfamiliar with the drug a patient took, the center will triage the call to a Specialist in Poison Information (the specialists are called SPIs, pronounced spies). For example, if a person took Banamine, a horse anti-inflammatory, the ED physician can call a poison control center and speak with an SPI who has access to a vast database that lists all chemicals and outcomes in previous exposures. The SPI would tell the ED physician what's happened in previous cases such as: "Above this amount we've seen these problems so you should watch the person for kidney function." If the situation is more complicated because the person took more than one

drug, then the ED physician's call would be forwarded to the toxicologist. (Typically, only 1 out 100 calls escalate to the toxicologist.)

The SPI also does follow-up and tracks outcomes. For example, if the person who took Banamine had a seizure, the SPI would add that to the database. They would also call the patient and ask how the person is doing and see if he or she needs an appointment. If a child drank bleach, the SPI would speak with the parents, telling them that they are not bad parents, and talking them through how to prevent the incident from happening again. They can even address more obscure poisonings. If a person eats a rare mushroom, the center will get the caller in touch with a mycologist (mushroom expert), local resources for dialysis, and the best hospital to care for the patient. The idea is that no matter where the person is at that moment, experts will be reached and local resources provided.

Psychiatric Triage with a Mental Health Center

Dr. Schneider says a similar structure for mental health would allow ED physicians to speak to experts and have strong confidence in their abilities. The call could be from an ED doctor who is uncomfortable giving Suboxone, a blockbuster medication that reduces symptoms of opiate addiction and withdrawal, for the first time. The mental health center would go through a checklist and then provide a dosage recommendation. If it does not work, the ED doctor would call back, and the center would walk her through the next dose. They would also give guidance on more complex cases.

Suppose a patient has depression but no suicidal plan, a supportive family, and no lethal weapons. The mental health center expert might recommend the patient be discharged and meet with a mental health worker the next day. If the ED physician is not comfortable sending the patient home, a psychiatrist for the center could get on a video call. Dr. Schneider believes the escalation rate would be similar to that at poison centers: roughly 1 out of 100 calls would triage to the psychiatrist. After the video chat with the patient, the psychiatrist might recommend he be admitted, and help with the process, or say the patient can go home, but the center would call him in the morning to arrange an appointment. "ED physicians spend 15 minutes with a patient. We aren't going be able to add a 30-minute psychiatric evaluation, but the center would give us access to experts and a database of resources. It closes the loop of care and is the warm handoff that gives us confidence that patients will get the care they need."

Sources:

[1] 24|7|365: The Evolution of Emergency Medicine. Retrieved March 11, 2019, from https://www.emra.org/about-emra/publications/legacy-documentary

Interview 3 – *Shelby Rowe*

The Elephant in the Room: Mental Health Professionals Experience Crisis Too

When Shelby Rowe realized she needed help in September 2010, she called a close friend, asking the friend to drive her to a hospital out-of-state. As the executive director of the Arkansas Crisis Center, Rowe didn't want to run into anyone she worked with or had trained. Her distress had been slowly escalating, culminating in months filled with ruminating flashbacks and anxiety. Her marriage was quickly unraveling, triggering trauma from when she'd been in a similar position. Years prior, during her first marriage, Rowe and her husband had a terrible argument, and he left. Thirty-minutes later she received a call that tragedy had occurred: while at a friend's house, someone accidentally shot and killed her husband. "The last time I'd been in this situation, someone I loved died. During our fight, I'd told my husband, 'I hate you and wish you were dead.' A half an hour later he was. Years later, at the end of my marriage, I feared if I walked away, one of us was going to die. It didn't make sense, and I knew that, but it didn't lessen my fear."

As Rowe spent her days overseeing the implementation of the Arkansas plan for suicide prevention and running the center that operated the state's only 24/7 crisis hotline, she was simultaneously experiencing increased distress. To mitigate it, she applied the coping skills she taught others, but it wasn't enough. Her expertise in suicide prevention made her achingly aware that she was experiencing hopelessness, but Rowe questioned her symptoms: how could she, a mental health expert aware of critical interventions, be at risk? She wasn't the only one applying scrutiny as her therapist told Rowe, "You don't need hospitalization because you're aware of what you're experiencing." The therapist, and other mental health experts Rowe came across during her crisis, assumed, because of her expertise, that she was a lower suicide risk than she was and knew what to look out for and do for herself during a crisis. "A mental health professional may know the signs and what to share with others, but it's challenging to apply those skills to one's own crisis. That's why people don't treat themselves."

As Rowe's symptoms increased, she performed the assessment she did with callers, asking herself, "When is the last time you ate or slept? How long do you think you can keep yourself safe?" The answers weren't comforting. She knew it was time to seek help. In the hospital, she received what would generally pass as good care—she met with the therapist daily and the psychiatrist every other day—but they failed to address what was at the core of her crisis, Post-Traumatic Stress Disorder from her first husband's death and childhood traumas. In the high-risk months following the hospital stay, Rowe continued to experience ruminating thoughts and felt frustrated that she couldn't just shake them off. She felt despair settle in her bones with no end in sight. "Hospitalization isn't a magic wand, and I came back feeling more hopeless because the experience hadn't changed how I felt, and now there was an additional hospital bill burden to figure out." Rowe wondered if this was how life would be from this point forward, getting angry at herself for not being able to control her PTSD. "It was the night before Thanksgiving, and I went into the bathroom, looked at myself in the mirror, and said, 'I hope I never see you again.' I then made an attempt on my life." Rowe woke up two days later in bed, not knowing what happened. Her 19-year-old son was home and said, "Oh, you're up. You missed Thanksgiving." She asked why he didn't take her to the hospital, and he said, "I didn't want you to get fired."

It took four years before Rowe publicly shared her story, doing so because she felt there was a great need for more people in the mental health profession to speak about their experiences. What people often don't understand, she says, is that just because a person survives a suicide attempt doesn't mean she's committed to living. It took years, separate from public scrutiny, to set the groundwork for healing and learn to acknowledge her feelings and not be angry at herself, which reaped a highly favorable outcome: a release from fearing failure. Before that, Rowe felt embarrassed and thought her suicide attempt was an indication she should no longer work in mental health. Fortunately, Rowe's therapist when hospitalized reassured her that the field needed her perspective and expertise. He told her, "I would hire you." This shifted Rowe's perception because he could have easily suggested she pick a different career path. "I'm not certain I'd be working in this field today if it weren't for the fact that, in my moment of crisis, this person believed in my ability to do my job and to play a meaningful role in mental health." Even so, Rowe did initially have concerns about coming out as an attempt survivor because well-intentioned colleagues, some of whom heard of or directly had negative experiences when coming forward, warned her not to go public with her story.

The final push for Rowe to speak about her suicide attempt was the release of The Way Forward Report in 2014 by the National Action Alliance for Suicide Prevention's Suicide Attempt Survivors Task Force. They were putting together 60-second YouTube videos featuring attempt survivors and others directly impacted by suicide such as siblings, parents, children, and spouses. Rowe says it was remarkable to witness the field start to recognize the value of experts with direct experience. Among those coming forward were Dr. Quincy Lezine and Dr. Sally Spencer-Thomas, who asked Rowe if she'd be willing to record a video as an ally, not realizing that she was an attempt survivor. After Rowe shared her story with Dr. Spencer-Thomas, the psychologist asked her to record a video about her experience. She did. "As mental health professionals, we work against stigma, calling suicide prevention a public health issue, but then we often hide that part of ourselves for fear of rejection within that same community." Still, Rowe says sharing isn't right for everyone, and those thinking of doing so should carefully examine what they are seeking. "I never tell my story hoping to get validation from the audience. This is who I am, and my perspective is one of the tools I bring to the table." Rowe has continued to work in mental health as the suicide prevention program manager for Oklahoma's Department of Mental Health and Substance Abuse Services. She says sharing her story with those working in mental health is destigmatizing, making it easier for others to do the same. "They see me sharing my story in front of 100 to 500 of their colleagues and think, 'No one is judging her. Maybe I can do it too.'"

Rowe says the mental health community needs to work together to alter the perception of mental illness not only in the general population but also within the very community designed to treat it. "For many of us, we are facing similar struggles to the people we work with every day but hiding in the shadows regarding our own experiences for fear of stigma. That needs to change."

Interview 4 – *Ron Bruno*

CIT International 2nd Vice-President Ron Bruno Says Mental Health Care Shouldn't Come in a Law Enforcement Car

There are police departments throughout the United States that no longer answer calls they believe could result in "suicide by cop." Around 100 shootings like this happen each year, making up roughly 10% of fatal police shootings. Ron Bruno, executive director of CIT Utah and 2nd vice president at CIT International, says this is a philosophy taking hold in law enforcement agencies all over the country, but he quickly points out, people can't just be left in distress. "Something has to be done, and that's why we need to examine our crisis response system as a whole, carving out clear roles for law enforcement and mental health services." Bruno says that law enforcement has a critical part to play in the mental health crisis response system, but it needs to be in a position of support to the mental healthcare system and only when necessary. "We have to challenge the belief that mental health crisis services must come in a police car."

While there are law enforcement agencies selectively unresponsive to some mental health calls, others are doubling down on their involvement. The impetus, says Bruno, is that, historically, mental health services haven't been appropriately funded and so law enforcement became the de facto mental health crisis response system. "It fell to us, but we aren't the best solution or help to a person in an escalated state." Bruno travels around the world, speaking to audiences on de-escalation and advocating for clearly defined roles for criminal justice and behavioral health services to create a more effective crisis response system. At some point during a presentation, he often asks the audience to raise their hand if they've ever been pulled over by a police officer. Most of the hands raise. Then, he'll instruct them to keep their hands up if the experience increased their anxiety level. Hands remain raised. "Every time a police officer goes out to a crisis situation, it's going to escalate the person's emotional state. Yes, we can and will train officers to de-escalate situations, but often, their mere presence is stressful, and the person in crisis can become fearful and enter flight or fight. That's when we see major problems."

Estimates suggest that 25-50% of fatal encounters with law enforcement involve a person experiencing mental illness. Bruno says that in most cases, the interaction between law enforcement and the person in crisis is unnecessary. Just like audiences raised their hands to indicate the distress they felt when pulled over by a police officer, in de-escalation training, officers share that, in the majority of cases where they were called out, the situation didn't warrant it. Bruno says having law enforcement be the go-to for mental health crisis care appears and feels criminalizing to the person in need. "Most departments have a policy that the person in crisis will be handcuffed, placed in the back of a caged police vehicle, and taken to an ER. This is traumatizing for the person and will make it so that they are reluctant to call for help the next time they are in crisis." The result is that people in distress, and their families, allow further decompensation than they should before reaching out for help because they don't want to interact with law enforcement. "With officers declining calls and people not wanting to interface

with law enforcement when they or a family member is in crisis, it highlights that something is wrong with the current system."

The solution, says Bruno, isn't complicated. When a call goes into the Emergency Communication Center—911 dispatch—operators can be trained to triage those calls and identify whether the person in crisis is a danger to her or himself or an immediate threat to someone else. If not, then the person can be passed along to appropriate care in the mental health crisis system through a warm handoff to the crisis line. At that point, says Bruno, the crisis line can also do a secondary triage and determine whether it's still a safe situation. If they decide that it's unsafe, Bruno says they can do a warm handoff back to law enforcement, and law enforcement can send out Crisis Intervention Team (CIT) trained officers to go out and respond to those situations. "Most calls that go through 911 don't require a law enforcement response and can be transferred to a crisis line where we know the majority of calls, 80% and upward, are resolved at that level, and there's no need for police involvement."
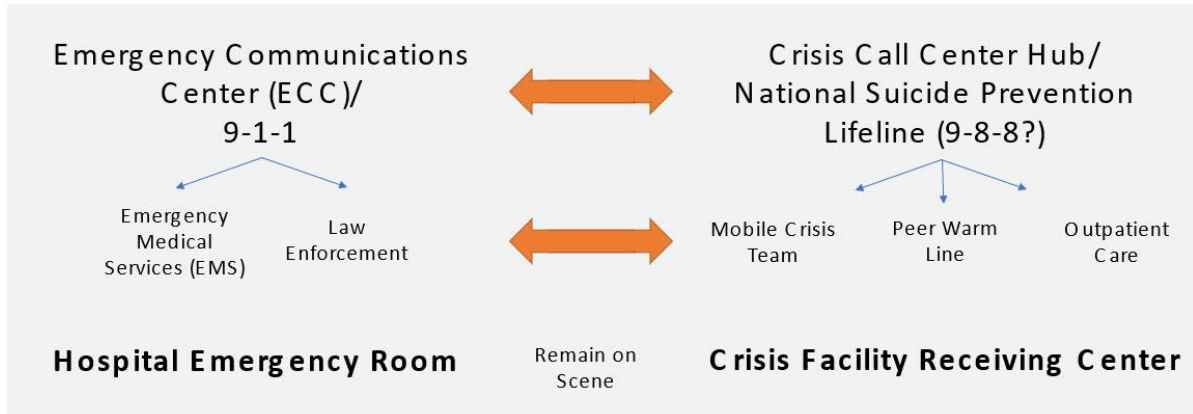
If an officer on the street comes across a person in crisis and assesses that the person is safe, she or he should reach out to mobile crisis. The challenge is that each community is unique, and many don't have a robust continuum of crisis care. Bruno says that's why each community needs to take a hard (and holistic) look at what's happening in their public mental health system, addressing potential funding and geographical challenges. Ironically, says Bruno, many communities are defaulting to the least economical solution, using law enforcement as the primary form of mental health crisis services or embedded co-responder models, where law enforcement agencies dedicate personnel and team them with clinicians to respond. "It's expensive because now you have dedicated law enforcement officers waiting around for mental health crisis calls or, like some agencies, a clinician rides around with a police officer who is handling unrelated calls."

Bruno says it's time for public mental health to return to the community and allow people in crisis to be treated within it, instead of removing them from their support systems by taking them out of their day-to-day lives and roles. "It's easier for people to transition back into their lives if they're never fully yanked out of them in the first place and can be treated in the community." He says by retraining people to call a crisis line instead of 911, it allows people to be treated in the least intrusive manner as opposed to the highest. "We've trained people to think that if a loved one is in crisis; they need to contact law enforcement who will come out and take the person into protective custody. He or she will be handcuffed, put in the back of the police car, and taken to the ER. That's what we've told people is the cost of stabilization." He says it's a grueling, stress-inducing process, that more often than not, was unnecessary. A crisis line can help decrease a person's distress, and if they are unable to, they can send out a clinician and certified peer specialist to talk to the person, and, when necessary, the support of a CIT trained police officer. The idea, says Bruno, is to maximize the use of a person's natural supports into their stabilization plan. "By doing this, we are going to retrain community members to think, 'If I become symptomatic, I contact the crisis line. If the specialist deems it appropriate, they will hand me off to a warmline. However, if necessary, they can also send out a professional who can talk to me."

Figure 6 – Law Enforcement/Crisis Triage Tree

Dedicated Mental Health Crisis Response Model

Emergency Communications Center (ECC)/ 9-1-1 ⬌ Crisis Call Center Hub/ National Suicide Prevention Lifeline (9-8-8?)

Emergency Medical Services (EMS)   Law Enforcement   Mobile Crisis Team   Peer Warm Line   Outpatient Care

Hospital Emergency Room   Remain on Scene   **Crisis Facility Receiving Center**

As contrasted with co-responder models or communities where the crisis response defaults to law enforcement and hospitals, the dedicated approach ensures law enforcement and hospitals are only involved as required by their core mission, public safety and/or medical stabilization. The vast majority of psychiatric crises require neither.

Bruno says it's time for a change, "Let's treat crisis in the most compassionate and least intrusive manner."

Want to see a flowchart that gives a clear example of risk assessment? Take a look at the recently released Broome County 911 call diversion emotionally distressed caller risk assessment in the CIT best practices guide.

Interview 5 – *John Draper, PhD*

Dr. Draper of the Lifeline Believes a Three-digit-number for Mental Health and Suicide Crisis will One Day be as Ubiquitous as 911

The murder of Kitty Genovese in Queens, New York, in 1964 sparked outrage and was one of the driving forces behind the 911 emergency call system people know and depend on today. It wasn't the murder itself that left people incensed but that 38 people witnessed Winston Moseley kill Genovese and did nothing about it. The behavioral reaction was later called The Bystander Effect or Kitty Genovese Syndrome. It turns out that at least one man did call the police to report that Genovese was seriously injured. His call went unanswered.

Most people can't remember a time before a centralized number for people to call in an emergency; when people dialed 0 for an operator or directly called the nearest police or fire station. John Draper, Ph.D., project director of the SAMHSA-funded National Suicide Prevention Lifeline (800-237-TALK or chat), hopes that a three-digit-number for mental health and suicide crisis will one day be equally ubiquitous. "Right now people have to remember an 800-number, and even though calls go up 15-percent per year and 2.2 million calls were answered in 2018, we know that 13-million people seriously think about suicide each year, which means we are far from the universe of people who could be reached."

In December, former Senator Orrin Hatch (R-Utah) wrote a letter to Marlene H. Dortch, Secretary of the Federal Communications Commission (FCC), urging the agency to use the three-digit-number 611 for Lifeline. The senator wrote that the designation would connect Americans experiencing mental health crises with life-saving counsel and resources. Currently, 611 links callers to telephone repair and telecom customer service. In 1997, the FCC noted it would continue to do so until needed for another national purpose. Sen. Hatch wrote that making the Lifeline more accessible and user-friendly to Americans is "a pressing, national purpose," and recommended that 611 be used solely for mental health and suicide crises to eliminate confusion and delay. He further stated that it would be more difficult to market 611 as Lifeline if the number has a dual purpose, which would limit its efficacy.

Dr. Draper says studies show it's easier to remember three-digits than an entire phone number, making a three-digit-number for mental health and suicide crisis more accessible. The designation would build off the national network infrastructure provided by the Lifeline, and trained mental health and suicide prevention counselors would answer calls. Much like 911 and Poison Control centers, the number would triage to local services and resources, including mobile crisis and respite services. It also, says Dr. Draper, has the potential to decrease stigma. While pondering the long-lasting effects of a three-digit-number for mental health and suicide crisis, Dr. Draper asked his daughter, who has a history of anxiety and depression, what she thought the impact could be. "She responded that people would finally understand mental health crises are real and require a different response than triaging to police or EMS. She said that by creating a cultural shift, 'It would likely do more than anything else to erase stigma against mental illness, and that's cool.'"

A three-digit-number, says Dr. Draper, will likely increase the number of callers to the Lifeline and, as a result, has the power to change how people think about mental illness. More callers equate to more data the national hotline can collect and analyze. He says this is precisely what's happening in the United Kingdom with 111, a three-digit designation for all urgent health needs, including behavioral, that provides advice and triages callers to the appropriate level of care. The number of calls to 111 grew from 12 million to 16 million, with an increase in demand over time. Today, roughly 20,000 people call 111 every day to get advice over the phone from doctors, nurses, and paramedics. Dr. Draper says a similar three-digit-number for mental health and suicide crisis would trigger real parity. "People phoning would give us the data we need in terms of caller expectations from the mental health system, which will increase voice representation and help tailor demands on policymakers to respond to these needs with adequate behavioral health resources in the communities callers live."

What Dr. Draper and his partners want is to create a culture that fosters autonomy where people's ability to get help during a mental health or suicide crisis is at their fingertips, quite literally. It's up to the caller, not his or her provider. "This gives people a sense of agency at a time when they are feeling incredibly helpless, which is powerful." He also believes that when society places mental health and suicide crisis on the same level as medical crisis, there will be a repositioning, making call centers a visible service similar to EMS. Graduating students will find it a real pathway for learning how to help others. "A cultural shift through a three-digit-number is good for callers and the mental health profession."

Interview 6 – *Nick Margiotta, Retired Detective*

Law Enforcement Are Critical Stakeholders in Behavioral Health Crisis Services

It was September 24th, 1987, and Memphis police answered a 911 call made by a mother desperate to help her 27-year-old son experiencing an episode of Paranoid Schizophrenia. Joseph DeWayne Robinson had cut himself 120 times with a butcher's knife, and his mother was fearful that he was going to kill himself. When police arrived at the scene at LeMoyne Gardens public housing project, it was a tight perimeter, and the officers asked Robinson to drop the knife. He didn't. What happened next is disputed: the officers said Robinson lunged toward them; witnesses said he did not. The officers shot and killed Robinson, prompting community outrage and charges of racial bias against the Memphis administration. Robinson was Black, and the two officers who shot him were White. Sabrina Taylor, Crisis Intervention Team Training Coordinator at the Phoenix Police Department, says this tragedy was the tipping point that led to the creation of the Memphis Crisis Intervention Team (CIT).

Robinson was what law enforcement calls a frequent flier: he had a history of psychiatric hospitalizations and was a high use 911 caller, but the police officers who answered the emergency call were not trained in behavioral health crisis or how to deescalate the situation. Taylor says that people in crisis may not be easy to engage and appear out-of-control. Law enforcement can interpret the behavior as an imminent threat. Officers trained in crisis intervention have additional tools to respond to behavioral health emergencies such as knowledge, understanding, empathy, and listening techniques that may calm people down and negate the need for force. The approach decreases conflict and diverts people from jail. Instead, says Taylor, police officers often take people experiencing behavioral health crises to psychiatric emergency centers.

Nick Margiotta, president of Crisis System Solutions and retired Phoenix police officer, says CIT sounds simple, and in many ways, it is, but it takes leaders in behavioral health who understand that police officers are critical stakeholders in crisis services. "Historically, the expectation has been that law enforcement officers fall in line with whatever policy leaders in behavioral health make. That doesn't factor in our culture and, as a result, officers won't do it." Margiotta was first introduced to CIT in 2001 in a training program. He says that trainings are essential, but without an infrastructure to support actual implementation, it's a disservice. In training, Margiotta learned about mobile crisis teams and psychiatric centers, where he and his colleagues could do a warm handoff. "The training shifted my perception and made me realize we can't arrest our way out of this problem, and I was excited to start applying CIT to my job." Margiotta answered a call from a frequent caller with Serious Mental Illness (SMI). She was depressed, had been drinking, and threatened to take 100 Advils. Margiotta thought this was an ideal opportunity to do his first psychiatric center drop-off. When he went to the facility, the staff rejected the drop-off because the woman had been drinking. Then he took her to the detox facility, and they rejected her because she was suicidal. "I was proud to apply my CIT training only for the person to be denied in both locations, so I didn't do again for years. All I could do was take her to the parking lot of the county hospital and say, 'Good luck.'"

Even though Margiotta didn't use the CIT training as initially designed, it made him rethink how law enforcement was engaging with the community. Over the next few years, he built a diversion program and housing first initiatives during the day while patrolling downtown Phoenix at night. Three years later, Margiotta worked to restart CIT, and this time it was successful. The reason, says Margiotta, is he spent 90% of his time working with the behavioral health system, educating leaders on police culture. "Law enforcement will default to the more convenient solution, which means drop-offs need to be easier than what it takes to book someone."

Police Drop-offs

The more limitations and challenges behavioral health facilities present, the less likely they will get police to drop off people in behavioral health crises. What law enforcement needs, says Margiotta, is a no-refusal policy, allowing officers to do drop-offs and return to their patrol duties. He says that initially, when he restarted CIT at his station, law enforcement faced numerous roadblocks. It took patience, collaboration, and walking crisis services staff and leadership through why service design must include a law enforcement voice to facilitate change. Margiotta says psychiatric centers were requiring police officers to take off their guns, refusing patients who had been drinking, requiring officers to obtain medical clearance, and the only door for drop-offs sometimes was the front door, with the seclusion and restraint room far away from the drop-off door. These were all barriers that, if they continued, would have made drop-offs unlikely. He says facilities also feared police officers were going to bring people experiencing delirium. If a person was clearly in need of a hospital, that's where Margiotta would take him, but in cases of delirium, which is harder for a law enforcement official to determine, the center could call for an ambulance. "If I'm going to get medically screened out and have to put the person back in my car and drive him somewhere else, why should I even bother going there in the first place? Psychiatric centers need to function like Emergency Medical Treatment and Labor Act (EMTALA) applies to them, accepting anyone police officers bring in and integrating cop culture into the development of their policies. Meaning, 100 percent of crisis workers must be trained to work with law enforcement effectively. Otherwise, officers will default to the hospital or jail."

Margiotta says successful collaboration also required law enforcement buy-in, which any refused drop-off could derail. "Years later, we've had a tremendous cultural shift here in Phoenix. Police officers automatically believe drop-offs allow them to do their job better and help people." He says increasing buy-in from law enforcement and crisis services required holding each other accountable. Side-by-side, they looked over data each month. The goal, says Margiotta, was for police drop-offs to take less than seven-to-eight minutes. "When that didn't happen, we all took a closer look at what went wrong and how to improve performance."

A threat to collaboration is inviting law enforcement officers to be part of the design and processes, but then not integrating any of their recommendations. Margiotta says this is what happened with one facility. "They brought me in, and we worked alongside one another for months, but during the grand opening, it was clear they didn't follow any of our recommendations. They were pretending to collaborate. I was there as window dressing to show that leadership had worked with us, and to keep me quiet during the implementation phase." He says the facility was unsafe for police: staff would need to buzz officers in and couldn't let anyone

in or out. "It was a lockbox with nearby instruments that were dangerous. I made it clear there was no way officers would be coming there until they made the necessary changes." In the end, the facility did an entire redesign. It took three years before police regularly started bringing drop-offs there.

Mobile Crisis

Margiotta says mobile crisis teams are a vital partnership for law enforcement, but working with them required similar collaborations. It took at least three years to create a robust, productive relationship. At first, they struggled with inconsistent mobile unit dispatch and crisis service provider fear of escalation. A good crisis mobile response team has rapid response and goes out 24/7, but, initially, that wasn't happening. "We were getting a 25% denial rate from mobile units. That's a no-no in our culture; officers will stop calling. We worked together and eventually, every time we called, a mobile unit was dispatched immediately. That's the compliance we needed." Police also need to be able to do a warm handoff of 5-15 minutes to the mobile unit and quickly get back to their jobs, but crisis services personnel often wanted officers to stick around for fear that the person might escalate. "This makes sense only if the person is violent, and suicidal ideation alone doesn't mean police need to be present." In one instance, says Margiotta, a caseworker was answering a call where the person hadn't taken her medication for a few weeks. The caseworker sent the mobile crisis team and simultaneously called police to go to the location. "There was no danger, she wasn't violent, and when I said that to the two-person mobile unit, they responded, 'She has Schizophrenia. She could be hearing voices.' They are the ones trained in behavioral health. I didn't need to be there."

Today, a person in a leadership role has to authorize if a mobile unit can call law enforcement, but if a situation escalates, the unit can immediately call the police. As a result, calls for police to respond have gone down between 70% and 80%. If the crisis line gets 18,000 calls a month, Margiotta says less than 10% will triage to mobile crisis units, and less than 1% need police response. Part of the struggle, says Margiotta is viewpoint, "Behavioral health workers believe these issues to be in the community, and that they are helping us. We view it quite differently; we are bringing them their customers for who they receive state and federal dollars. We see ourselves as critical stakeholders." He has spent most of his career developing and maintaining partnerships between law enforcement and crisis services. "You can't keep people out of the Emergency Department and jail without these relationships. It's a public safety and public health issue: we are in this together."

Interview 7 – *Anonymous Peer Recovery Coach*

Peer Recovery Coach Says "Stigma of MAT Persists in the Recovery Community"

Veronica* slid into addiction slowly, increasingly drinking as a teen, and by the time college came around, she needed alcohol first thing in the morning to stop her hands from shaking. She says it escalated from there. For Veronica, addiction wasn't a straight line, more like there were times she stopped entirely and others when there was a litany of drugs she used each day, including heroin and oxycodone. She quit multiple times, promising her family she was done, but it wasn't until a close friend died in front of her, his arm hanging limply off the EMS gurney, that Veronica made a promise to herself for herself that she was going to get help. She turned a corner that day, driving to a nearby clinic where she started Medication-assisted treatment (MAT) and that, she says, "was all she wrote." It's not though, because six years later, Veronica is now an award-winning peer recovery coach, helping people navigate the challenges she faced. When asked what or who she credits for her recovery, Veronica doesn't hesitate to say ongoing MAT and caring recovery coaches, but, she lowers her voice, her colleagues don't know. She fears they wouldn't accept her and she has good reason to think so. "There's a lot of stigma within the recovery world and a belief that MAT is simply substituting one drug for another." Veronica says in a recent discussion, a colleague said just that. "It's startling because no one would say that about a person with a physical illness. Can you imagine if those in the medical field said to people with diabetes, 'You shouldn't use insulin as treatment.' Well, that's what's happening in the field of recovery: people are often judged for using evidence-based medicine."

The belief that MAT is exchanging one drug for another is not uncommon among the general population and even among physicians in the medical field. In May 2017, Dr. Tom Price, former Secretary of Health and Human Services, said, "If we're just substituting one opioid for another, we're not moving the dial much." He faced immediate backlash from the medical and scientific community. Dr. Vivek Murthy, former Surgeon General of the United States, responded on Twitter that an abstinence-only approach isn't backed by science, unlike MAT, which leads to better outcomes compared to behavioral treatment alone. Months later, in September, there appeared to be a shift in the federal government, with Dr. Scott Gottlieb, the FDA Commissioner at the time, saying that MAT "…is one of the major pillars of the federal response to the opioid epidemic in this country. He went on to say that MAT is an essential tool that has the potential to allow millions of Americans to regain control of their lives.

What's surprising to Veronica isn't that people in the general population don't understand that MAT is an evidence-based practice but that those working in recovery are perpetuating misinformation. Medication-assisted treatment is a holistic approach for substance use disorders that combines counseling, behavioral therapy, and FDA-approved medication. She says that without MAT, she would likely be dead. "I would have continued using, or relapsed, unsure of what I was taking and the dosage. Heroin is no longer pure. It's increasingly packed with other ingredients, many of them potentially lethal, like Fentanyl." Veronica says that without treatment, she wouldn't have been able to enter recovery because the pain associated with withdrawal is horrendous. It's not just acute pain that's problematic, but also precipitated withdrawal that happens months later, making each day unbearable. "People in recovery who

haven't had an opiate addiction often don't understand what this type of withdrawal feels like in the short- and long-term. I think that's why they aren't sympathetic."

Last year, Veronica's 29-year-old half-sister died of endocarditis from intravenous drug use. Having shared similar struggles, Veronica believes she and her sister ended up on divergent paths because of money and stigma. "My sister went to the nearest clinic for two years, and she did well, but then she could no longer pay the $80 a week it costs to go to the clinic." Her sister's family refused to help with the fees because they thought taking Methadone would limit her job opportunities. "Because of stigma and fear of stigma, my sister is now in a mausoleum."

Not sharing her treatment with colleagues has been taxing, and Veronica has struggled with whether she's contributing to stigma by not telling her story. "I wonder about it every day. Am I living a lie? I don't think they would accept me. From what I've heard them say, my guess is it would diminish their respect for me. If I make a human error, will they blame the fact that I'm on treatment, even if that doesn't make sense?" Every week, Veronica goes into the clinic with her take-home bottles. The clinic fills them with medication for the next six days; on the seventh day, she goes back in to get her final dosage. She says it didn't start off that way. At first, she had to go to the clinic daily, then, over time, the recovery team would give her medication to take home. After six years, she still goes to the clinic once a week. It makes Veronica nervous because there are weeks where it has been challenging to get to the clinic. For instance, last year, a massive storm was headed to her area. She lives out in the country, and snow would have made it impossible to get to the clinic. Veronica arranged to stay with family in town so that she wouldn't risk missing the final dosage or filling her bottles for the next week. It's these small changes that colleagues can notice, she says, and it makes her worried that they will figure it out; for example, wondering why she stayed with family instead of at home. The fact that she has to worry about it at all makes her angry. "I work in a recovery environment, but, ironically, I'm forced to hide my recovery and treatment from my colleagues. Stigma inside of an industry designed to help people recover and fight stigma is problematic."

Veronica worries about how stigma affects others in recovery and how judgment toward those in recovery impacts people not quite there yet. At a recent team meeting, a colleague vented that Narcan—a medication that entirely or partially reverses an opioid overdose, including respiratory depression—enables people addicted to opioids, saying, "We'll bring them back, and they will just use again." "It made me so upset to hear someone in this role make a statement like that. We hope to keep people alive. We have many repeat clients, which is why the person was frustrated, but we want to be there for them when they take that long-lasting step into recovery. It took me multiple times to get there. What if people at the clinic had just given up on me? Where would I be? We want to do our best to create an environment for people to get the help they need when they need it."

Veronica is not the peer recovery coach's real name. She has asked to remain anonymous.

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