SAMHSA'S 2022

# TRANSFORMATION TRANSFER INITIATIVE

## Initiatives to Improve the Behavioral Health Crisis **Workforce** and Enhance Crisis Services for **Children**, **Adolescents**, and **Special Populations**


SAMHSA
Substance Abuse and Mental Health Services Administration

NASMHPD

Since 1987
NRI
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This work was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Contract HHSS2832017000241 and the National Association of State Mental Health Program Directors, Inc. (NASMHPD).

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## Background and Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI) in 2007 to assist states in transforming their mental health systems of care. The TTI provides, on a competitive basis, flexible funding awards to states, territories, and the District of Columbia to strengthen innovative programs. Beginning in 2019, with specific support to states to establish or expand web-based electronic registries of crisis beds, TTI awards have focused on implementing innovative programs and practices to improve the delivery of behavioral health crisis services.[1]

In 2020, SAMHSA released the *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* that outlines the best practices for states and providers to follow when implementing a comprehensive behavioral health crisis system. The National Guidelines prescribe three essential types of services that must be included in an effective crisis continuum: 1) someone to call – a centralized crisis line that is available 24 hours, seven days a week that assesses a caller's needs, can triage crises, and – when necessary – dispatch support; 2) mobile crisis teams dispatched as needed in the community; and 3) crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime."[2] In 2022, SAMHSA released a follow-up to the 2020 report focused on children and youth, the *National Guidelines for Child and Youth Behavioral Health Crisis Care*, "which describes the urgent need to improve crisis response services for children, youth, and families, and provides guidance on how communities can address the existing gaps in care for youth."[3] A companion piece was also released, providing additional guidance on *Crisis Stabilization Services and Other Supports for Children and Youth*.

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[1] NASMHPD. (2022). Improving access to behavioral health crisis services with electronic bed registries. *The National Association of State Mental Health Program Directors.* https://www.nasmhpd.org/sites/default/files/Bed_Registry_Full_Report.pdf

[2] SAMHSA. (2020). National guidelines for behavioral health crisis care best practice toolkit. *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[3] SAMHSA. (2022). National guidelines for child and youth behavioral health crisis care. *Substance Abuse and Mental Health Services Administration.* https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep-22-01-02-001.pdf

According to SAMHSA's *Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.*[4] all states provide at least one of the three core services, with all providing the "someone to call" component of a crisis system now that 988, the three-digit number for the National Suicide and Crisis Lifeline, has been implemented.[5] The effectiveness of these services varies in their ability to reach and engage with diverse populations, including children and youth, the LGBTQ+ community, tribal communities, and those living in rural and remote areas when they are experiencing behavioral health crises. This is especially true given the strain on the behavioral health workforce that has been exacerbated by the COVID-19 pandemic.[6]

During the COVID-19 pandemic, youth and young adults experienced significant isolation, challenges with school, depression, and anxiety disorders, all of which put them at an increased likelihood for risky behaviors, suicidal ideation, and suicide attempts.[7] Between March and October of 2020, the proportion of emergency department (ED) visits by U.S. children ages five to 11 increased by 24 percent, and by 31 percent among adolescents ages 12 to 17.[8] The increase in youth seeking behavioral health crisis services in EDs led to multiple pediatric health organizations declaring "a national emergency for children's mental health," and the release of an Advisory from the U.S. Surgeon General about the mental health of young people.[9] The calls to action from nationally recognized organizations and the federal government led to a priority in finding unique and innovative ways to serve children and adolescents and their families experiencing behavioral health crises, and ensuring that age-appropriate services are available and accessible in the community rather than creating a reliance on EDs to deliver behavioral health services.

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[4] SAMHSA. (2023). Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S. *Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.* *https://www.samhsa.gov/sites/default/files/behavioral-health-crisis-services-snapshot.pdf*

[5] NRI, Inc. (2023). State behavioral health crisis services continuum, 2022. *NASMHPD Research Institute, Inc.* https://www.nri-inc.org/media/jlqocgys/2022-profiles-smha-the-bh-crisis-continuum-april-2023.pdf

[6] HRSA. (2023). Health workforce shortage areas. *Health Resources and Services Administration.* https://data.hrsa.gov/topics/health-workforce/shortage-areas

[7] Schnitzer, P.G., Dykstra, H., & Collier, A. (2023). The COVID-19 pandemic and youth suicide: 2020-2021. *Pediatrics* (2023) 151(3): e2022058716. https://doi.org/10.1542/peds.2022-058716

[8] Radhakrishnan, L., et al. (2021). Morbidity and mortality weekly report. *Centers for Disease Control and Prevention.* https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm

[9] Radhakrishnan, L., et al. (2021). Morbidity and mortality weekly report. *Centers for Disease Control and Prevention.* https://www.cdc.gov/mmwr/volumes/71/wr/mm7108e2.htm

While suicide rates have increased across the nation since the pandemic, sexual and gender minorities and members of tribal communities are experiencing health disparities and an excess burden of suicide.[10] Traditional crisis services may not be as effective at engaging these populations. Research from the Trevor Project, an organization that provides resources for LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Questioning) youth, found that "60% of LGBTQ+ youth who wanted mental health care in the past year were not able to get it for a variety of reasons, including not believing they would be understood."[11]

In the U.S. there are 574 federally recognized tribal nations, each with their own unique cultures, histories, and needs. Tribal communities have unique barriers to accessing behavioral health care, including behavioral health crisis services. Barriers include a lack of sustainable funding, rural and isolated areas with few services, a mistrust of government services, and a lack of cultural competence among available providers.[12]

Developing a culturally competent workforce to provide behavioral health crisis services and appropriately respond to the unique needs of children, adolescents, sexual and gender minorities, and tribal communities is especially challenging given the significant workforce shortage of behavioral health professionals across the nation; according to the Health Resources and Services Administration (HRSA), nearly half of Americans (49.2 percent) live in an area with a shortage of mental health professionals, with 8,289 practitioners needed to ensure accessible services.[13] SAMHSA's *Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.* found that state mental health agencies (SMHAs) "are focusing efforts on training and diversifying their crisis workforce to be more representative of those they serve… including LGBTQ+ individuals, racially and ethnically diverse communities, older

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[10] CDC. (2023). Disparities in suicide. *Centers for Disease Control and Prevention.* https://www.cdc.gov/suicide/facts/disparities-in-suicide.html

[11] Peacock, A. (2022). What 988 means for LGBTQ young people. *The Trevor Project.* https://www.thetrevorproject.org/blog/national-suicide-lifeline/#:~:text=Our%20research%20found%20that%20more%20than%2080%25%20of,reasons%2C%20including%20not%20believing%20they%20would%20be%20understood.

[12] NAMI. (2023). Indigenous. *National Alliance on Mental Illness.* https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Indigenous

[13] HRSA. (2023). Health workforce shortage areas. *Health Resources and Services Administration.* https://data.hrsa.gov/topics/health-workforce/shortage-areas

adults, children and youth, Native American/Alaska Natives, and those living in rural and remote communities."[14]

SAMHSA's *Snapshot* also concludes that one of the largest barriers to crisis system implementation is the lack of an available workforce that makes it difficult to staff crisis call centers, mobile crisis teams, and crisis stabilization services. According to NASMHPD Research Institute (NRI's) 2022 Profiles Data[15], 39 of 44 responding states report workforce shortages within their crisis continuum. Thirty-two (32) states described workforce and staffing shortages as a major barrier to expanding mobile crisis ("someone to respond"), and 32 states identified workforce shortages as a major barrier to operating crisis receiving and stabilization facilities ("someplace to go") open 24/7, especially in rural and remote areas, and 28 states report a shortage of workforce in crisis call centers ("someone to call").[16] Financing crisis services is also a barrier, given the often disjointed funding structure that includes private and third-party reimbursements, and the added difficulty of collecting demographic and other identifiable information from individuals during a crisis to submit for reimbursement.

## Methodology and Limitations

SAMHSA announced the availability of 2022 TTI awards focusing on strengthening state behavioral health crisis systems in the fall of 2021, and states were provided with the TTI awards in December 2021. Throughout the award period, TTI awardees met regularly with staff from the National Association of State Mental Health Program Directors (NASMHPD) and NRI to discuss progress of the work, discuss any challenges, and identify opportunities for technical assistance to help support their projects. Awardees participated in a final project interview in late summer 2023 with staff from NRI.  During these interviews, NRI staff asked awardees about the problems and needs they hoped to address with the award funding, their vision and approach for addressing the problems and needs, discussed any outcomes observed by the awardees,

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[14] SAMHSA. (2023). Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S. *Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/sites/default/files/behavioral-health-crisis-services-snapshot.pdf

[15] NRI, Inc. (2023). State behavioral health crisis services continuum, 2022. *NASMHPD Research Institute, Inc.* https://www.nri-inc.org/media/jlqocgys/2022-profiles-smha-the-bh-crisis-continuum-april-2023.pdf

[16] NRI, Inc. (2023). State behavioral health crisis services continuum, 2022. *NASMHPD Research Institute, Inc.* https://www.nri-inc.org/media/jlqocgys/2022-profiles-smha-the-bh-crisis-continuum-april-2023.pdf

how the project can be used to transform other systems, and any lessons learned. Specifically, NRI staff asked awardees the following:

- What was the need driving the TTI application?
- How does this project fit into your state mental health authority's (SMHA) long-term strategic system's need?
- What are the desired outcomes of the project?
- Is the work completed or ongoing?
    - If completed, when was the work finished, and how/why did you decide it was done?
    - If ongoing, what activities are continuing (e.g., are trainings still being conducted? Is a learning community still meeting?)? What is the status of completing your project?
- If there were delays in starting or completing your project, please describe them.
- What happens to the project when TTI funding ends?
- What is the legacy of this project going to be and what are you doing to make that happen?
- What deliverables were produced from this project? How would you quantify them?
- Please provide any resources developed from the project (e.g., websites, documents, slides, brochures).
- What measures are you using to determine whether the project is having an effect?
    - Please provide any charts.
- What advice would you give to other states interested in pursuing projects like yours?
- What would you want SAMHSA to know about how this TTI project benefited individuals experiencing a behavioral health crisis or other behavioral health needs in your state?

While funding to states was allocated in December 2021, there was no requirement that work had to be completed within the first year of the TTI project.[17] Therefore, the status of projects during the final project interviews in July and August 2023 varied significantly across states. Many states experienced delays due to lengthy procurement processes and were only able to start work in the Spring of 2023. Additionally, the award did not require the awardees to collect standardized data or outcomes across the projects, making it difficult to summarize results and outcomes.

To facilitate and support each project's success, NASMHPD provided extensive technical assistance (TA) to project directors, both individually and collectively. In summary, NASMHPD staff:

- Met monthly with individual project directors to monitor progress, identify problems early on and help awardees develop solutions. Subject matter experts from NASMHPD and NRI attended monthly meetings to offer resources and answer questions.
- Hosted virtual "Meet and Greet" gatherings among awardees early in the contract cycle.
- Created two TTI 2022 Listservs, one consisting of TTI 2022 awardees, and one including current awardees and TTI alumni. Awardees had the opportunity to post questions to the listserv directly or submit queries anonymously through NASMHPD staff.
- Assembled and distributed resource guides to project directors, organized by award areas (Special Populations, Workforce, Children and Adolescents). They included best practices and noteworthy examples of similar projects, challenges and opportunities in states and territories.
- Hosted virtual information exchanges monthly for TTI project directors and their invited stakeholders. Exchanges were organized around the award areas and facilitated by subject matter experts.

[17] The 2022 TTI awards were awarded in December 2021; however, many states were unable to begin work on their TTI projects until the procurement process was completed, which took several months for many states. Although the contract year for the 2022 TTI projects officially ended in August 2022, and the TTI project directors submitted draft "final" reports, many projects were ongoing well beyond August 2022.

- Facilitated the delivery of technical assistance to individual awardees. NASMHPD arranged 29 calls connecting awardees with national experts on topics such as elevating youth and LGBTQ+ voices, children's mobile crisis response services, behavioral health equity, and engaging AI/AN communities.
- Provided supplemental funding to projects seeking additional technical assistance and expertise. Targeted additional funds supported training to crisis service providers on trauma-informed care, trauma-informed supervision, and provider self-care; consulting on the development of a Peer Guild; facilitating a media campaign to improve awareness of services amongst rural/frontier populations; conducting a comprehensive assessment of a state's current crisis system and making recommendations; and providing training and technical assistance in support of crisis services to LGBTQ+ populations.

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## SAMHSA's 2022 Transformation Transfer Initiative

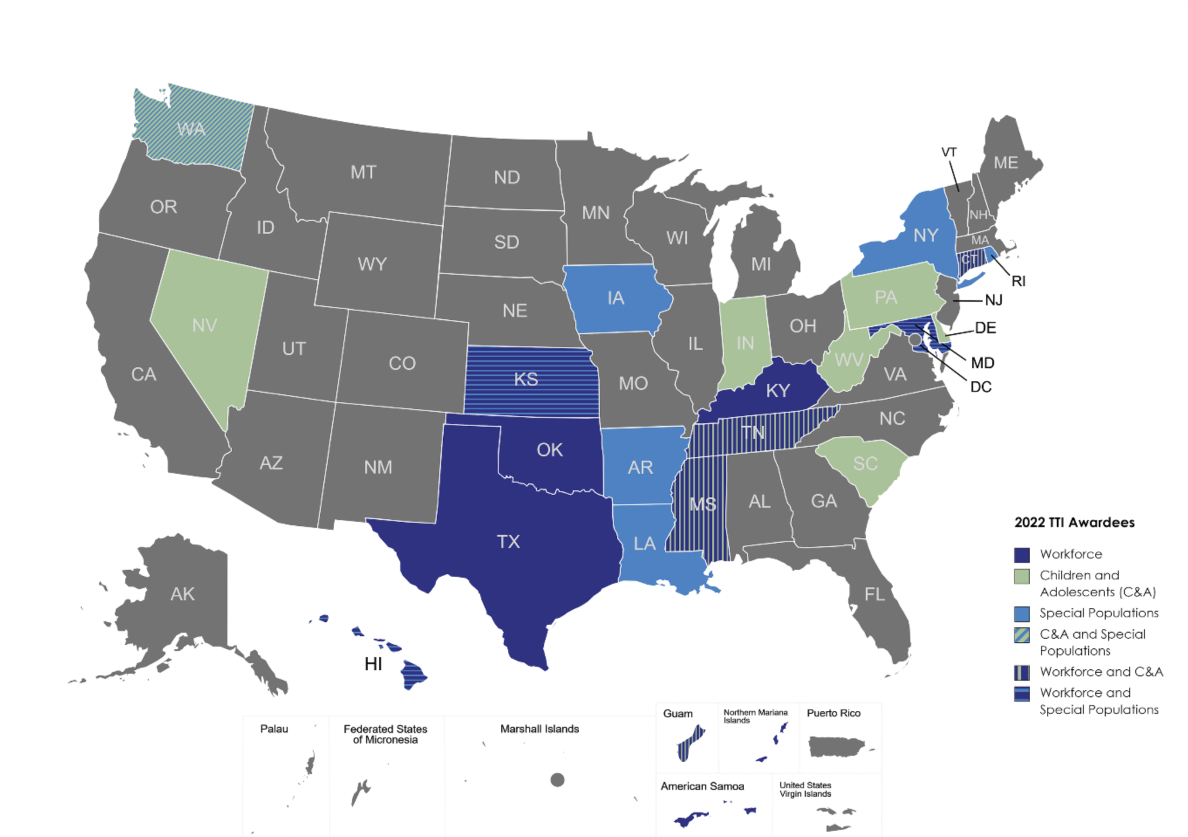
TTI funds were focused on the most pressing needs states faced in implementing and integrating 988 and comprehensive crisis systems in 2022. Funding was distributed by the National Association of State Mental Health Program Directors through contracts with each of the states. NASMHPD and NRI supported TTI state projects throughout their implementation and expansion efforts.

CMHS approved 37 awards of $250,000 to 24 states and territories (Figure 1 on the following page) to promote and strengthen innovative programs that address these three priority areas:

- **Special Populations, including American Indian/Alaska Native (AI/AN) Communities and LGBTQ+ individuals**: This topic was identified to ensure the needs of these populations are addressed throughout the continued development of 988 and crisis services response systems. Specifically, projects related to these populations can initiate or enhance efforts to expand crisis services and evolve 988 responses to address the unique needs of individuals within these populations. Ten states were awarded 11 TTI awards in this topical area, with two focused on improving crisis services for AI/AN communities, and eight focused on improving crisis services for LGBTQ+ individuals.
- **Behavioral Health Crisis Workforce**: This topic was identified by CMHS to support creative strategies and initiatives to support the behavioral health crisis workforce throughout continued development of 988 and crisis services response systems. Twelve states were awarded 14 TTI awards in this topical area.
- **Children and Adolescents**: This topic was identified to support creative strategies and initiatives to better reach children and adolescents and their families experiencing a crisis throughout continued development of 988 and crisis services response systems. Thirteen states were awarded 14 TTI awards in this topical area.

This report provides an overview across all three topical areas, as well as an analysis of each of the three award categories. In addition, a snapshot of each of the 50 TTI projects is included in Appendix A:
State Awardee Snapshots.

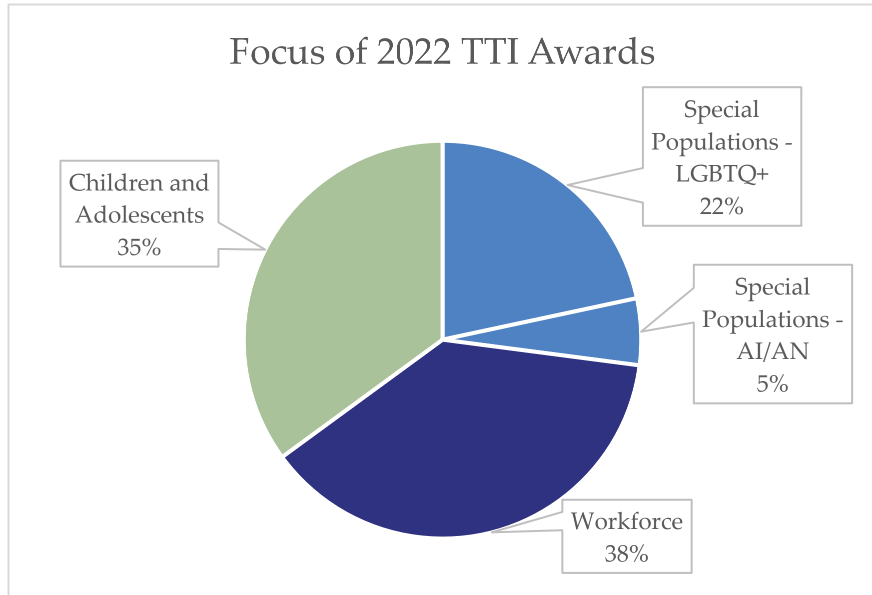
*Figure 1: State Recipients of TTI Awards in 2022*



## Summary of 2022 TTI State Projects

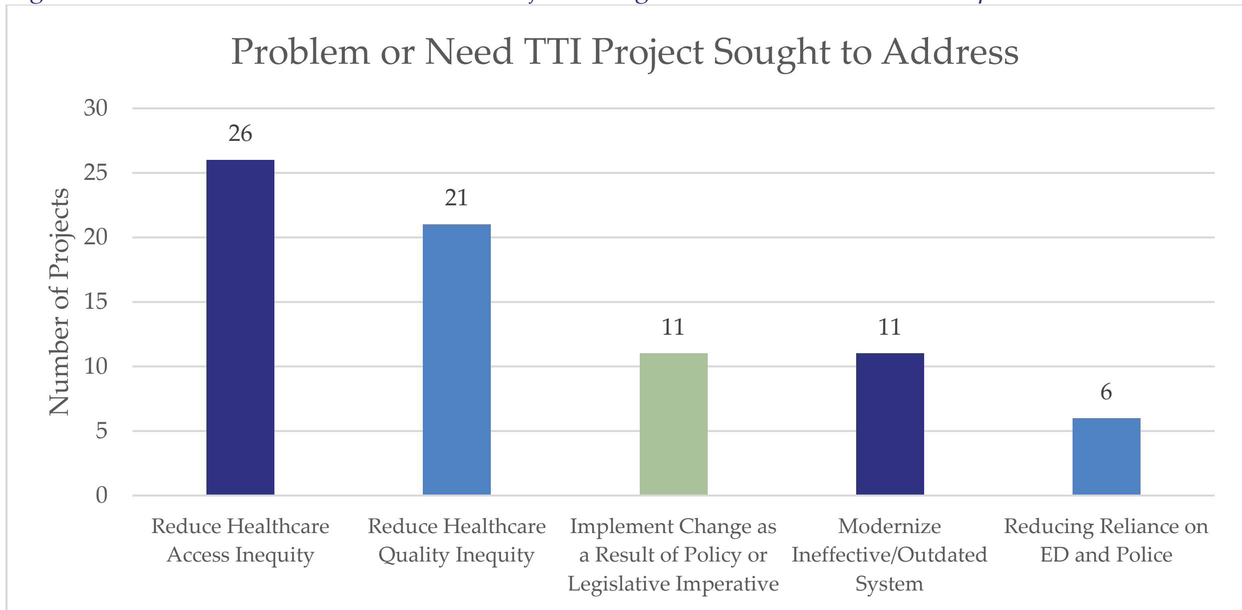
Of the 37 awards, the majority were awarded to states planning to implement innovative strategies and practices to improve their behavioral health crisis workforce (38 percent); over a third (35 percent) focused on improving behavioral health crisis services to children and adolescents; and slightly less than one-quarter (22 percent) focused on improving behavioral health crisis services for special populations, including LGBTQ+ communities (eight projects) and American Indian/Alaska Native populations (two projects) (five percent). See Figure 2.

*Figure 2: Focus of the 2022 TTI Awards*




Most of the 2022 TTI projects sought to improve access to behavioral health crisis services (26 projects), and more than half sought to improve the quality of behavioral health crisis services (21 projects). Initiatives funded through the 2022 TTI awards also sought to implement change as a result of new state policies and procedures (11), improve ineffective and outdated systems (11), and reduce reliance on hospital emergency departments (EDs) and law enforcement for providing behavioral health crisis services (6). See Figure 3.

*Figure 3: Problem or Need the 2022 TTI Projects Sought to Address, Across all Topical Areas*




## Vision and Approach for TTI Projects

Awardees had flexibility in determining a strategy to pursue in the expenditure of funds to accomplish their TTI projects. The majority of projects (26) utilized TTI funding to develop and/or implement training programs to improve behavioral health crisis system response. See Figure 4. Nearly all (nine of 10) of the projects in the special populations category pursued the development of training curricula and programs to increase culturally competent services to the LGBTQ+ and AI/AN communities. This strategy is also the most common among the workforce projects (nine) and the projects for children and adolescents (eight). Often, if a project was developing a training curriculum, it would also dedicate TTI funds to support an e-library and other electronic resources to serve as a repository for the courses that could be easily accessible beyond the TTI contract period; nine projects incorporated these strategies into their plan. Other uses of TTI funds include joining or developing a learning collaborative (seven), establishing a pilot project (three), funding scholarships to recruit and retain a qualified workforce (three); supporting staff (three); investigating crisis system effectiveness (two); and implementing technology (two).

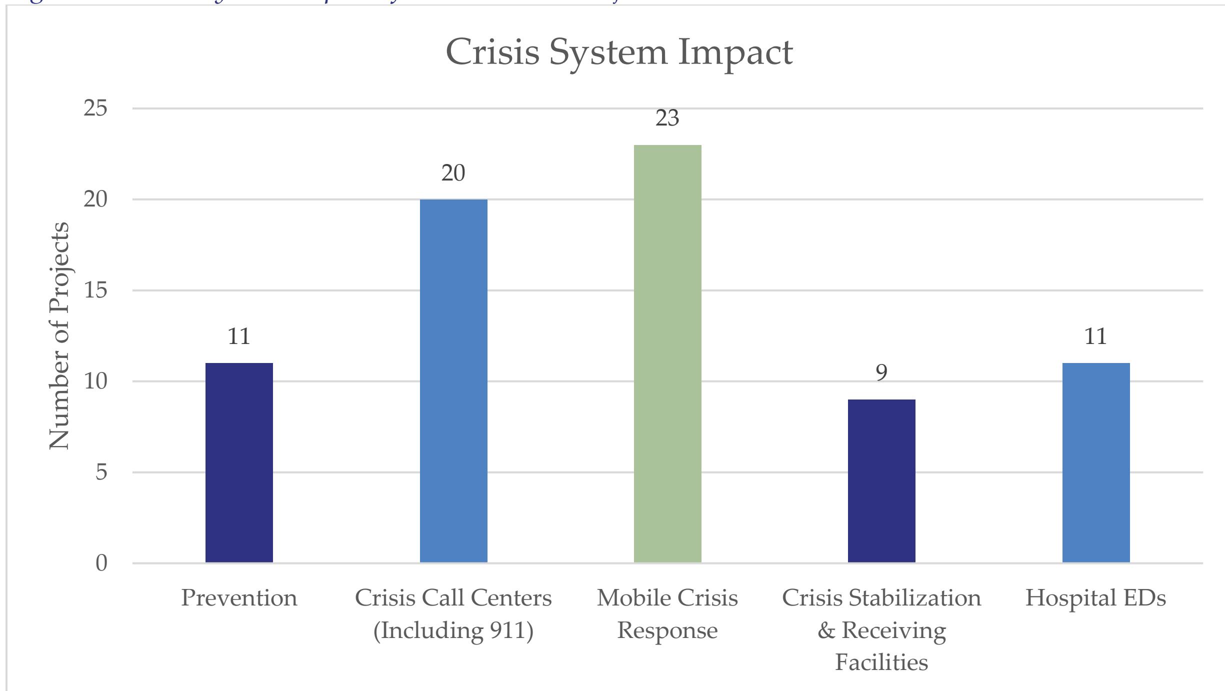
*Figure 4: How TTI Projects Used their Funds to Accomplish their Goals, 2022*

## Crisis System Impact

Each of the 2022 TTI projects intends to improve the crisis service system response in their state. To do so, many of the projects specifically target one or more components[18] of the crisis system for the biggest impact. Among the TTI projects, more than half are targeted towards improving mobile crisis response (23 projects), and 20 of the TTI projects are aimed at improving services at call centers, including integration with 911. Eleven projects each aim to improve crisis prevention services and limit the use of hospital EDs. Finally, nine projects aim to improve behavioral health crisis services provided at crisis receiving and stabilization facilities. See Figure 5.

[18] Since some projects focused on improving more than one component of their crisis system, the total number exceeds the number of 2022 TTI projects.

*Figure 5: Crisis System Impact of the 2022 TTI Projects*




## Measuring the Impact of the TTI Projects

The diversity of TTI projects, even within a single focus area, meant that states used a variety of methods to measure the outcomes of their projects and their enduring impact. The 2022 TTI projects also faced variable timeframes for operation, with several projects starting much later than others due to delays in the state procurement processes.

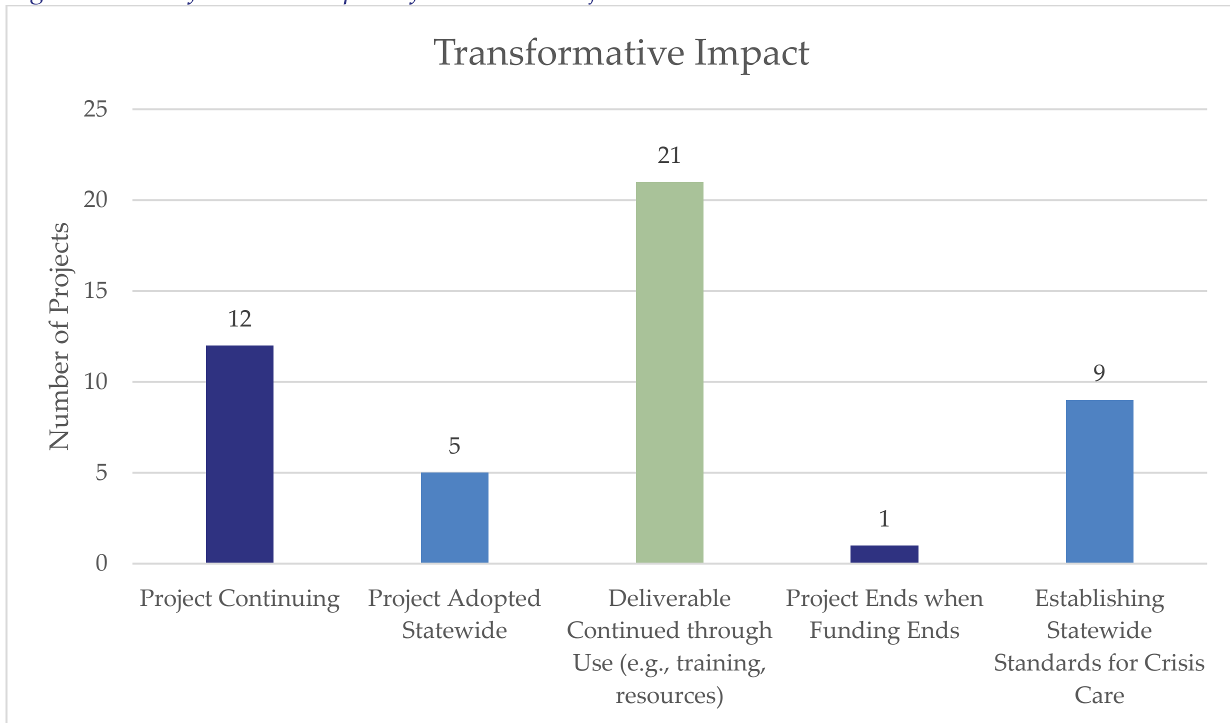
Many of the TTI projects collected process measures to ensure that products were completed, and services were delivered as planned. For example, states that developed in-person and digital trainings measured the number of training participants, completion, and certification rates. Some also intend to measure the degree of behavioral and attitudinal change among training participants and the number of potential staff trained and/or certified through training the trainer processes and digital services. Few of the projects measured or plan to measure the outcome such training has on the populations served. Capturing outcome measures is both time intensive and costly.

## Transformative Impact

Project directors identified multiple ways their TTI projects have had significant impact on improving the delivery of services and the integration of systems that often interact in crisis response. More than half (21) of the projects indicate that deliverables created

(e.g., training, resources) during the project will continue to be in use after the project funding ends. Twelve projects indicated that their initiatives would continue once TTI funds have been expended. Nine of the TTI projects have been successful in establishing statewide standards for crisis care, which will continue to raise expectations for access and quality crisis services. See Figure 6.

*Figure 6: Transformative Impact of 2022 TTI Projects*

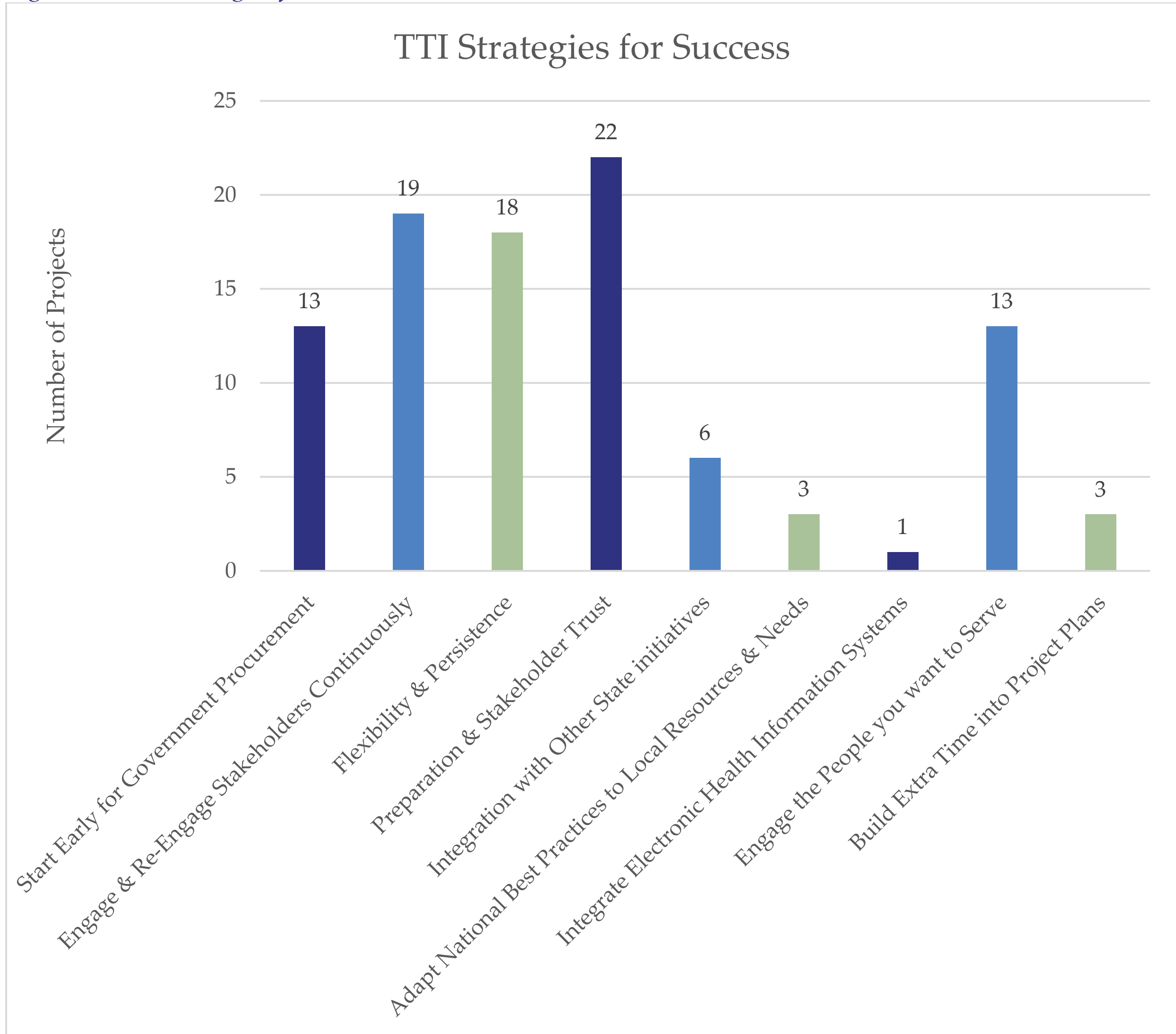



## Successful Strategies

2022 TTI project directors shared some of the lessons they learned throughout this project cycle. Most (22) of the awardees recommended conducting some planning and research in advance to understand the issues to be addressed by the project before engaging stakeholders. Nineteen TTI projects remarked that the continuous engagement of stakeholders helps establish trust and creates a more robust and useful product than if stakeholders were not included. Eighteen project directors observed that flexibility and persistence moved their project along especially when unexpected obstacles (e.g., slow procurement processes, difficulty identifying subject matter experts) occurred, allowed them to pivot to accomplish the task. Relatedly, 13 projects recommended starting as early as possible to move through the government procurement process, which can be lengthy and present barriers to beginning work.

One project recognized the importance of engaging in difficult conversations and committing to addressing disparities from the outset, so that when challenges occur, they can be meaningfully addressed. See Figure 7.

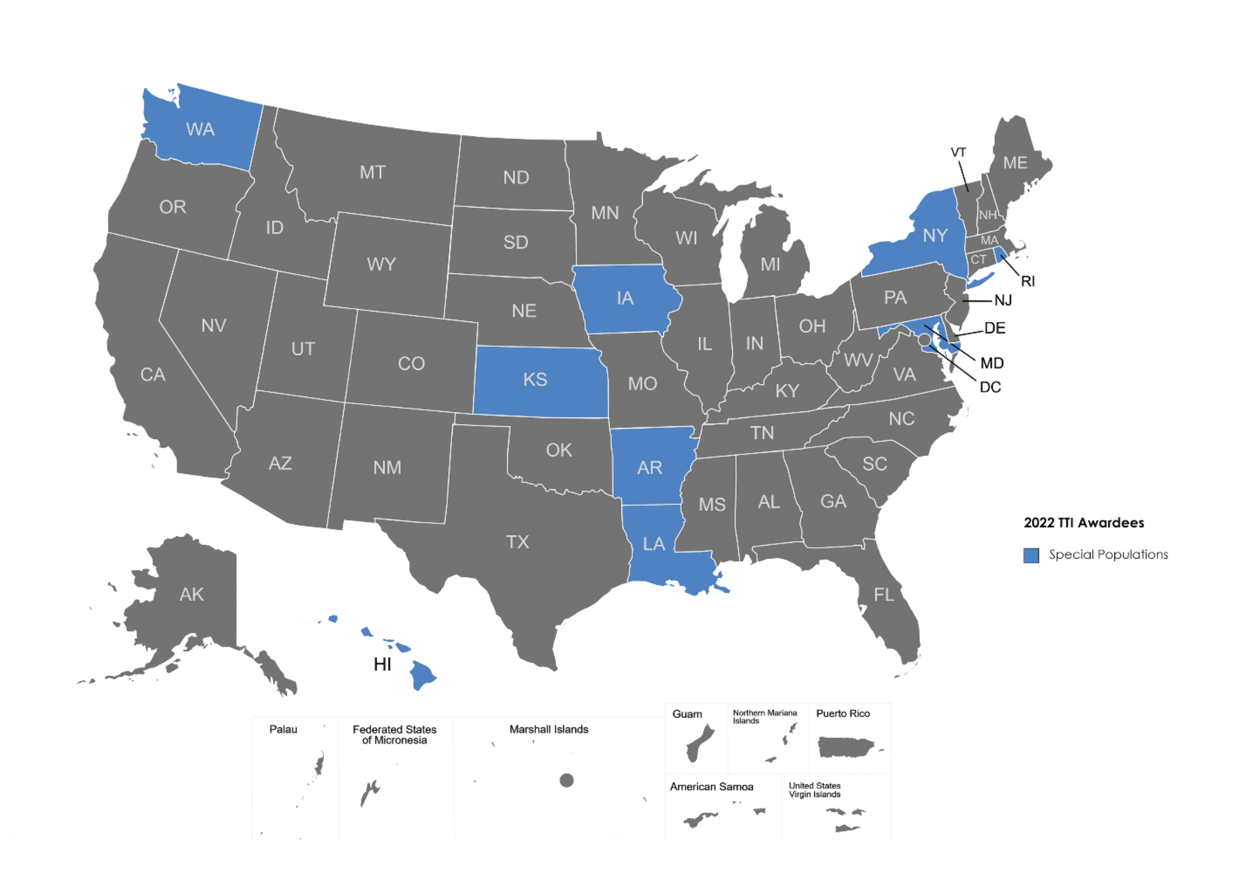
*Figure 7: TTI Strategies for Success*



## TTI 2022 Behavioral Health Crisis Services for Special Populations

In 2022, nine states worked on 10 TTI projects[19] focused on improving behavioral health crisis access and quality for individuals within two special populations: the LGBTQ+ community and American Indians and Alaska Natives (AI/AN). Of the 11 awards, the majority (nine) focused on better serving LGBTQ+ individuals, and two focused on improving behavioral health crisis services for AI/AN communities.[20] Figure 8 identifies the states receiving TTI awards under the Special Populations category, along with their population of focus.

*Figure 8: States Receiving 2022 TTI Awards for Behavioral Health Crisis Services for Special Populations*




[19] Ten TTI projects were awarded to states undertaking innovative activities to improve behavioral health crisis services for special populations; Arkansas, Iowa, Kansas, Louisiana, Maryland, New York, Rhode Island, and Washington, each received one award, while Hawai'i received two TTI awards in this topical area.

[20] CDC. (2023). Suicide data and statistics. *Centers for Disease Control and Prevention.* https://www.cdc.gov/suicide/suicide-data-statistics.html

The majority (eight) of these projects sought to improve access for these special populations. LGBTQ+ individuals and tribal members are at a significantly increased risk of suicide when compared to the general population.[21] It is critical that members of these communities have services readily available that are culturally competent so that individuals feel comfortable accessing care. During the interviews with the TTI project directors, they identified the following barriers to accessing care, which align with the barriers identified in the *2022 National Survey on LGBTQ Youth Mental Health* from the Trevor Project[22]:

- Barriers to access for the LGBTQ+ community:
    - Promotional materials and the behavioral health crisis workforce are not representative or inclusive of LGBTQ+ individuals.
    - Fear by LGBTQ+ individuals that they would not be taken seriously.
    - Fear by LGBTQ+ youth that parental permission would be required for services.
    - Fear by LGBTQ+ individuals that they would face discrimination and not be taken seriously while receiving services.
    - Inability to afford services (which can be a challenge across all populations).
- Barriers to access for AI/AN communities:
    - Typical behavioral health crisis care does not adequately incorporate cultural healing principles, leading to a disconnect between what members of the AI/AN communities need and what services are available; therefore, members of AI/AN communities may avoid services that are not culturally competent.

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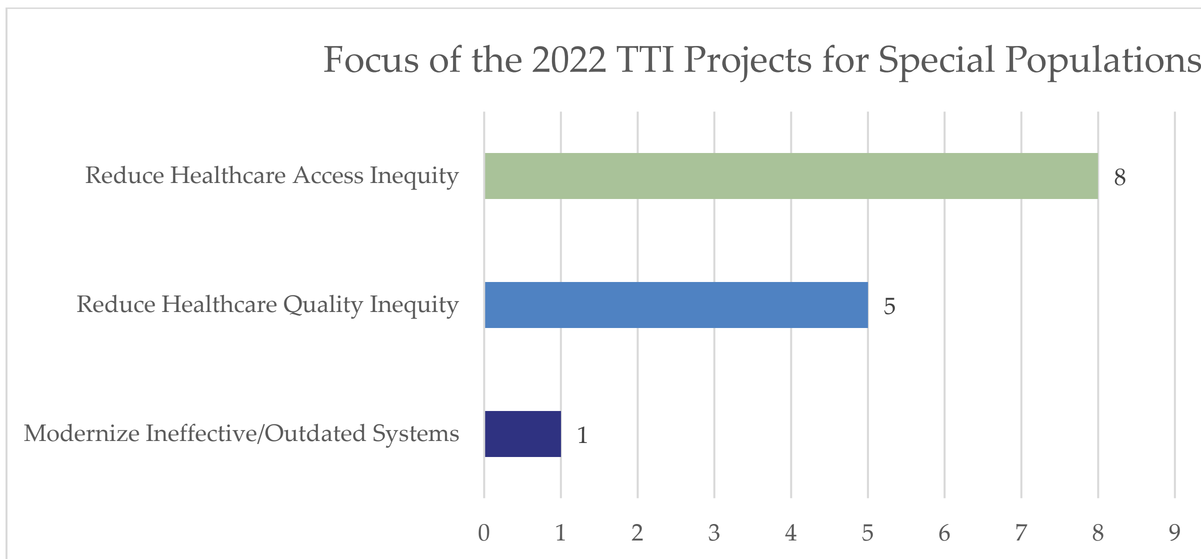
[21] CDC. (2023). Suicide data and statistics. *Centers for Disease Control and Prevention.* *https://www.cdc.gov/suicide/suicide-data-statistics.html*

[22] The Trevor Project. (2022). 2022 national survey on LGBTQ youth mental health. *The Trevor Project.* https://www.thetrevorproject.org/survey-2022/

- Tribal sovereignty, culture, and service eligibility requirements make accessing services very complicated.
- A lack of knowledge of state, federal, and tribal health resources by both individuals seeking care and those who provide crisis services result in many missed opportunities for care.

Awardees also identified a need to improve the quality-of-service delivery, with five of the awardees identifying this as an area of focus. By providing culturally competent services to both the LGBTQ+ community and the AI/AN community, members of these communities are expected to be more likely to pursue behavioral health crisis services during their times of need and have better outcomes. One awardee (Maryland) identified a need to modernize an ineffective and outdated system. See Figure 9.



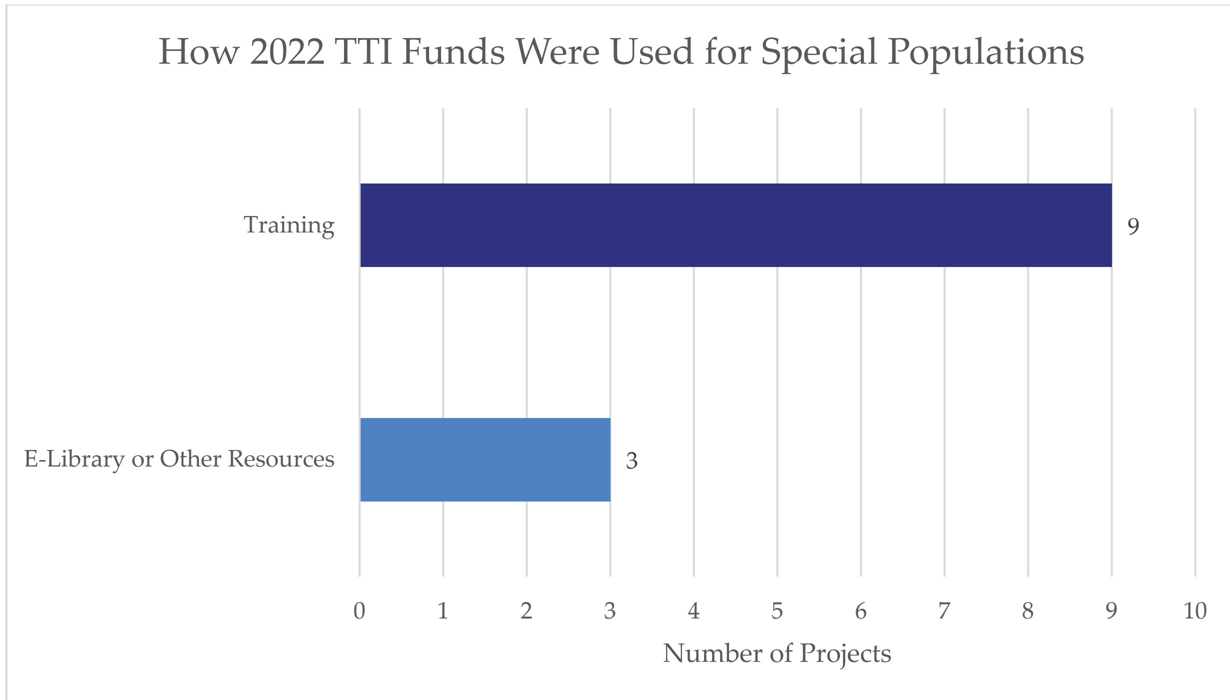

## Vision and Approach for TTI Behavioral Health Crisis Projects for Special Populations

To address these needs, most (nine) of the 2022 TTI awardees for special populations developed innovative projects to develop and promote training materials and curriculum for providers that address the barriers identified above and enable them to provide culturally competent services. Examples of some of the training activities developed by the TTI projects include:

- **Arkansas** used a portion of the TTI funds to hold a one-day meeting for a variety of stakeholders which featured sessions on key terms for the LGBTQ+ community, how to be a good co-worker to LGBTQ+ individuals, and cultural competence for the LGBTQ+ community. The remainder of TTI funds were distributed to nine providers to deliver training in cultural competency for LGBTQ+ individuals directly to their staff.
- **Hawai'i** is using TTI funds to produce and deliver ongoing LGBTQ+ crisis training to 988 crisis call center workers.
- **Kansas** is developing training modules for crisis providers and other clinicians at Certified Community Behavioral Health Clinics in partnership with LGBTQ+ youth.
- The **Louisiana** Office of Behavioral Health is developing training courses that are person-centered, resolution-focused, and delivered by a system that is coordinated, responsive, and efficient to all individuals, including those in the LGBTQ+ community.

Three of the TTI projects have created or expanded an electronic library or online platform to make these training courses available in the future. See Figure 10.

*Figure 10: Vision and Approaches Used by Projects to Improve Behavioral Health Crisis Services for Special Populations*



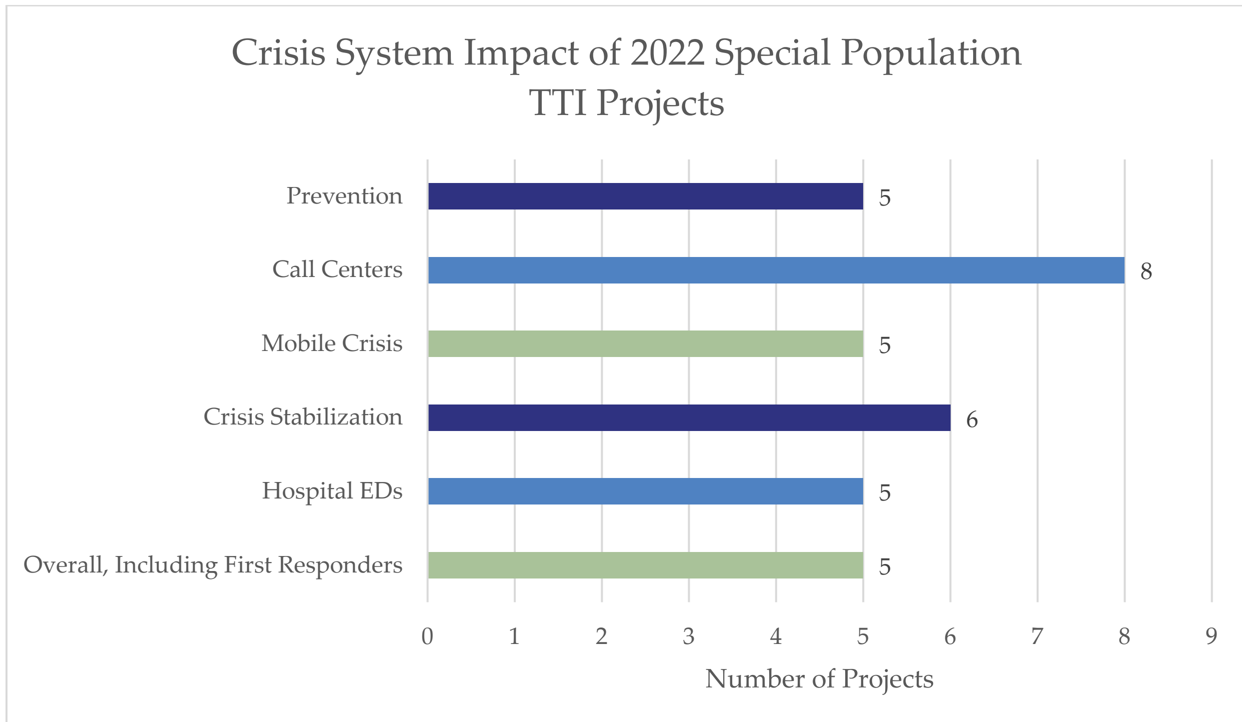

During the follow-up interviews with the TTI project directors, the TTI awardees were not specifically asked if they involved peers in the process, or if their efforts were intended to improve the cultural competence of peer support specialists working with these populations. However, three awardees did indicate that peers are involved in the planning processes, with one awardee identifying peers as a potential training recipient. Hawai'i selected peer support groups as the most direct means to blend cultural healing with evidence-based practices and were selected to receive training in cultural healing to improve access and the quality of service delivery to the Native Hawai'ians seeking behavioral health crisis services.

## Crisis System Impact

Eight of the 10 TTI projects for special populations in 2022 focused on crisis call centers, including 911 dispatchers. Six of the 11 projects focused on improving crisis stabilization services for LGBTQ+ individuals and members of the AI/AN communities. Five projects each focused on innovative solutions to improve mobile crisis response for these special populations, as well as overall improvement to the entire crisis system, including first responders. Finally, five projects each focused on prevention services

and hospital emergency departments. See Figure 11.

*Figure 11: Crisis System Impact of the 2022 TTI Projects for Special Populations*




## Metrics to Determine TTI Impact on Behavioral Health Crisis Services

Eight of the 10 TTI projects focused on special populations are collecting process measures. These measures capture the effect the TTI project has on the overall system or specific audiences of the project. Four of the TTI projects focused on special populations are currently collecting or planning to collect additional measures to determine the impact of the project on the delivery of services and make necessary adjustments to improve quality of the products moving forward. Specifically, awardees are collecting, or plan to collect, the following:

- Process measures:
    - **Arkansas** collected information on the number of attendees at its one-day conference and plans to collect the number of times meeting materials are accessed on the NAMI Arkansas website.
    - **Hawai'i** is collecting analytics from the training website and social media pages, including number of visits, session length, and source of referral. The state will also collect data from the train-the-trainer program

component to determine how many individuals are trained to deliver culturally competent services to LGBTQ+ individuals.

  - For **Hawai'i's** project focused on Native Hawai'ians, the state is tracking the number of peers trained, the number of train-the-trainer recipients, and the number of Native Hawai'ians participating in support groups.
  - **Iowa** is tracking the number of registrants and participants for its training series and distributing a survey to collect feedback from participants on how the training impacts their work.
  - **Louisiana** is monitoring the number of participants who access training courses, as well as the types of professions they represent to ensure a diverse audience is reached.
  - **Maryland** is collecting feedback from training participants on the content of each model. Feedback will be used to improve the quality of training administered.
  - **Rhode Island** is collecting data on the number of individuals who participate in trainings. Supervisors are also monitoring the trainings and documenting the results of providers' trainings.
  - **Washington** is collecting a series of measures related to crisis call center caller demographics, service data, and outreach.

- Additional measures to determine impact:
  - **Hawai'i** is monitoring reductions in depression diagnoses after participation in support groups whose leaders have participated in the cultural awareness training.
  - **Kansas** is developing protocols to determine if there is a reduction in suicide attempts and completions among LGBTQ+ youth who call the crisis lines, comparing rates from before to rates after training is administered.
  - **Maryland** is looking into how to collect outcome data on the quality of crisis services being received.

- **New York** is assessing the performance of trainings and related curriculums. Information from this assessment will be used to identify knowledge gaps and inform development of future products.

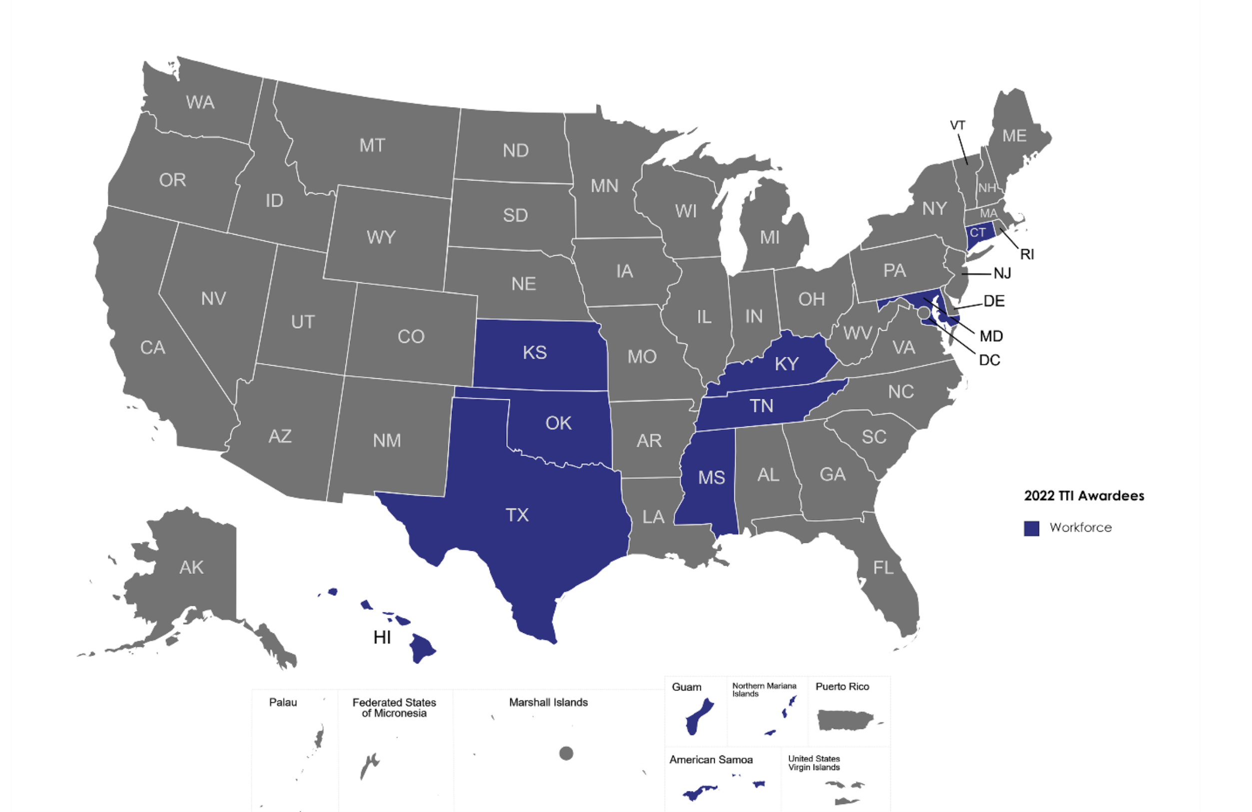
## Successful Strategies

The most frequent lesson shared by TTI projects focused on special populations is to engage the population of focus (eight projects), including engaging with stakeholders early and often (six), and prepare and research issues in advance (six). Five TTI projects also acknowledged that the procurement process within the state government system can add unexpected delays to the projects' timelines; starting early and having someone who understands the process help with the procurement process will facilitate the process. Building extra time (recommended by three projects) into the project plans can be helpful should the procurement process cause delays and also helps to ensure that all stakeholders are identified and given the opportunity to meaningfully participate in project design and implementation. One project noted that when developing projects for typically underserved populations, the project team should be prepared to engage in difficult conversations and commit to addressing disparities.

## TTI 2022 Behavioral Health Crisis Workforce

Fourteen crisis workforce projects were funded during the 2022 TTI cycle (Figure 12). Eleven states and territories, including American Samoa, the Commonwealth of the Northern Mariana Islands, Connecticut, Guam, Hawai'i, Kansas, Kentucky, Maryland, Mississippi, Tennessee, and Texas each received one TTI crisis workforce award, and Oklahoma received three awards for three separate workforce projects.

*Figure 12: State Recipients of Crisis Workforce TTI Awards, 2022*

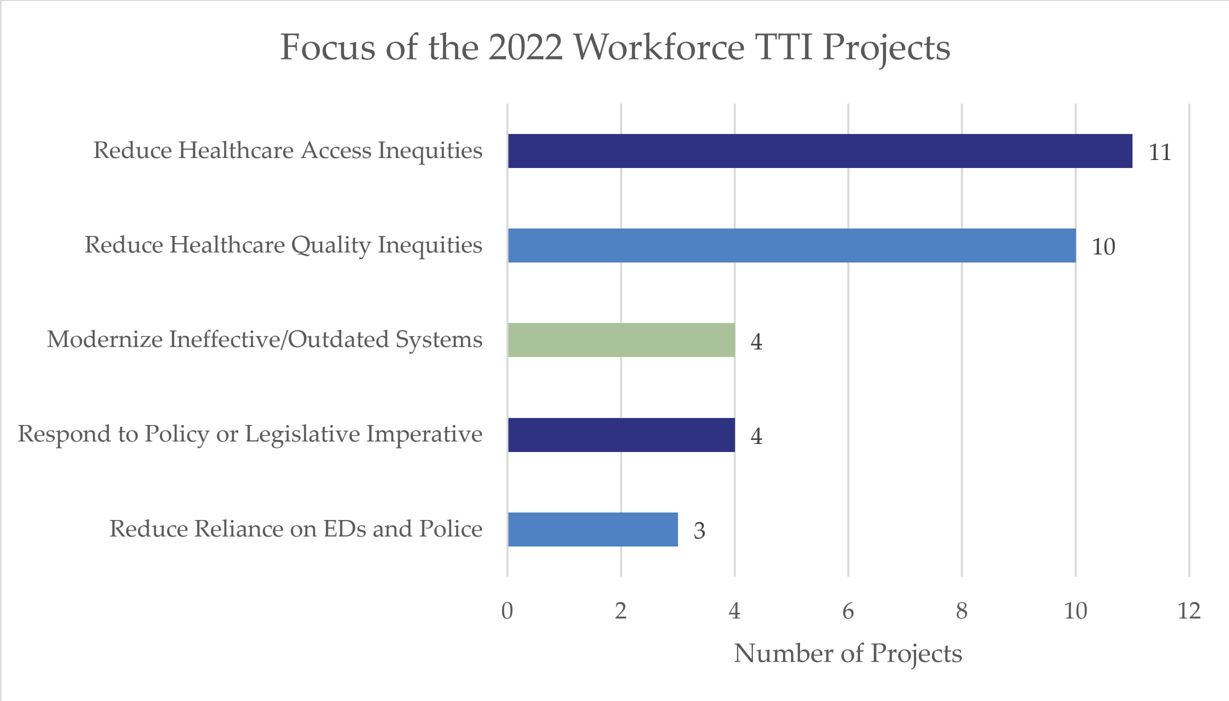



The majority of these workforce-related projects (11) focused on reducing crisis access inequities, and ten of the projects focused on crisis quality inequities (Figure 13). Briefly, the crisis workforce awardees addressed the following:

- In **American Samoa**, the rollout of 988 underscored the need for a more robust crisis response system.
- The **Commonwealth of the Northern Mariana Islands** recognized that their crisis response system was over-reliant on public safety and hospital emergency departments.

- **Connecticut** dispatches mobile crisis service team members from dispersed locations (including their homes), which has made it difficult to identify responders closest to the person in crisis.
- In **Guam**, the combination of an increase in crisis calls as well as high rates of employee turnover created an over-reliance on inadequately trained law enforcement and other first responders to respond to individuals in crisis.
- In **Hawai'i**, law enforcement is most often dispatched to 911 behavioral health calls, often leading to the arrest of the individual in crisis.
- In **Kansas**, peers are an essential component of crisis response; however, the state has experienced a rapid turnover of peer crisis responders, in part due to ambiguity over their role.
- In **Kentucky's** rural areas, limited availability of mental health staff to respond to crises has led to training EMTs and other first responders.
- **Maryland** is rapidly transforming and expanding crisis services beyond a narrow focus of suicide prevention and identified a need to expand the knowledge of the state's crisis staff to include how to effectively serve minorities, veterans, older adults, individuals experiencing homelessness, individuals with gambling disorders, and victims of sex trafficking.
- **Oklahoma's** three workforce projects are focused on addressing treatment delays resulting from overburdened staff and a simultaneous expansion of services.
- **Tennessee**, like many states, has struggled to attract and keep behavioral healthcare workers.
- In **Texas**, most of their 254 counties have been designated as mental health professional shortage areas.

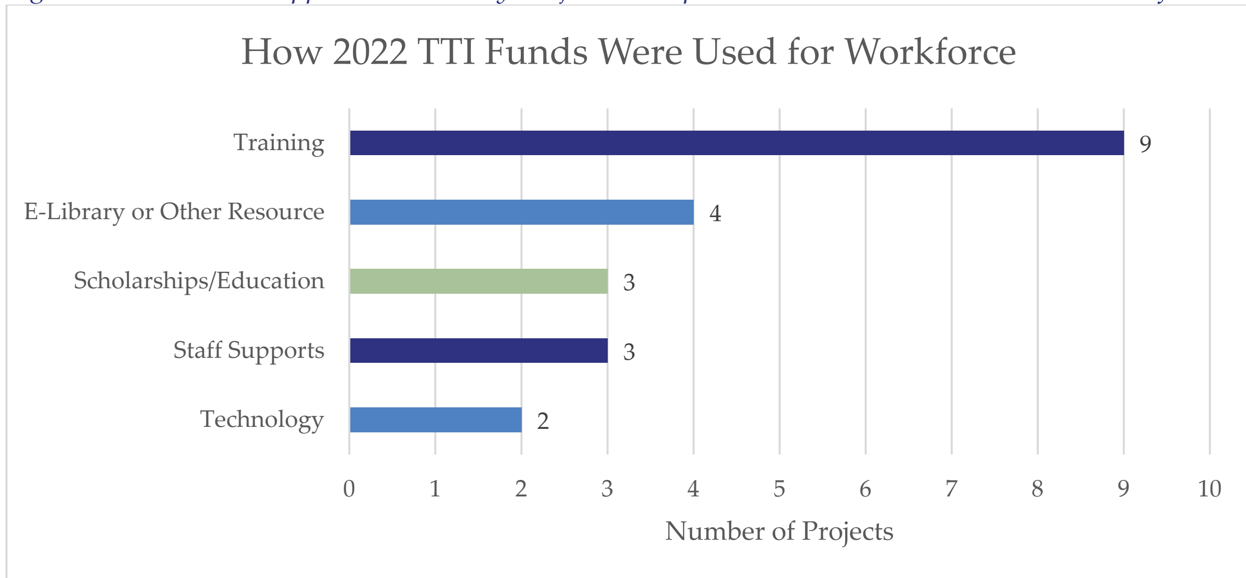
*Figure 13: Problem or Need the Workforce Projects Sought to Address*




## Vision and Approach for TTI Behavioral Health Crisis Workforce Projects

The most common approach used by the TTI awardees among the 14 workforce projects is the development and procurement of training materials (nine projects), including the distribution of training materials via an e-library (four). In addition, awardees are undertaking a variety of educational activities to increase interest in pursuing careers in behavioral health (three); are taking innovative approaches to supporting staff (three); and are making workforce changes related to technology (two). See Figure 14.

*Figure 14: Vision and Approaches Used by Projects to Improve the Behavioral Health Crisis Workforce*




Awardees that used their TTI funds to procure training for their workforce undertook the following strategies:

- **American Samoa** is building their crisis service response capacity through increased and improved partnerships with first responders, and by recruiting and training new staff.
- The **Commonwealth of the Northern Mariana Islands** is preparing to implement standard crisis operating procedures for their staff and to work with partners, including first responders, correctional officers, schools, 911, and others.
- **Guam** is preparing to conduct Crisis Intervention Team (CIT) training for law enforcement, some of whom will be certified to conduct further CIT training. Guam will also use the TTI funds to hire and train peers as certified peer specialists to support and improve crisis response.
- **Hawai'i** is developing enhanced training of hospital-based crisis staff and law enforcement, training materials, and a standardized training manual. Hawai'i will also equip law enforcement on Maui with electronic tablets that will allow people in crisis that they encounter to receive telehealth services.

- **Kansas** is procuring additional expertise in peer support aimed at retaining their peer support workforce. Kansas worked with a local university to develop a certified peer specialist training website.
- **Kentucky's** TTI project will improve the services provided to individuals experiencing a crisis and to better serve people in rural areas by providing evidence-based training.
- **Maryland's** project provides specialized training through a web-based portal to enhance crisis services' staff ability to serve niche populations.
- **Texas'** project refocuses their existing training platform towards organizational development to help local behavioral health agencies foster healthier workplaces that are better able to recruit and retain staff.

For projects with the goal of recruiting and retaining staff, their approaches include:

- **Mississippi's** project created staff-level court liaison positions in four community mental health centers (CMHCs) that serve areas with high rates of involuntary commitments to inpatient facilities.
- **Oklahoma** is establishing a clinical center of excellence to assess the workforce training needs, provide a single point-of-entry for behavioral healthcare trainings, and develop and host trainings.
- Another of **Oklahoma's** projects has developed partnerships with colleges, universities, and community service providers to implement an e-learning platform to simplify the training and certification of case managers, and to modify current certification standards.

Other workforce projects pursued the following:

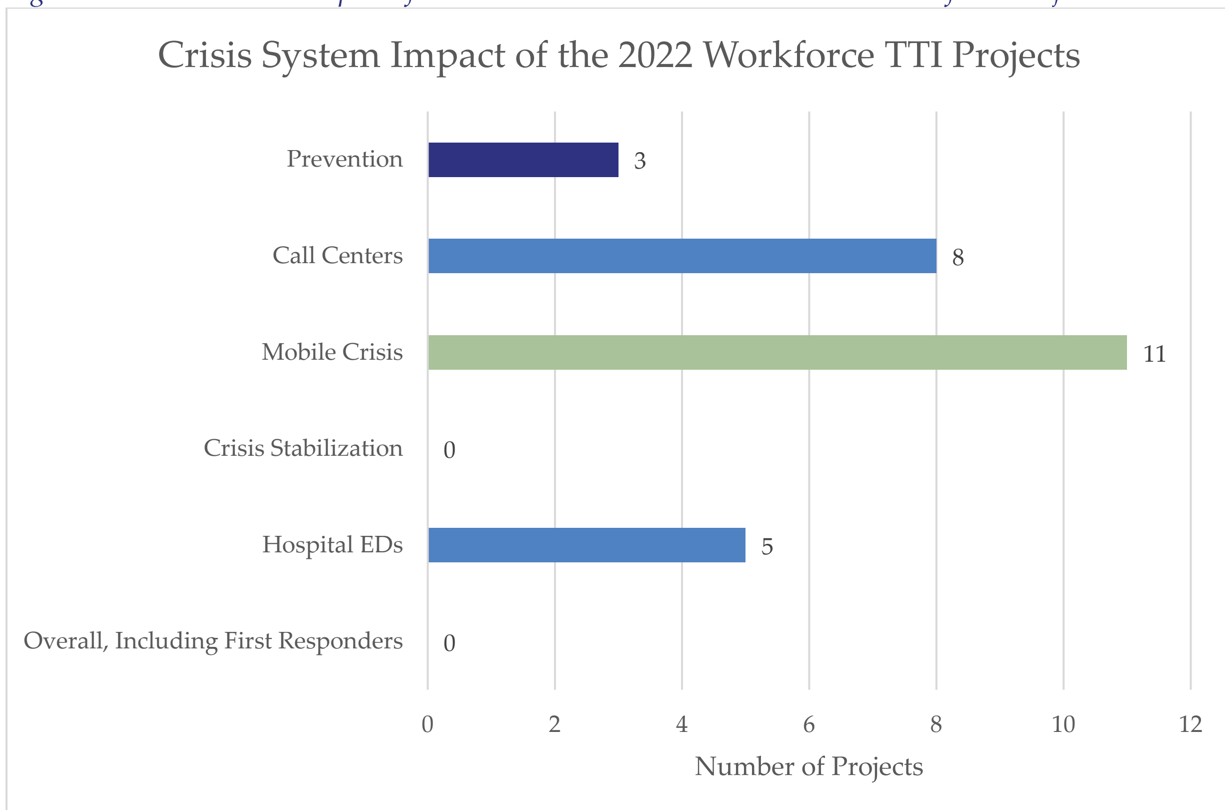
- A third **Oklahoma** project improved the availability of clinical staff and reduced vacancies by creating specialized graduate study tracts at the state university to provide scholarships to mental health staff who work in rural and remote mental health centers in the state. Class schedules are organized to accommodate travel and work schedules so that staff can continue to provide services while they pursue a clinical degree and license to practice.

- **Tennessee's** TTI project is creating a sustained media campaign directed at high school students with the intent of generating interest in a career in behavioral healthcare.
- **Connecticut** is procuring an electronic system that would enable the most efficient dispatch of mobile crisis workers to respond as quickly as possible to individuals in crisis.

## TTI Crisis System Impact

The 14 workforce projects were designed to have an impact on the crisis service system at various points in the crisis continuum. [Note that some projects addressed more than one workforce area.] Eleven of the projects sought to improve mobile crisis services; eight intended to improve services provided through crisis call centers, including 911 operators and their ability to serve individuals in crisis; five projects were directed at hospital emergency departments as part of the crisis service system; and three focused on the prevention of crises or the triaging of crises by improving service provision. See Figure 15.

*Figure 15: Crisis Service Impact of the 2022 TTI Behavioral Health Crisis Workforce Projects*



Of the 14 behavioral health crisis workforce projects, just under one-third (four projects) involved peer support specialists. These projects included hiring and training peers, and/or providing training to other staff to best support and utilize peers in mental health care:

- The **Commonwealth of the Northern Mariana Islands** is incorporating peer support specialists into their behavioral health mobile crisis response teams.
- **Kansas** is improving the working environment of peer specialists and increasing the number of qualified peer supporters to become certified peer support specialists.
- **Mississippi** is expanding peer support to improve how courts, law enforcement, and corrections work together to keep people in the community and out of institutions, including jails.
- **Texas** used TTI funds to host webinars, including a session on recruiting and managing peer specialists.

## Measures of Impact

Of the 14 behavioral health crisis workforce projects, most (13) have not yet completed their projects as of August 2023. More than half (eight awardees) plan to measure some outcomes of the projects; slightly more than one-third (five awardees) are measuring processes (e.g., the number of trainings or training materials created); and two (Mississippi and Tennessee) of the projects are currently measuring outcomes. The two projects currently measuring outcomes include:

- **Mississippi** is measuring the rate of hospitalization within the project's catchment area to determine the success of the project. The project's court liaisons were so successful at reducing involuntary commitments that the project has received increased funding from the state to expand the project statewide.
- **Tennessee's** project has reached more than 150 high school students at behavioral health career days across four high schools. The SMHA found that the use of college and university students to provide high school students with information on the behavioral health field greatly enhanced the effectiveness of the outreach and education program.

## Transformation Transfer and Project Sustainment for Workforce TTI Projects

While some of the projects have yet to be completed, all projects funded through the 2022 TTI workforce cycle will continue to exist and impact their state's crisis service system. Four of the 14 projects funded by the 2022 TTI workforce awards were so successful that the state not only continued the project, but also had plans to expand to other parts of the state.

## Successful Strategies

For many of the 2022 behavioral health crisis workforce projects, delays in procurement processes and other interruptions have required both patience and flexibility.

In addition to flexibility and patience, project directors found that the time they took to meaningfully engage stakeholders and incorporate their ideas and suggestions into the project contributed to a more robust project, increased trust, and achieved buy-in to adopt the project. Specifically, awardees identified the following challenges and lessons related to flexibility and patience:

- The **Commonwealth of the Northern Mariana Islands** experienced turnover in administrations and in partner agencies which created a need to continuously establish relationships with new staff and leaders of these agencies to achieve on-going support for the project.
- **Kentucky** found that to pursue their project they needed to develop a better understanding of ambulance services in their state, including the rules governing them, funding structures, staffing, and staff training.
- **Maryland** did not experience difficulties with the procurement process, but instead needed to identify additional subject matter experts beyond their original plan to create the project's training content.
- **Mississippi** needed patience and flexibility to build trust across the systems to change policies and practices.
- **Oklahoma** recommends that states first assess their readiness to undertake the work of the project, including whether the necessary infrastructure and organizational resources are in place and available.

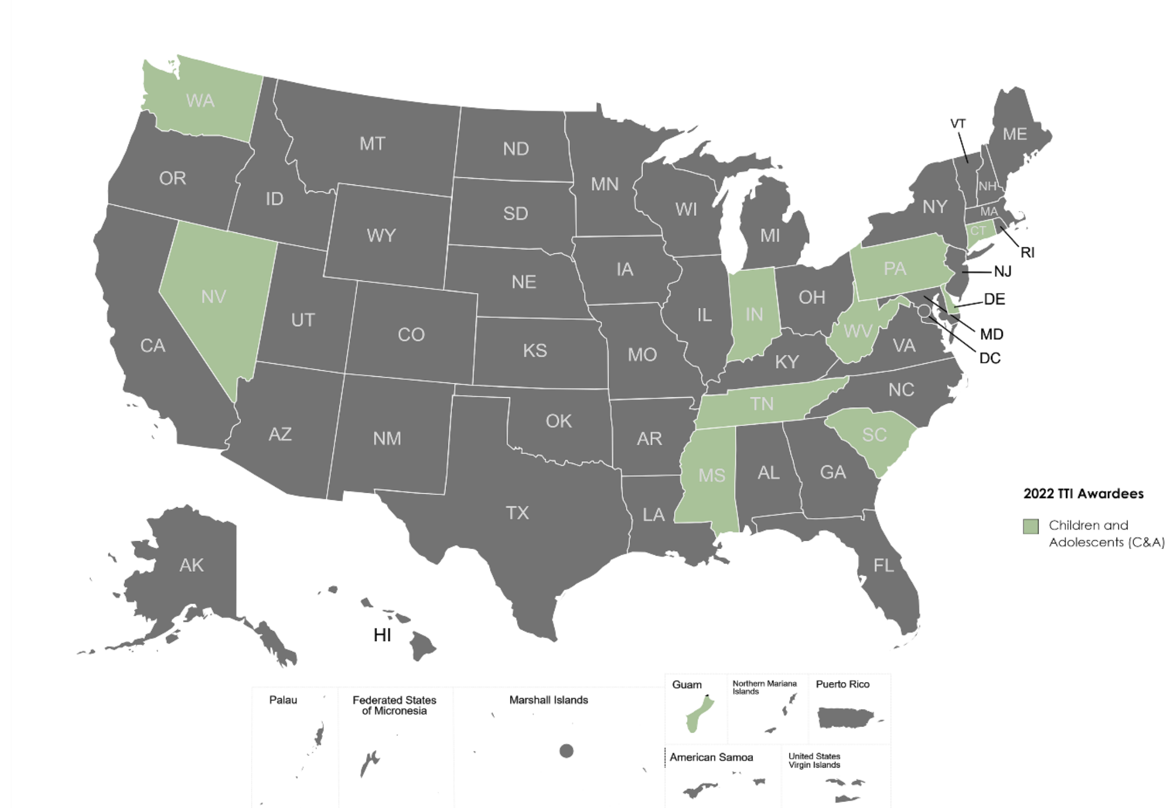
- **Texas** altered its training curricula based on input from the CMHCs. This stimulated a new approach that improved the project.

Many project directors identified challenges with state procurement processes. Two project directors recommended that projects either incorporate staff with experience in the procurement process or obtain expertise with procurement.

## TTI Category: Behavioral Health Crisis Services for Children and Adolescents

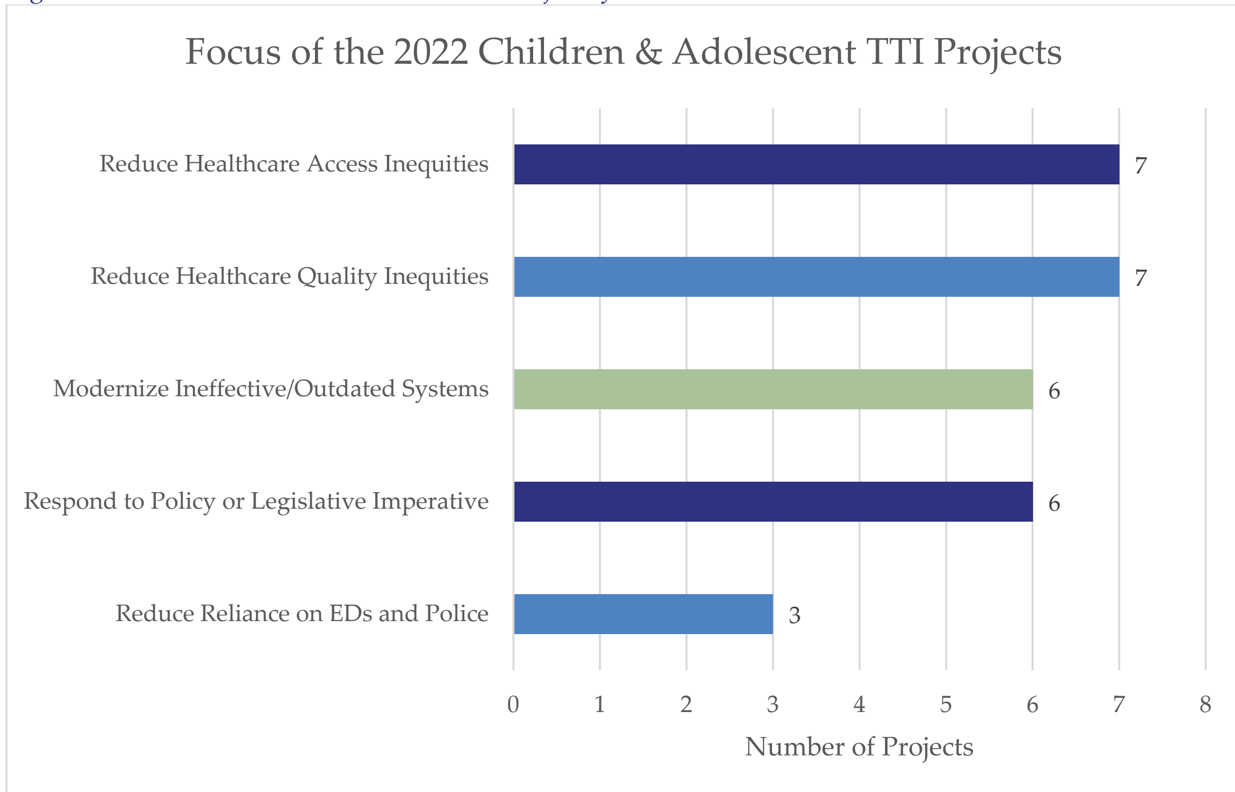
In 2022, 10 states and one territory completed 13 TTI projects focused on the crisis system needs of children, adolescents, and their families; Tennessee had two TTI projects in this category. See Figure 16.

*Figure 16: States Receiving 2022 TTI Awards Focused on Children and Adolescents*




TTI project directors were asked what problem or need their 2022 TTI project sought to address; states were able to identify more than one need. Across the 13 Behavioral Health Crisis Services for Children and Adolescents projects, project directors identified several system problems that the project was addressing. Seven identified the need to reduce healthcare access inequity, as well as reduce healthcare quality inequity for children and adolescents. Six projects identified a need to modernize ineffective and/or outdated systems, and six used their TTI funds to respond to a policy or legislative imperative, and three identified a need to reduce reliance on emergency departments and law enforcement response for children and adolescents in crisis. See Figure 17.

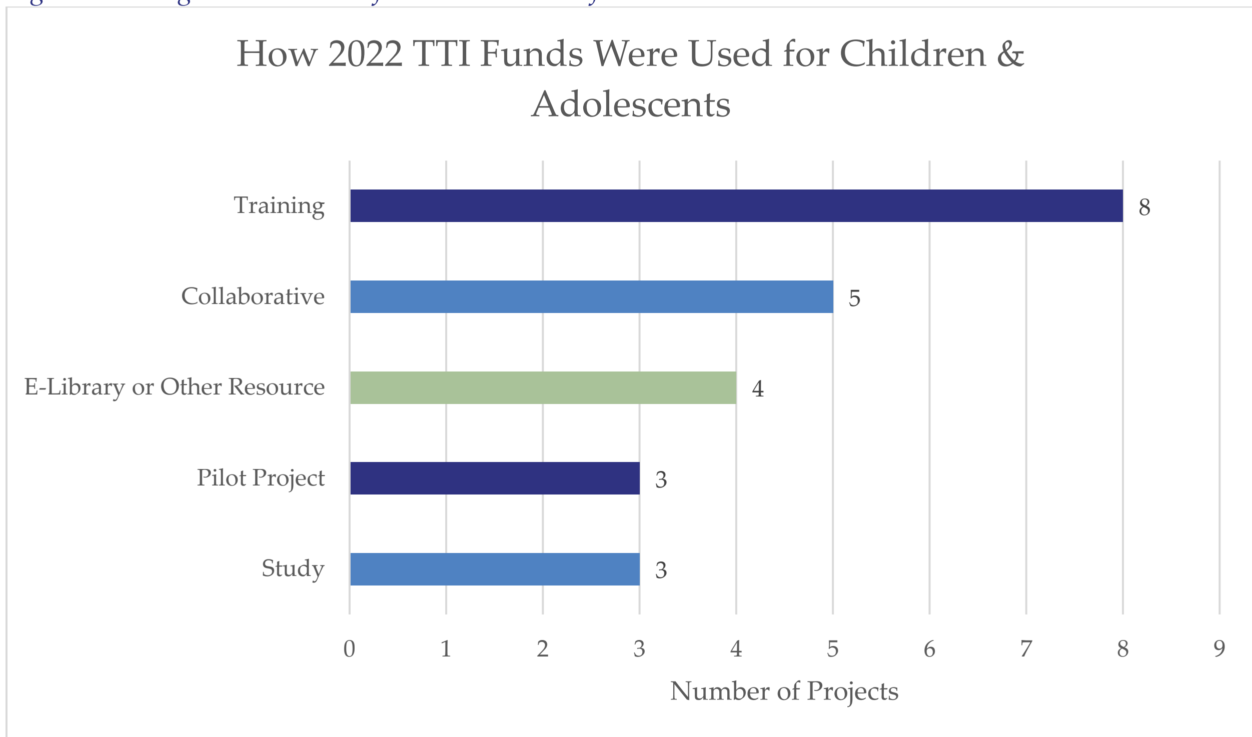
*Figure 17: Problem or Need the 2022 TTI Projects for Children and Adolescent Crisis Services*




## Vision and Approach for Behavioral Health Crisis Projects for Children & Adolescents

Among the 13 TTI projects focused on children and adolescents, eight used their funds to procure training for clinical staff. Five used their funds to establish or join a collaborative within their state or nationally to connect crisis system practitioners with other members of state government (or with crisis system practitioners in other states) to share lessons learned and strategize across systems. Three of the projects involved a pilot project of a transformational method of improving access to or the quality of crisis care for children and adolescents. Three of the 2022 TTI projects supported the creation of an educational resource for staff or a study that sought to increase understanding of a particular aspect of the state's crisis system as experienced by children and adolescents. Four projects that created an e-library or other resources. See Figure 18.

*Figure 18: Target Investment of 2022 TTI Funds for Children and Adolescents*

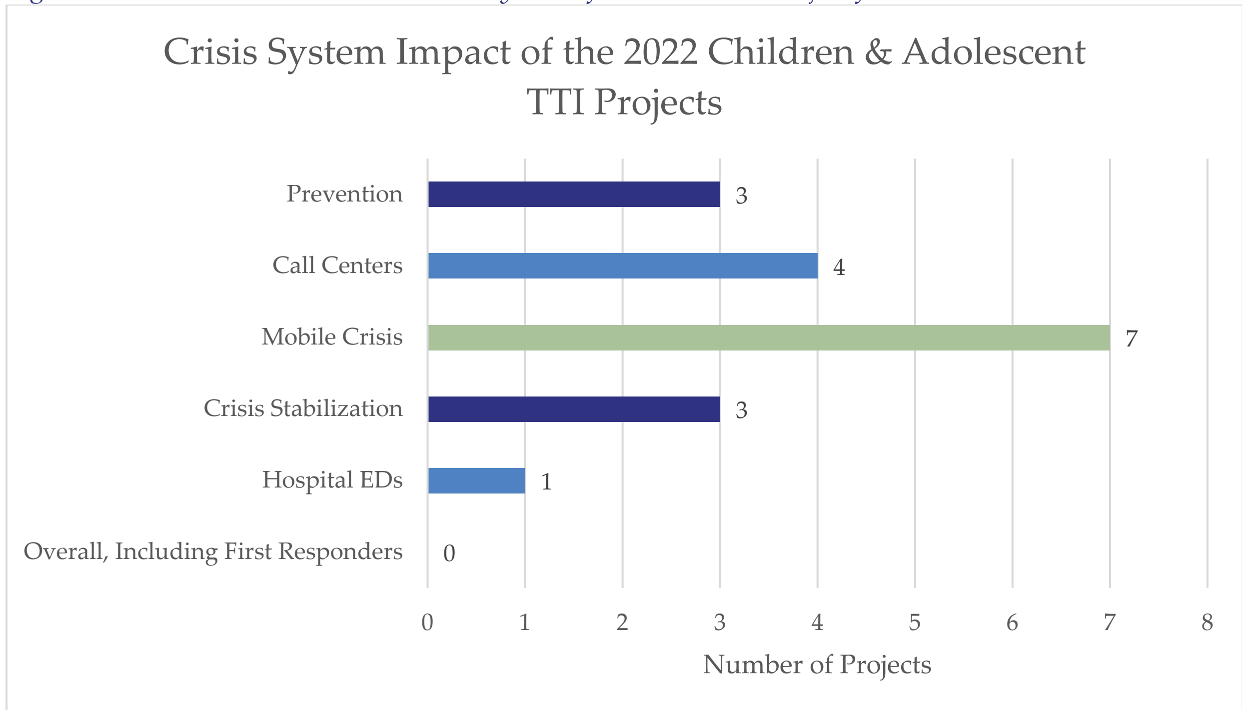



Many projects recognize the importance of involving peers to improve access and quality of crisis care for children and adolescents. The plurality of 2022 children and adolescent TTI projects involved peers (six) or allowed for the involvement of peers (two). However, six of the projects did not involve the use of peers.

## Crisis System Impact

Seven of the 13 TTI projects for children and adolescents in 2022 targeted mobile crisis services. Four of the projects focused on improving services at crisis call centers and/or improving the integration of 911 and 988. Three of the projects targeted crisis receiving and stabilization facilities. Another three targeted prevention of crises among children and adolescents. Finally, one project targeted hospital EDs, seeking to improve pathways to crisis care and to minimize ED boarding. See Figure 19.

*Figure 19: Focal Point within the Crisis System of the 2022 TTI Project for Children and Adolescents*




## Measures of Impact

The diversity of TTI projects, even within a single focus area, means that states use a variety of methods to measure the outcomes of their TTI projects and their enduring impacts.

Five of the 13 children-and-adolescent-focused TTI projects collect process measures to determine the effect the project has on the overall behavioral health crisis system. Three of the TTI projects indicated collecting some outcome measures. Further, two of the TTI projects intend to collect measures later in the project period.

## Transformation Transfer & Project Sustainment for Child & Adolescent TTI Projects

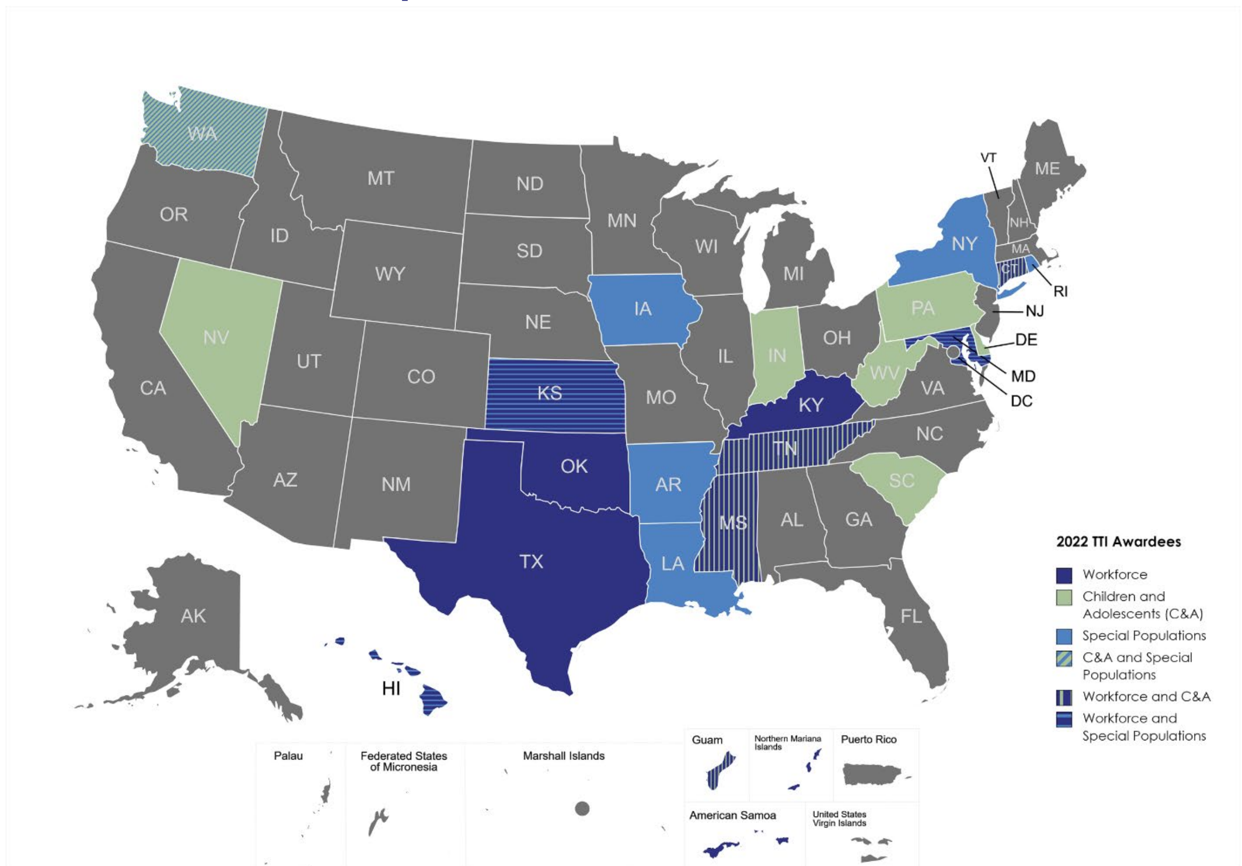
Awardees identified several ways that their child and adolescent behavioral health crisis services TTI project will continue to impact their crisis services system. Half (seven) of the child-and-adolescent-focused TTI projects indicate that their project helped establish statewide crisis care standards. Six of the projects indicated that the deliverable, often a training series or module would continue to be used after award funding is exhausted. Three of the TTI projects report that the pilot projects funded through TTI will continue after TTI funding ends. One pilot project funded by the 2022

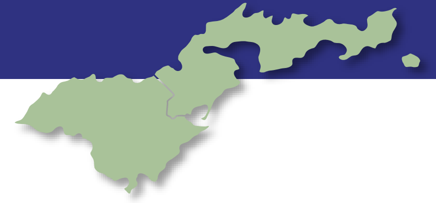
TTI will be adopted as a model to use statewide. Finally, only one child-and-adolescent-focused TTI project will end when the award concludes.

## Successful Strategies

Ten projects identified the necessity of preparing stakeholders and building trust as an important component of success. Seven noted the importance of engaging and reengaging stakeholders in a continuous process. Flexibility and persistence in the implementation of their TTI projects was the lesson shared by six projects. Five of the TTI projects found synergy by integrating their efforts with other state initiatives to improve outcomes and amplify results. Four of the TTI projects emphasized the need to start early, as there can be many steps in the state government procurement process. Five also identified engaging the people you want to serve as important to the success of the project. Three of the projects found the best approach to training was to adapt national best practices with local resources and needs to implement their TTI project successfully. Finally, one state mentioned how useful it is to integrate their work into existing electronic health information systems within the state.

# Appendix A:
# State Awardee Snapshots





## American Samoa – Workforce

**Problem/Need**

> ***We were able to use this opportunity to create what our crisis response unit should be and how it needs to operate."***
>
> *- Talalupelele Fiso, TTI Project Director*

With the COVID-19 pandemic and other external factors, American Samoa began to see an increase in risky behaviors, suicidal ideation, and deaths by suicide. American Samoa's suicide prevention crisis lifeline has been staffed by a combination of workers from the Department of Human and Social Services Behavioral Health Services Division (DHSS BHSD) and local behavioral health providers to ensure coverage. However, the limited supply of local behavioral health professionals from the islands posed a challenge in the face of the widespread 988 rollout in July 2022. DHSS BHSD took this opportunity to apply for TTI funds for capacity building, including recruiting and training personnel for American Samoa's behavioral health crisis workforce.

**Vision and Approach**

*Figure 20: Cohort of Crisis Response Workers*

The desired outcome of this work is to establish a workforce for crisis response in American Samoa and build capacity and skill to respond to crises via the crisis call center, as well as in partnership with other crisis services. The knowledge gained along the way, as well as the process itself, can also be shared with partner agencies implementing similar work in the future. DHSS BHSD began by developing position descriptions for crisis response workers based on guidance and resources shared during regularly scheduled TTI calls with NASMHPD and NRI. Positions were advertised publicly and, in collaboration with the Department of Human Resources, were filled expediently via an emergency hire program. Following interviews of qualified candidates, an initial cohort

of six individuals were hired and trained as crisis response workers to respond to 988 crisis call center calls.

### Outcomes

A little more than a year after initial hiring, two individuals from the original cohort of crisis response workers were recognized as having the necessary skills, capacity, and understanding to transition into treatment services. As a result, DHSS BHSD began recruiting for these two vacancies to continue the program. DHSS BHSD is also planning to administer surveys and questionnaires, as well as convene focus groups to evaluate the effectiveness of the recruitment and training processes.

### Transformation Transfer

Through this work, DHSS BHSD staff developed a framework that can be adapted as needed to train behavioral health crisis response workers. Recent collaborations with the Department of Agriculture showcased DHSS BHSD's ability to apply this process to help with training for a local farmer helpline. Collaborations forged through this work have created strong cross-agency relationships, and have resulted in cross-pollination, as BHSD has also requested help from the Department of Agriculture in developing farmer-relevant scenarios for crisis response worker training.

### Strategies for Success

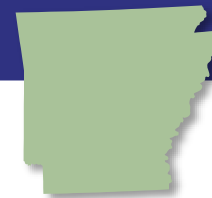
American Samoa faced many challenges in developing their 988 services, which were exacerbated by shutdowns resulting from the COVID-19 pandemic. This work established high levels of collaboration necessary to implement the American Samoa 988 Suicide and Mental Health Helpline. The lesson here is that establishing and sustaining working relationships between partner agencies is a necessary first step in the successful implementation of large-scale initiatives.

Cultural adaptations for trainings require appropriate planning, especially for the Pacific Jurisdictions. It is important to ensure resources adapted from off-island are culturally appropriate and culturally sensitive, are adapted to the local language (in this case, Samoan), and incorporate cultural scenarios. These steps are not always easy, as they require significant time to accomplish.

**TTI Contact**

For more information, contact Lupe Fiso at talalupelele.fiso@doh.as.

## Arkansas – Special Populations (LGBTQ+)



### Problem/Need

Limited resources exist to effectively serve individuals in the LGBTQ+ community in crisis with cultural competence. The goal of this TTI project is to develop training for providers and other stakeholders to effectively engage and serve these communities with cultural competence.

> ***"It is not getting any easier for the LGBTQ+ community, and we need to develop more resources for them to turn to."***
> *-Buster Lackey, NAMI Arkansas*

### Vision and Approach

*Figure 21: Program for NAMI's Mental Health for All Conference*

NAMI Arkansas, the ultimate recipient of the TTI funds, distributed approximately $88,000 of TTI funds in mini awards to nine non-profit providers across the state that work with the LGBTQ+ community to train their staff on how to appropriately and competently serve individuals identifying as LGBTQ+. The remaining TTI funds were used to host a one-day conference for approximately 120 participants from a variety of stakeholder groups that work with the LGBTQ+ community, including providers, law enforcement, fire fighters, EMS, and others. The one-day conference on November 2, 2022 in North Little Rock that covered a wide variety of important topics, including key terms to know in relation to the LGBTQ+ community; the definition and importance of self-selected pronouns; LGBTQ+ family building, suicide and LGBTQ+; how to be a good co-worker to LGBTQ+ individuals; cultural competency in the LGBTQ+ community; how to accept a child coming out as gay or trans; and intersectionality of LGBTQ+ and other risk factors for health disparities. Special training sessions were held concurrently for law enforcement and other first responders on how to effectively respond to and work with the LGBTQ+ population. The agenda (cover, Figure 21) for the conference and other training materials were developed based on other already established trainings, including trainings from Princeton and the University of

Arkansas. It was developed under oversight from an advisory board consisting of representatives from Pride Leaders in Little Rock, providers who received the mini TTI awards, members of the Arkansas Inclusion Network, as well as first responders, and individuals who identify as members of the LGBTQ+ community. All materials were vetted to make sure they were appropriate and on-target.

**Outcomes**

The goal of the one-day training is to improve the cultural competency of providers and other public servants who respond to LGBTQ+ individuals and their families experiencing a crisis; thereby improving trust among the LGBTQ+ community for first responders and behavioral health crisis providers, as well as improving the quality of care they receive once engaged in services. While specific outcomes are not being collected, many of the 120 participants at the one-day conference, including law enforcement, have provided feedback to NAMI about the value of the conference.

**Transformation Transfer**

The *Mental Health for All* conference was only held once; however, the conference was recorded and is being posted to the NAMI Arkansas's website[23] to allow others to access the conference. Additionally, the one-on-one training courses initially supported by the 2022 TTI funds are ongoing with support from the NAMI Arkansas general budget. NAMI Arkansas is offering two-hour classes in the evenings focused on cultural competency and the appropriate and respectful use of pronouns.

**Strategies for Success**

> ***"The Mental Health for All conference created a fundamental shift in some law enforcement participants' mindset that it's okay to work with people I may not agree with. Without the TTI funding, this conference never would have happened."***
>
> *-Buster Lackey, NAMI Arkansas*

NAMI Arkansas hoped for a large, diverse group of participants at the *Mental Health for All* conference. They found that advertising on the radio during rush hour was the most effective

[23] As of the writing of this report, the conference has not been posted to the website, but activities are ongoing to share the conference materials and recordings.

form of promotion for the conference and the way to reach a diverse audience. To develop an effective and culturally competent curriculum, NAMI Arkansas relied on a diverse group of stakeholders to serve on an advisory committee. Having multiple perspectives and voices helped to bridge the gap between communities to create an effective learning environment.

**TTI Contact**

For more information, contact Buster Lackey, Ph.D., LPC, LADAC at buster.lackey@namiarkansas.org.

## Commonwealth of the Northern Mariana Islands – Workforce

**Problem/Need**

> *"Engage in a strategic planning process guided by data and focus patiently on building partnerships if you want long-term investment, sustainable outcomes, and positive impact to community members most in need."*
>
> *-CNMI 988 Team*

With the launch of 988, many state and territorial mental health authorities have taken the opportunity to reexamine the coordination and delivery of crisis services to their constituencies. The Commonwealth Healthcare Corporation of the Commonwealth (CHCC) of the Northern Mariana Islands, like many other Pacific Jurisdictions, has come to recognize the impact of the existing system's overreliance on public safety and hospital emergency departments to respond to behavioral health crises. To reduce that overreliance, CHCC leveraged TTI funds to expand and train its crisis care workforce and to develop and implement protocols and practices that reduce the involvement of public safety systems and hospitals. Establishing such alternatives has required buy-in from public safety, fire and emergency medical services, and urgent care and emergency department medical staff to view behavioral health care and crisis response through a similar lens.

**Vision and Approach**

*Figure 22: First Responders Attending MHFA Training in CNMI*

To implement a crisis response system, CHCC needed to develop and implement crisis response standard operating procedures for its staff. In addition, CHCC continues to work closely with leadership in law enforcement, fire and emergency medical services, corrections, schools, 911 call centers, and other organizations to establish common protocols that define roles and responsibilities in meeting the behavioral health needs of individuals in crisis. Collaboration is occurring as CHCC

expands its crisis care workforce by training and adding certified peer support specialists to its mobile crisis team and plans to open a short-term crisis stabilization unit soon. CHCC is training its workforce, including 988 call responders, on Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST). CHCC also built train-the-trainer capacity in both practices so that training can continue beyond TTI funding. With greater clarity of roles and responsibilities, the Department of Public Safety has partnered with CHCC to begin training its law enforcement officers in MHFA and plans to train all officers through train-the-trainer instruction. Similar training partnerships are being established with the CHCC Emergency Room, Psychiatry Unit, Department of Fire and Emergency Medical Services, the Department of Corrections, and other key stakeholders.

**Outcomes**

Fifty-six (56) training sessions have been conducted in MHFA, resulting in:

- 329 individuals certified in Adult MHFA.
- 377 individuals certified in Youth MHFA.
- Nine (9) individuals certified as MHFA Instructors.

*Figure 23: Cohort of ASIST Training Students in CNMI*

Six training sessions have been conducted in ASIST, resulting in:

- 164 individuals trained in ASIST.
- Five (5) individuals certified as ASIST Instructors.

CHCC is reviewing and monitoring data that tracks wait times, call response, and follow-up to its crisis response system to see if there is a difference in outcomes pre- and post-training.

### Transformation Transfer

CHCC's vision is to deploy a skilled workforce that provides an alternative to hospital emergency departments and response by public safety officers when a person is in crisis. That vision is already in process as 988 is being implemented, the crisis care workforce delivers services, ongoing assessment and evaluation activities are being engaged to meet identified standards of timeliness and quality as collateral agencies and organizations adopt and support this vision, and as the workforce expands and adjusts to meet demands and/or course correction measures.

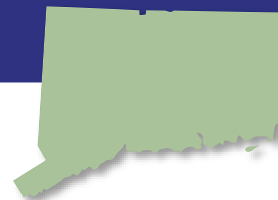
### Strategies for Success

Focus on establishing and building partnerships as ongoing relationships with collateral departments and agencies to ensure the long-term buy-in and sustainable outcomes. In some cases, this means reestablishing relationships with key stakeholders when leadership changes, and collectively addressing setbacks and identifying solutions to keep moving forward. In addition, meeting the unique community and cultural needs, implementing data-driven processes, engaging in strategic planning, and adhering to standards of crisis care are critical to determining priorities and guiding plans to implement and monitor the delivery of quality crisis care.

### TTI Contact

For more information, contact Reyna Saures at reyna.saures@chcc.health.

## Connecticut – Workforce



**Problem/Need**

The Connecticut Department of Mental Health and Addiction Services (DMHAS) developed, as part of their long-term strategic plan, the goal of implementing statewide crisis services based on SAMHSA's *National Guidelines for Behavioral Health Crisis Care.* One core component of this model is an electronic "Air Traffic Control"[24] (ATC)-type system that can be used to mobilize and track crisis staff and monitor a variety of metrics central to the Crisis Now model. The state is using TTI funds to bring this system into operation and thus move closer to a fully functioning Crisis Now crisis-response system.

DMHAS believes that crisis response time is a critical metric of any crisis system and is currently tracking this outcome. Crisis response time affects clinical outcomes, collaboration with other first responders, and perception by the public of the system's reliability. DMHAS is cognizant of these factors and believes that the ATC model will assist in improving the responsiveness of their crisis system.

A related problem or need is that DMHAS often lacks an adequate workforce to provide 24/7 crisis response statewide. DMHAS believes that the use of an ATC system will, in part, strengthen DMHAS's and its providers' abilities to hire and maintain sufficient crisis staff by allowing them to respond from their homes rather than being a strictly office-based workforce.

**Vision and Approach**

The vision of this project is to operationalize a crisis system that is responsive to individuals in crisis throughout the state. In addition, the implementation of an ATC system will provide the state with the tools to continually evaluate the effectiveness and responsiveness of the state's crisis services system. The ATC is not a clinical data system; rather, its purpose is to provide the state with information to manage the

[24] Air Traffic Control (ATC) serves as a conceptual model for real-time coordination of crisis care and linkage to crisis response services. It may involve real-time connections to GPS-enabled mobile teams, true system-wide access to available beds, and outpatient appointment scheduling through the integrated crisis call center. For more information, see SAMHSA's *National Guidelines for Behavioral Health Crisis Care*: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

application of crisis resources whenever and wherever needed. However, the state will use the ATC in conjunction with their clinical data system to fully manage responses to crises, outcomes from crisis services, and ongoing trends of activities and outcomes.

DMHAS initially intended to implement ATC throughout the state; however, this approach was altered to start in one region and expand gradually throughout the state. The pilot and phased approach allows DMHAS to dedicate adequate time and resources to address any challenges before fully expanding the ATC statewide. DMHAS's current plan is to begin training crisis staff in the use of ATC and operationalizing the ATC in September 2023.

**Outcomes**

DMHAS is in the process of purchasing an ATC system. DMHAS has selected a vendor and will pilot the new system in two of the state's local mental health authorities (LMHAs). Once the ATC is successfully implemented in these LMHAs, the ATC will be expanded statewide. The ATC captures several important metrics related to effective crisis response (e.g., response time from initial call to contact, geographic distribution of crises, use of resources to respond to a crisis, and time to resolution). Once the system is operational, the state will begin to monitor these metrics and respond, when needed, to any issues that arise. The state also plans to provide initial and ongoing training to crisis staff throughout the state to ensure that the crisis system is functioning as intended, and that staff are using the ATC to manage and improve responses to crises, wherever and whenever they may occur.

**Transformation Transfer**

Connecticut is committed financially and operationally to fully transitioning their crisis response system. A core component of DMHAS's Crisis Now model is the use of an ATC system, allowing the state to monitor and improve all facets of the crisis response system. The ATC, once implemented, will assist in transforming the state's current crisis system to one that is continually monitored for effectiveness and efficiency.

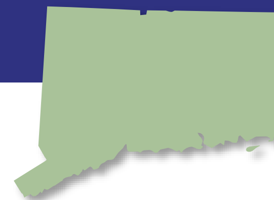
**Strategies for Success**

DMHAS has several lessons learned from this TTI project. First, procurement, particularly the procurement of a component of a state IT system, takes more time than anticipated. Second, as DMHAS presented the ATC to providers, the providers were

skeptical that the new system would be used to manage the performance of non-state staff, something the providers were not willing to cede. DMHAS is assuring providers that the management of this ATC system will remain collaborative and that human resource issues within provider organizations will remain within those organizations.

**TTI Contacts**

For more information, contact Dana Begin at dana.begin@ct.gov; Yvette Cortez at yvette.cortez@ct.gov; or Erika Echevarria at erika.echevarria@ct.gov.



## Connecticut – Children and Adolescents

### Problem/Need

> *We were providing introductory training, and now we are taking it to another level."*
>
> *-Yvette Cortez, TTI Project Director*

The Connecticut Department of Children and Families (DCF) has established a strategic goal of fully implementing the *National Guidelines for Behavioral Health Crisis Care*.[25] Through an ongoing quality assessment process, the Department has determined that it would focus its Transformation Transfer Initiative (TTI) on two components of its children and adolescent mobile crisis intervention services. First, the DCF had determined that children and adolescents with special needs (e.g., Intellectual and Developmental disabilities, Autism spectrum disorders, Substance use and co-occurring disorders) in crisis were not being consistently well served through its mobile crisis resources as well as within the larger behavioral health service system. Second, while the DCF has made significant progress in developing and managing its mobile crisis resources, it understood that dispatching mobile crisis teams and linking individuals to needed behavioral health resources could be improved. DCF tracks crisis response time and its impact on clinical outcomes, collaboration with other first responders and perception by the public of the systems reliability. To better manage this process, DCF requires a more effective means of dispatching mobile crisis teams, monitoring the teams progress and overseeing the connection of individuals in crisis to needed on-going resources.

### Vision and Approach

The DCF Mobile Crisis clinicians currently receive standardized crisis training to address the wide range of diagnoses and presenting problems that they encounter. However, a DCF survey of various stakeholders has identified specific disorders and needs that require additional expertise among Mobile Crisis teams as well as more

[25] SAMHSA. (2020). National guidelines for behavioral health crisis care best practice toolkit. *Substance Abuse and Mental Health Services Administration.* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

broadly across behavioral health providers. To meet these identified needs, the State is developing additional and enhanced training and staff competencies that focus on children and adolescents with special needs such as Intellectual and Developmental Disabilities. Furthermore, the State is developing informational resources for children, adolescents, and their families to better understand crises, and help in accessing assistance in times of crisis. These resources are being developed on web-based asynchronous training platforms to ensure they are widely available and improved and expanded, as needed.

To improve the management of the mobile crisis system, the State is developing a GPS "air traffic control" system. This system will allow DCF to quicky and effectively dispatch mobile crisis resources, monitor critical outcomes such as response time and disposition and implement a more data driven approach to quality improvement of the mobile crisis system.

**Outcomes**

The State is developing new crisis training curriculums that are based on a needs assessment of stakeholders, including staff and individuals with lived experience. Several curriculums are fully developed and are available on DCF's web platform. The remaining curriculum will be completed by the end of 2023.

The State is in the process of procuring the needed tracking Global Positioning System (GPS). DCF is purchasing and implementing this in conjunction with the Connecticut

**Transformation Transfer**

DCF is committed, financially and operationally, to fully transitioning their children and adolescent crisis response system. Their expanded training curriculums will assist staff and the system in general, with helping individuals with special needs who are in crisis. These individuals were not always well served previously.

The DCF is furthermore committed to meeting its transformational goal of fully implementing the services and supports of a statewide crisis system based on the *National Guidelines for Behavioral Health Crisis Care*. A core component of this approach is the use of GPS enabled management of crisis resources and the monitoring of those

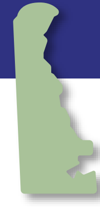
resources and outcomes. The DCF purchase and implementation of such a system will greatly improve the quality, efficiency, and effectiveness of its crisis response system for children, adolescents, and their families.

**Strategies for Success**

Two strategies for success were identified in this project. First, the state sought to assist individuals with special needs who were in crisis and to improve the training of staff who were tasked with providing these services. To better understand how to achieve this, DCF sought input from a wide array of stakeholders including families, individuals with lived experience, staff, providers, and other relevant professionals. This "wide net" approach was essential in understanding the gaps and flaws in the current system and better meeting the needs of anyone who finds themselves in a behavioral health crisis. Second, procurement, particularly the procurement of a component of a state IT system (i.e., GPS tracking software) takes more time than was anticipated. This time and its complexity should be incorporated into the project plan as far in advance as possible. A related complexity to this project was the skepticism of the provider community in DCF's adoption of GPS tracking. Providers were skeptical that the new system would not be used to manage the performance of non-state staff. DCF has assured providers that the intent of using this technology is to better manage client outcomes and that the system will remain collaborative at all phases of implementation and management.

**TTI Contact**

For more information, contact Yvette Cortez at yvette.cortez@ct.gov.



## Delaware – Children and Adolescents

**Problem/Need**

***People's needs when in a crisis do not always fit into the neat categories of state government."***

*-Kris Fraser, DSAMH*

The State of Delaware has a comprehensive but fragmented crisis response system that provides services to individuals facing a behavioral health crisis. Currently, mobile crisis services are provided by the Division of Substance Abuse and Mental Health (DSAMH), which has primary responsibility for adults with a mental illness and/or substance use condition; and the Division of Prevention and Behavioral Health Services (DPBHS), which has primary responsibility for children and adolescents and their families with serious emotional disturbances through a contract with Delaware Guidance Services. Each of these agencies operates its own call center with toll-free numbers. In addition, a long-standing non-profit organization, Contact Lifeline, currently answers calls to 988. Delaware also has crisis receiving facilities operating in two of its three counties.

DSAMH understands that the needs of individuals in a behavioral health crisis do not necessarily fall within the distinct service offerings, expertise, and resources of these separate governmental agencies. This siloing of services can impede the delivery of services and supports necessary to overcome a crisis. Publicizing multiple toll-free numbers of varied service scopes also creates confusion and frustration among individuals and families seeking support during a crisis.

**Vision and Approach**

The goal of DSAMH's 2022 TTI initiative was to lay the groundwork for establishing a statewide Behavioral Health Crisis Communication Center (BHCCC) to serve as the central hub for all 988 and behavioral health communications, regardless of age, diagnoses, and/or disability of individuals in crisis.

Delaware approached this complex goal by engaging stakeholders from partner agencies, including DSAMH, DPBHS, the Delaware Division of Developmental Disabilities Services (DDDS), and Delaware 911; community provider agencies; as well

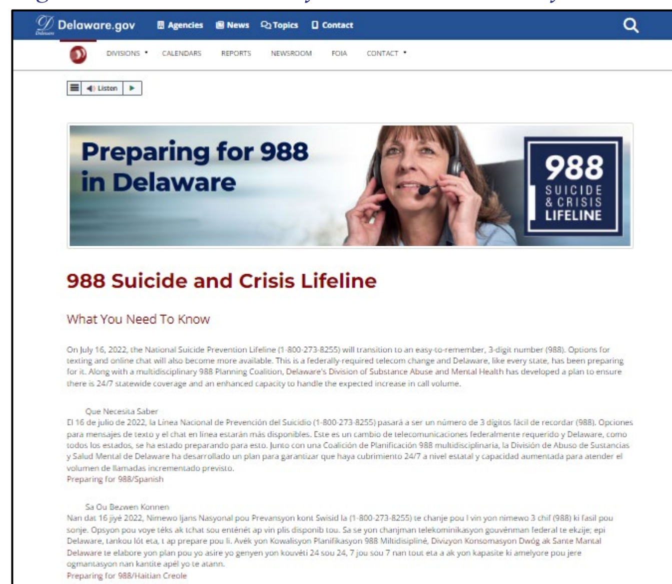
as individuals, families, and advocates. The 988 Planning and Implementation Coalition began regular meetings in April 2021 and continues to engage these stakeholders. Leveraging the TTI funds, the state contracted with Beacon Health Solutions (now Carelon Behavioral Health) to assist and guide the process of creating a BHCCC implementation plan with input from all stakeholders. This group continues to support DSAMH to develop staff-certification requirements, to design and conduct cross-training of staff, and to establish cross-agency operational policies and referral protocols.

**Outcomes**

This project has successfully completed its primary objectives:

- A coordinated effort among multiple state agencies to develop needed critical infrastructure for the statewide BHCCC as part of Delaware's 988 Implementation Plan.
- The completion of a needs assessment addressing BHCCC workforce development, required technology, and interagency coordination.

*Figure 24: Delaware's Informational Website for 988*




- The launch of an informational website for the public specific to 988 implementation (https://www.dhss.delaware.gov/dhss/988.html), with translation options available in English, Spanish, and Haitian Creole.
- The development of a data-driven evaluation plan that is used to analyze various pertinent measures (e.g., call volume, call time, location, presenting issue, client demographics, and disposition). This analysis is and will be used to improve training/cross-training, resource allocation and funding, and ongoing development of this crisis-response system.

This project is continuing cross-agency training and certification, virtual co-location of crisis staff, and ongoing communication to all relevant stakeholders. These activities lay a timely foundation for the continued expansion of Delaware's crisis continuum. In August 2023, Delaware's Governor signed House Bill 160 (HB160) into law to ensure sustainable funding for 988 and related crisis services, as well as to establish a Behavioral Health Crisis Intervention Service Board.

**Transformation Transfer**

This TTI project has transformed the relationship between various state agencies and the public they serve. It has improved coordination of effort, cross-training of staff, and ongoing review and monitoring of the combined systems' responsiveness and outcomes so that individuals experiencing a crisis will receive services responsive to their needs. The State intends to build upon this foundation by involving additional stakeholders and agencies (e.g., Divisions of Services for Aging and adults with Physical Disabilities and DDDS) and their constituents.

**Strategies for Success**

DSAMH sought to engage with key stakeholders early and often to ensure the widest possible group of stakeholders are involved in all stages of the project. Engaging the first responder/911 community early helped to create a shared vision. The State is finding that a more expansive approach to crisis services that encompasses and coordinates resources from each of the stakeholder organizations is more successful in meeting the complex needs of individuals in crisis. The State also indicated that they plan each of their TTI projects at least one year in advance and use each successive project to advance their ongoing goals.

**TTI Contacts**

For more information, contact Jessica Crumbacker at jessica.crumbacker@delaware.gov or Kris Fraser at kris.fraser@delaware.gov.

## Guam – Workforce

### Problem/Need

Guam Behavioral Health and Wellness Center (GBHWC) was experiencing an increase in mental health crisis service requests, 15 percent of which were being identified from law enforcement, including calls to 911. The agency has an employee turnover problem driven by a desire for better pay and less stressful work. GBHWC identified a need to improve their relationship with law enforcement, including Guam Police Department (GPD), Guam Fire Department (GFD), Judiciary of Guam's deputy marshals and probation officers, and other first responders through the Crisis Intervention Training (CIT).

### Vision and Approach

> *"The vision is to have a more robust crisis response system that is streamlined, and involves collaboration between agencies, along with more peer support and a reduction in unnecessary incarceration."*
>
> *-Rita Marie Untalan, TTI Project Director*

GBHWC will be contracting off-island trainers to conduct CIT training for law enforcement. They have been working on the procurement process with Guam's Department of Administration to secure the contract with CIT International to conduct the training for Guam. The goal is to have 20 law enforcement officers trained in CIT and for ten of these officers to become certified CIT coordinators so that they can conduct further CIT training. There will also be training for Guam's 36 911 call-takers. The funding will also be used to recruit and train up to ten peers as State Certified Peer Specialist to provide peer support to GBHWC's Mobile Crisis Response Team (MCRT) and the crisis hotline/Lifeline. Peer specialists have been very helpful especially in crisis response, where they help handle incidents that don't have to involve the police. The peers have brought awareness to their partner agencies.

### Outcomes

This project has not yet been completed. Employee turnover at GBHWC and the difficulty in navigating the territory's procurement process have hampered progress. As

of the end of August 2023, they have conducted three peer academies and have used the TTI funds to fund one project coordinator position.

**Transformation Transfer**

Once funding ends, Guam hopes to have an integrated response system with smooth transitions between crisis partners.

**Strategies for Success**

GBHWC recommended finding a population similar to the one you are trying to serve and partnering with the agency from another state or territory to learn from their experience and plan ahead.

**TTI Contact**

For more information, contact Rita Marie Untalan at ritamarie.untalan@gbhwc.guam.gov.

## Guam – Children and Adolescents

**Problem/Need**

Guam Behavioral Health and Wellness Center (GBHWC) experienced a significant increase in new referrals for child and adolescent's crisis services. Thirty-three percent of those referrals were for suicidal ideation, with the largest percentage of those being 16 years of age or younger. The agency determined that they needed to address three goals with their TTI project: 1) the need for peer-led mentorship; 2) to increase the continuum of care services for children and adolescents, and 3) to address the identified gaps which included support for families.

**Vision and Approach**

GBHWC utilized the technical assistance from NASMHPD to identify the Strengthening Families Program[26] training. The training program has been purchased, and 12 participants have been identified to participate. The participants include members from GBHWC, as well as members from three partner agencies - the Sanctuary Program, Project Taika (which serves older adolescents) and Project Link (which focuses services on the un-housed population). The goal is to develop "train-the-trainers" who can then support the expansion of the Strengthening Families Training Program into other departments who work with youth and families. GBHWC hopes to collaborate with other Public Health agencies such as the Guam Department of Education and CPS.

Additional programs are being considered for development that may benefit from the Strengthening Families Training Programs. This includes a therapeutic foster care program and a diagnostic and treatment program for children with autism disorder.

**Outcomes**

This project is ongoing. The Strengthening Families Training Program has been purchased and the initial 12 "train-the-trainer" participants have been identified. Demands on personnel time related to responding to recent tropical storms have

[26] Strengthening Families Program. (2020). https://strengtheningfamiliesprogram.org/

hampered the scheduling of the trainings. However, the initial training will occur over the next several weeks.

**Transformation Transfer**

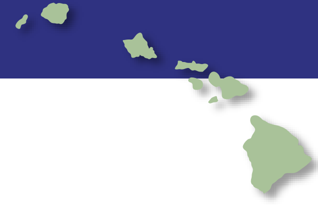
Once funding ends, GBHWC hopes that the training will result in a more collaborative relationship with partner agencies that can contribute to the continuation of this training across agencies.

**Strategies for Success**

GBHWC found that focus groups need to involve parents, treatment staff, children and adolescents, and all other necessary stakeholders in order to provide meaningful guidance and feedback. This process allows for open discussion related to the needs of the population and fosters parental and child/adolescent engagement in the training (i.e., peer mentorship).

**TTI Contact**

For more information, contact Rita Marie Untalan at ritamarie.untalan@gbhwc.guam.gov.



## Hawai'i – Special Populations (LGBTQ+)

**Problem/Need**

*How do we communicate to our LGBTQ+ community that Lifeline is a safe space to call?"*

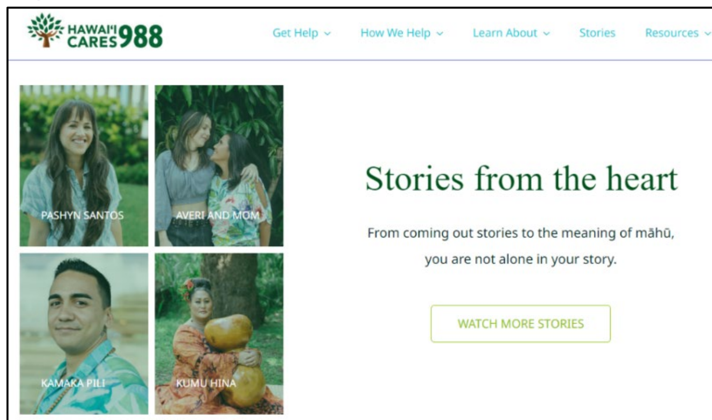
*-John Oliver, TTI Project Director*

In a report from the Hawai'i Department of Health on sexual and gender-minority communities, the experiences of individuals identifying as LGBTQ+ in Hawai'i mirror many national trends.[27] The report compares trends between LGBTQ+ youth and heterosexual youth and those between LGBTQ+ adults and heterosexual adults. It finds that every year nearly one-in-three youth identifying as LGBTQ+, and nearly one in five identifying as questioning in Hawai'i attempt suicide. In addition, LGBTQ+ youth in Hawai'i are found to abuse substances at rates that are significantly higher than heterosexual youth. LGBTQ+ youth are also less likely to have access to supportive adults at home and are therefore more likely to need crisis hotline services for support. With the rollout of 988, Hawai'i's Department of Health, Adult Mental Health Division (AMHD) recognized that the graphics and language on its current Lifeline website do not reflect the people they serve, including Native Hawai'ians and LGBTQ+ individuals, and may have inadvertently been pushing them away.

[27]Hawaii State Department of Health. (2017). Hawaii Sexual and Gender Minority Report. *Hawaii State Department of Health, Chronic Disease Prevention and Health Promotion Division.* Honolulu. Retrieved from https://health.hawaii.gov/surveillance/files/2017/05/HawaiiSexualandGenderMinorityHealthReport.pdf

**Vision and Approach**

Figure 25: Hawai'i Cares 988 Website




Efforts to create an inviting and safe space for all people to call, text, or chat when experiencing a crisis led to an examination of the 988 website, social media sites, and an environmental scan of the attitudes and understanding of the LGBTQ+ community among the behavioral health crisis workforce. AMHD used TTI funds to redesign the Hawai'i Cares 988 website (Figure 25) and social media presence, including Facebook, Instagram, and TikTok. Sites also contain video segments of LGBTQ+ individuals to create a sense of connection, support to the community in Hawai'i, and bring awareness to 988 and crisis services.

Based on the results of the environmental scan, the project partnered with the Hawai'i Health and Harm Reduction Center (HHHRC) to produce and deliver ongoing LGBTQ+ crisis training to 988 crisis call takers.

**Outcomes**

The launch of the website and social media pages have analytics built in that track number of visits, session length, and source of referral. AMHD plans to collect these data to inform updates and revisions to its digital presence. The training program for 988 call takers is taking place. AMHD's Performance Information Evaluation and Research (PIER) Branch will establish a train-the-trainer program based on HHHRC's model.

**Transformation Transfer**

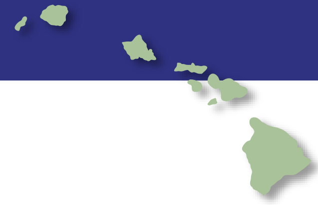
This project employed resources commonly used by the population-of-focus to spread the message and promote trust that crisis services provide a safe space to address the needs of all individuals, including those within the LGBTQ+ community.

**Strategies for Success**

There is a tremendous amount of local support for the LGBTQ+ community. Behavioral health services must reflect the diversity of its population and ensure that services are representative and welcoming to all populations and individuals.

### TTI Contact

For more information, contact John Oliver at john.oliver@doh.hawaii.gov.



## Hawai'i – Special Populations (Native Hawai'ians)

**Problem/Need**

The Hawai'i Department of Health, Adult Mental Health Division (AMHD) has been looking for ways to improve access to behavioral healthcare for Native Hawai'ians and Pacific Islanders. In 2019, a report from the Office of Minority Health[28] showed that these populations were three times less likely to receive mental health services, including medications, than the non-Hispanic white population. The report also shows that suicide is the leading cause of death for young Native Hawai'ians/Pacific Islanders ages 15 through 24. A key component of crisis services is follow-up stabilization and prevention, including those services that address isolation and enhance a sense of membership and community. AMHD used 2022 TTI funds to develop a curriculum and train existing and future peer support staff who lead groups on Native Hawai'ian cultural healing principles to help Native Hawai'ian clients to connect with both Native Hawai'ian cultural healing practices, as well as western treatment practices to achieve a more holistic path to recovery.

**Vision and Approach**

***We are designing treatment that integrates cultural healing with evidence-based practices."***

*-John Oliver, TTI Project Director*

Groups are naturally designed to connect people to one another and create natural supports. The peer support groups offered by CMHCs allow individuals the opportunity to see and talk with peers of their gender, race, ethnicity, and who share experiences, particularly related to substance use and other mental health issues. For these reasons, peer support groups were selected as the most direct means to blend cultural healing with evidence-based practices. Peer support specialists in each of the mental health centers who lead substance use support groups and cognitive behavioral therapy groups will receive the

[28] U.S. Department of Health and Human Services. 2019. Mental and Behavioral Health – Native Hawai'ians/Pacific Islanders. Office of Minority Health. Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=172

training in cultural healing. Support groups also include the development of individual wellness programs that empower participants to prevent and manage future crises.

The Native Hawai'ian Health Board (Papa Ola Lokahi) is designing and conducting the training curriculum. The Health Board has held "talk story" sessions with staff and stakeholders, including individuals with lived experience, to determine the direction of the curriculum development tailored culturally to populations on each of the Hawai'ian islands.

DMH also anticipates that integrating cultural healing and western practices will draw Native Hawai'ians with lived experience to become certified peer support specialists and improve the cultural diversity of its staff.

**Outcomes**

The project has a three-year lifespan, with curriculum development, training, and evaluation following in consecutive years. Anticipated project metrics include:

- The number of certified peers trained.
- The number of staff certified to provide the training through train-the-trainer approaches, and how many staff they train.
- The number of Native Hawai'ians who have participated in support groups.
- Cognitive behavioral therapy's associated measures, such as reduction in depression.
- Survey of clinical staff on the impact of blended support groups on treatment outcomes.

**Transformation Transfer**

Efforts such as this to blend or adapt evidence-based practices with cultural healing is yet another way to engage people who may feel stigmatized by mental health treatment and find it ineffective. Working across cultures enriched AMHD's understanding of wellness and provided new avenues to improve access to care and reduce the impact of mental illness among marginalized populations.

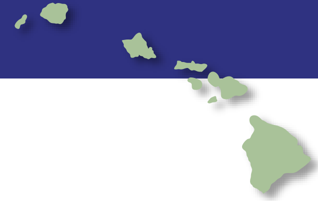
### Strategies for Success

Working with indigenous populations requires flexibility with timelines as behavioral health systems build “pilina” or connection, understanding common goals, and build a potential future path forward.

Practitioners of western medicine also hold biases requiring strict adherence to evidence-based practices that must be addressed when adapting services to meet the needs of special populations.

### TTI Contact

For more information, contact John Oliver at john.oliver@doh.hawaii.gov.





### Problem/Need

*Figure 26: News story about 2023 fatal officer-involved shooting on Maui*

Behavioral health emergencies comprise between five and 15 percent of 911 calls.[29] While the trend is slowly changing, law enforcement officers are most often dispatched to respond to behavioral health calls made to 911. In response to other calls, the precipitating behavioral health conditions may only become evident after an encounter has begun. Encounters often lead to arrest, and in worst cases, become volatile and may sometimes turn tragic.[30] A recent tragic encounter between police and a man with mental illness on Maui energized efforts to improve coordination between law enforcement, hospital emergency departments, and state crisis services. Figure 26 displays a television news story about the incident. People who live in Maui County (Islands of Maui, Moloka'i, Lāna'i, and Kaho'olawe) access crisis services primarily through calling 988, bringing themselves or a loved one to the emergency department of a hospital, or through an encounter with law enforcement and are determined to need a psychiatric evaluation. Due to a lack of coordination and training, law enforcement and staff of hospital emergency departments have not established protocols that serve each other or the person receiving services well.

### Vision and Approach

Hawai'i Department of Health used TTI funds to develop and provide enhanced training of hospital-based crisis staff and law enforcement officers in Maui County. The

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[29] Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Alexandria, VA: National Association of State Mental Health Program Directors.

[30] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2020). Executive order safe policing for safe communities: addressing mental health, homelessness, and addiction report. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf.

training project includes developing training materials, a standardized training manual for Mental Health Emergency Workers (MHEW – Hawai'i's crisis counselors who hold advanced degrees), and formal examinations that lead to MHEW certification. MHEWs are authorized to aid law enforcement in determining whether a person is a danger to self or others.

**Outcomes**

Due to staff shortages and turnover, as well as the devastating August 2023 wildfires, the project has been substantially delayed. Potential metrics include:

- The number of calls from law enforcement to crisis staff for consultation.
- The frequency of use of electronic tablets by law enforcement to crisis staff for consultation.
- Police-based diversions from arrest, incarceration, and hospital emergency departments.
- Reductions in adverse incidents resulting from police encounters with mental health calls and domestic disturbances.

**Transformation Transfer**

Regardless of how crisis care is accessed, the project ensures that people in need receive safe, quality care that supports their recovery. Engaging law enforcement and hospital staff directly to coordinate care will result in a smoother and safer experience for people in crisis.

**Strategies for Success**

Because relationships matter, previous negative experiences hinder new efforts to improve coordination. Obtaining the buy-in of leadership is particularly important.

Staff knowledge and experience with state procurement rules is critical to moving a project forward. For example, recognizing that small procurements for multiple products and services move much more quickly than a single large procurement for the same set of products and services.

**TTI Contact**

For more information, contact John Oliver at john.oliver@doh.hawaii.gov.

## Iowa – Special Populations (LGBTQ+)

### Problem/Need

As the Iowa Department of Health and Human Services (HHS) prepared to implement 988, a statewide survey of LGBTQ+ individuals identified disparities in how they access behavioral health services. TTI funding provided Iowa HHS the opportunity to develop a new model to disseminate training and guidance to crisis care staff across the state to ensure that everyone, regardless of sexual orientation or gender identity, receives effective crisis care.

### Vision and Approach

Iowa HHS began their TTI work by conducting an analysis of strengths, gaps, and needs in the system, which included interviews with regional directors and behavioral health providers, as well as surveys of individuals and families who receive services. Seven topics were selected based on the results of the analysis and input from stakeholders; the TTI project team was careful to not duplicate efforts with local and regional initiatives (Figure 27). Of the seven training courses developed, *LGBTQ 101* and *LGBTQ 201 & Trauma-Informed Care* were developed specifically to improve services for the LGBTQ+ community. Training courses are scheduled through calendar year 2023. Based on provider input, Iowa HHS scheduled two hybrid (live and virtual) training sessions on each topic. The training sessions are scheduled at different times of day to allow participants who work different shifts the opportunity to participate via chat or voice to share resources, ask questions, and comment. As an

*Figure 27: Iowa HHS's Crisis Provider Training Series*

**CRISIS PROVIDER TRAINING SERIES**

The Iowa Department of Health and Human Services is hosting a free webinar training series to assist Iowa's 988 and behavioral health crisis providers in serving children and their families and individuals who identify as LGBTQ+. While this series was developed for crisis service providers it is open to everyone.

**Participants may choose to attend one or more of the training sessions**. Each training webinar will be presented twice during the series and will be available as a recorded event. Certificates of attendance will be offered for each training following completion of a survey.

For more information and to register, visit **hhs.iowa.gov/mhds/training**

If you have questions, please contact **Wendy DePhillips: wdephil@dhs.state.ia.us**

| Training | Sessions |
|---|---|
| **SUICIDE RISK SCREENING AND SAFETY PLANNING**<br>*with Drew Martel, LISW, CADC, Foundation 2 Crisis Services* | **Thursday, July 6, 2023**<br>5:00 p.m. to 6:30 p.m.<br>**Thursday, August 3, 2023**<br>1:00 p.m. to 2:30 p.m. |
| **CHILD INTERVENTION AND DE-ESCALATION WITH FAMILIES AND YOUTH**<br>*with Drew Martel, LISW, CADC, Foundation 2 Crisis Services* | **Wednesday, July 26, 2023**<br>5:00 p.m. to 6:30 p.m.<br>**Thursday, August 31, 2023**<br>1:00 p.m. to 2:30 p.m. |
| **CHILD BEHAVIOR AND BRAIN DEVELOPMENT**<br>*with Gladys Noll Alvarez, LISW, IECMH-E, Orchard Place Child Guidance Center* | **Wednesday, August 16, 2023**<br>2:00 p.m. to 3:00 p.m.<br>**Wednesday, October 18, 2023**<br>2:00 p.m. to 3:00 p.m. |
| **HOW TRAUMA IMPACTS BEHAVIOR**<br>*with Gladys Noll Alvarez, LISW, IECMH-E, Orchard Place Child Guidance Center* | **Wednesday, August 30, 2023**<br>2:00 p.m. to 3:00 p.m.<br>**Wednesday, October 25, 2023**<br>2:00 p.m. to 3:00 p.m. |
| **INTERVENING AT THE STAGE NOT THE AGE**<br>*with Gladys Noll Alvarez, LISW, IECMH-E, Orchard Place Child Guidance Center* | **Wednesday, September 6, 2023**<br>2:00 p.m. to 3:00 p.m.<br>**Wednesday, November 1, 2023**<br>2:00 p.m. to 3:00 p.m. |
| **LGBTQ 101**<br>*with Max Mowitz, One Iowa* | **Thursday, September 7, 2023**<br>4:00 p.m. to 5:00 p.m.<br>**Wednesday, October 4, 2023**<br>10:00 a.m. to 11:00 a.m. |
| **LGBTQ 201 & TRAUMA INFORMED CARE**<br>*with Max Mowitz, One Iowa* | **Thursday, September 14, 2023**<br>4:00 p.m. to 5:30 p.m.<br>**Wednesday, October 11, 2023**<br>10:00 a.m. to 11:30 a.m. |

Iowa HHS

added benefit, participants can earn certified educational units (CEUs) for attending the training that can be applied towards licensure. Recordings of training sessions are available on the University of Iowa's e-learning website. Based on input from subject matter experts, the recorded training will be removed from the website, updated, and refreshed one year after the presentation of the training to ensure that the resources remain relevant.

**Outcomes**

***The training approach we use recognizes that each person in crisis is unique."***

*-Laura Larkin, TTI Project Director*

Crisis response staff from around the State are invited to register and participate in this training series. Launched in the summer of 2023, the first session had 66 participants, and double that number were registered for the second session to be held in August.[31] At the end of each training, Iowa surveys participants asking for feedback on the quality of the training and if it will change their knowledge, competence, performance, and/or client outcomes. A subsequent survey will be distributed to participants three months after the training to ask how the training has impacted their work.

**Transformation Transfer**

Iowa HHS's training on crisis response is one part of a larger effort to transform crisis care in the state and make it more available and effective for individuals and their families that are traditionally underserved. Training sessions such as these are designed to ensure that everyone, regardless of gender or sexual orientation, has access to high-quality crisis care.

**Strategies for Success**

The entire process of seeking input from stakeholders, narrowing the field of topics, identifying subject matter experts, organizing and scheduling training sessions, obtaining authorization to issue CEUs, and using web-based education platforms has been a learning experience for Iowa HHS staff. If this effort proves successful, this

[31] The August session was held after the interview for this report took place, so exact attendance figures are unavailable.

approach will be replicated in the future to deliver training on trending and urgent topics.

**TTI Contact**

For more information, contact Laura Larkin at llarkin@dhs.state.ia.us.

## Indiana – Children and Adolescents

**Problem/Need**

> ***We want everyone in the state to feel comfortable calling 988 when they are in a crisis.”***
>
> *-Kara Biro, TTI Project Director*

In 2022, the Indiana Recovery Council, an advisory committee to the Department of Mental Health and Addiction (DMHA) Mental Health and Addiction Planning and Advisory Council, conducted an informal survey of individuals with behavioral health needs about their level of comfort calling 988. The Council reported that most respondents were uncomfortable for a number of reasons, including having experienced long waits or negative attitudes by crisis call takers in prior contacts, others feared monetary charges, and a fear that police may be dispatched to their homes. DMHA realized the need to make changes to how they marketed and designed 988 if they want everyone to feel safe to call during a crisis.

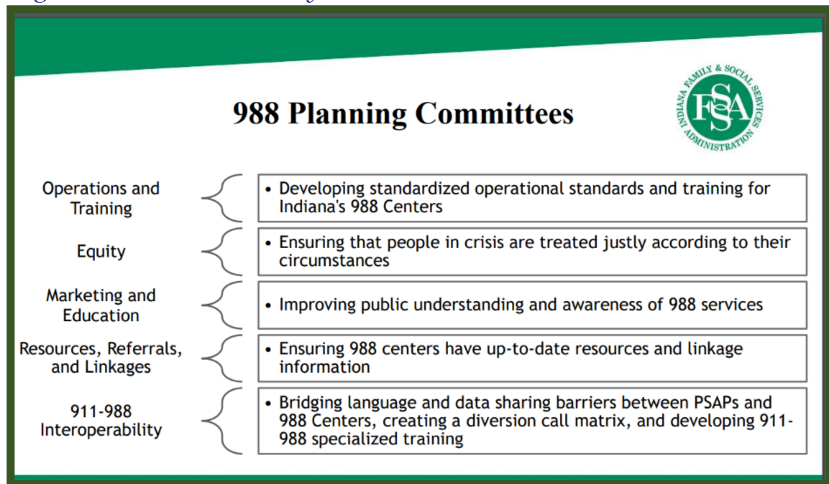
**Vision and Approach**

988 has been implemented with the participation of many stakeholders through a variety of oversight and consultative committees (Figure 28). The 988 planning committees include:

- Operations and Training Committee: ensures people can expect the same standard of quality and responsiveness across the State.
- Equity Committee: ensures that quality crisis care is delivered with cultural competence to all populations, regardless of location, age, race, gender, or sexual orientation.
- Resources and Referral Committee: identifies linkage and system navigation for follow-up services.
- Marketing and Education Committee: seeks to improve public awareness of 988.
- 911/988 Interoperability Committee: ensures bilateral coordination and referrals between the two systems.

Working within this structure, DMHA is building a crisis system that meets the needs of every person in the State. The TTI award was used to fund outreach efforts through staffing and contracting to obtain input from underserved populations and communities, including families of children with behavioral health disorders, youth and young adults, American Indian/Native Americans, African Americans, people of color, and LGBTQ+ individuals. The project continues to conduct focus groups and solicit input from underserved and marginalized populations. Through additional support, DMHA is consulting with the University of Connecticut on Mobile Response and Stabilization Services (MRSS), which is a child, youth, and family-specific intervention model designed to meet the youth and caregivers' sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis.[32] Children's crisis situations significantly impact and involve the caregiver due to the nature of their relationship with the child.

*Figure 28: Indiana Family & Social Services Administration 988*




### Outcomes

The Equity Committee has assembled recommendations for 988 to be incorporated into 988 standard operating procedures and training that is specific to the people who live in Indiana. In addition to the populations already mentioned, the project has investigated and made recommendations regarding services for the deaf and hard-of-hearing, specialized knowledge and resources for immigrants from Myanmar and Afghanistan,

[32] "Mobile Response & Stabilization Services (MRSS) is a specific kind of mobile crisis service and stabilization service for children and youth with behavioral health conditions. It is an upstream intervention for children and youth that are beginning to experience an acute behavioral health issue and are in crisis. This evidence-based service can help prevent unnecessary emergency department utilization and hospitalization." https://healthlaw.org/wp-content/uploads/2022/02/Mobile-Response-and-Stabilization-Services-publication.pdf#:~:text=Mobile%20Response%20and%20Stabilization%20Services%20(MRSS)%20is,that%20are%20beginning%20to%20experience%20an%20acute

and people with autism and developmental disabilities. For example, sensory kits have been distributed to all mobile crisis teams to aid in soothing individuals with autism. Teams report that the kits have been useful and that many other people find the equipment (e.g., headphones, weighted blankets) to be soothing and calming during a crisis.

DMHA intends to measure the success of their recommendations by collecting information from various communities through focus groups. To determine the impact the project has had, surveys and focus groups will evaluate respondents' knowledge of and comfort in calling 988 when they or a loved one are in crisis. Some specific measures and questions under consideration include:

- The percentage of Hoosiers who know about 988.
- Expansion of mobile crisis teams to more counties.
- Mobile crisis team diversions from hospitals and/or incarceration.

**Transformation Transfer**

Data collected thus far from underserved populations has led to the design of a comprehensive system of care for everyone. The crisis system under development provides all three components of crisis care: someone to call (988), someone to respond (mobile crisis teams dispatched by 988), and someplace to go (crisis stabilization centers).

**Strategies for Success**

DMHA is learning about the complexity in mobile crisis team expansion. Successful implementation requires connection and collaboration with new partners and the input of system users.

**TTI Contact**

For more information, contact Kara Biro at kara.biro2@fssa.in.gov.

## Kansas – Special Populations (LGBTQ+)

**Problem/Need**

> *“We want to create safe spaces for LGBTQ+ youth and to meet them with compassion when they are in crisis.”*
> *-Laura Brake, TTI Project Director*

As Kansas rolled out a crisis system designed to reach all parts of the state, the Kansas Department for Aging and Disability Services (KDADS) became concerned that a group of people who are at high risk of suicide may not use the system due to stigma and discrimination. The Centers for Disease Control and Prevention reports that high school students who identify as sexual minorities have higher rates of suicide attempts compared to heterosexual students.[33] Based on its national survey in 2022, the Trevor Project reports that nearly two-thirds of individuals who identify as LGBTQ+ youth who wanted and needed mental health care were unable to receive services. For many, fear is at the heart of health inequity: fear of talking to someone else about mental health, fear that they would not be taken seriously, and the fear that they would need parental permission for services. These fears are born of real concern due to high rates of discrimination (75 percent) and incidents of physical harm (40 percent), and threats that they have experienced due to their gender identity and sexual orientation. KDADS is working with partners at Kansas University, Kansas Suicide Prevention HQ, and the Center for Daring to create training for crisis responders in call centers, mobile crisis teams, crisis stabilization units, and Community Mental Health Centers (CMHCs) throughout the State.

**Vision and Approach**

KDADS seeks to improve the quality and timeliness of crisis services by certifying its mental health centers to meet criteria as Certified Community Behavioral Health Clinics (CCBHCS are required to coordinate with 988 and statewide crisis systems to ensure the delivery of 24/7 crisis care in their service areas) and by providing training on special populations. Its vision is to create a behavioral health space that is welcoming, safe, and

[33] Centers for Disease Control and Prevention. (2023). Suicide Prevention. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/suicide/facts/disparities-in-suicide.html.

non-judgmental for everyone who needs services. The goals of these efforts are to increase the volume of requests for services and a decrease in the rates of suicide attempts and completions among LGBTQ+ youth. Training modules are to be developed that are informed by interviews and listening sessions conducted with LGBTQ+ youth. The modules will be housed on KDADS learning management systems and available to all crisis responders and CCBHC clinicians.

**Outcomes**

KDADS is working closely with Kansas University to develop protocols to distinguish LGBTQ+ youth who call crisis lines and rates of suicide attempts and completions by LGBTQ+ youth in the State before and after training is conducted. Listening sessions and interviews with LGBTQ+ youth will provide the insights KDADS needs to train its workforce to deliver compassionate care to a population that often feels alone and in peril.

**Transformation Transfer**

Through this TTI project, the entire crisis system staff within the State, including call takers, mobile crisis teams, and the local CMHCs will have access to specialized training in responding to LGBTQ+ youth in crisis. The training materials will be available after project funding is expended and accessible to all crisis response staff. By training all staff throughout the system, KDADS will establish a unified approach to LBGTQ+ youth that is welcoming, safe, and non-judgmental.

**Strategies for Success**

Other states interested in developing training on LGBTQ+ youth should anticipate a lengthy planning process to obtain input from the population of focus. Because sexual and gender-minority youth are vulnerable to physical and emotional harm resulting from societal stigma and discrimination, creating research protocols to safely obtain input from them was more complex and time consuming than originally anticipated. Questions such as, "is parental consent required from youth who have not informed their parents of their gender identity or sexual orientation" were raised that needed to be addressed. Concern for the welfare of respondents has led to greater caution as KDADS and its partners develop processes that protect the confidentiality of respondents and result in candid observations, experiences, and opinions.

**TTI Contact**

For more information, contact Laura Brake at laura.brake@ks.gov.

## Kansas – Workforce

**Problem/Need**

Having worked several years as a licensed clinician responding to behavioral health crises, Laura Brake, the project director for Kansas's TTI award, had seen many peer support crisis responders come and go, often working for just a few weeks or months. She attributed the rapid turnover in these positions to overwork and agency ambiguity over the role of peer staff. Ms. Brake's concern is reflected in a recent *SAMHSA Advisory on Peer Support Services in Crisis Care*. "Peers may experience challenges related to role integrity, stigma from co-workers, and sustainable employment. They also face funding challenges unique to providing crisis care, including the complexity of managing crisis situations and often a lack of specialized crisis training." [34] Peer services have become an essential component of crisis care as evidence has steadily grown for their effectiveness. Figure 29 describes the impact of peer support as outlined in SAMHSA's Advisory on Peer Support Services in Crisis Care. NASMHPD's report on the 2021 TTI projects notes increasing demand and diminishing supply of peer specialists in crisis care reported by project directors.[35] The Kansas Department for Aging and Disability Services (KDADS) used TTI funds to increase efforts to recruit, train, and retain individuals with lived experience to ensure readiness for 988 and improve and expand crisis services across the state.

*Figure 29: Impact of Peer Support from 2022 SAMHSA Advisory*

[34] SAMHSA. (2022). Peer Support Services in Crisis Care – SAMHSA Advisory. Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf
[35] NASMHPD. (2023). The nexus between jail diversion and crisis services. National Association of State Mental Health Program Directors. Retrieved from https://www.nasmhpd.org/sites/default/files/2023-05/Report-Jail-Diversion-508.pdf.

## Vision and Approach

With the understanding that peer services are critical to delivering timely and effective crisis care, the KDADS team realized that they needed additional expertise in peer support. The TTI funds enabled KDADS to receive technical assistance through C4 Innovations to help design program enhancements and wellness components for peer retention. The project then examined work being done by other state mental health authorities (SMHAs) to:

- Conduct focus groups of certified peer specialists and peers interested in becoming certified.
- Develop a network of peer support providers.
- Develop wellness resources, including toolkits.
- Increase the number of qualified peers who become certified as peer support specialists.
- Utilize peers in mobile crisis response, 988 call centers, and crisis stabilization facilities in order to achieve best and desired outcomes for everyone.
- Track certified peer specialists and peers interested in becoming certified to support career development and fill peer service gaps with interested candidates.

KDADS is working with the Wichita State University Community Engagement Institute that currently manages KDADS's Certified Peer Specialist Training for Mental Health. The Certified Peer Specialist Training website currently provides training and other resources for peer support and will be expanded to include the toolkit as well as newly developed policies and resources on grievances and ethics.

> ***"If we don't take care of our peer support staff, we won't be able to keep them."***
> *-Laura Brake, TTI Project Director*

## Outcomes

The wellness products currently in development will be made publicly available through the Kansas Peer Support Services website. The project is exploring how it can track peers who are interested in becoming peer support specialists, those who have

begun and completed training, and those who have begun and completed supervised practicums.

**Transformation Transfer**

The TTI project comes at an opportune time for KDADS. The Governor's Behavioral Health Services Planning Council established a Peer Subcommittee in mid-2023. The Peer Subcommittee has expressed interest in this project and is likely to use and further develop the data and resources developed under TTI to support peers and peer services and build a network of peers to address the growing need for them.

**Strategies for Success**

For SMHA staff who come to government with clinical backgrounds, procurement processes are both new and tedious. Delays naturally abound as government rules and regulations slow procurement. During the sometimes-lengthy intervals, project staff must be both patient and vigilant. While many projects have called out NASMHPD for its outstanding support, this project analogized the NASMHPD TTI staff to a racing car pit crew because they helped keep the project on the trajectory towards successful completion.

**TTI Contact**

For more information, contact Laura Brake at laura.brake@ks.gov.

## Kentucky – Workforce

### Problem/Need

The Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) manages its responses to psychiatric emergencies through its CMHCs, which are situated throughout the state. The CMHCs typically provide an array of behavioral health services, including medication, therapy, case management, and crisis support. In much of rural Kentucky, there are limited resources for responding to crises, and the CMHCs rely on a combination of their staff and other first responders, specifically private ambulance services. The state prioritized training first responders in providing services to individuals in crisis and focused TTI funding on creating and providing this training to rural EMS, who are often the first – if not the only – first responders in rural areas of the State.

### Vision and Approach

The goal of this project is twofold: 1) to improve the experience of individuals in crisis and to better ensure that they receive necessary and appropriate services that are delivered in the least-restrictive manner and settings that reduce unnecessary hospitalizations and justice involvement; and 2) to leverage existing first-responder resources, specifically in rural areas with limited capacity, for the CMHCs to respond expeditiously. The benefit of this approach is that these resources (county-based ambulance services) already exist throughout rural Kentucky and are a known and trusted entity in these communities.

The Governor of Kentucky has chosen this approach as a policy and funding priority, and the initiative has the backing of the State Medicaid office, the SMHA, and its rural CMHC partners and providers.

Kentucky selected the Collaborative Assessment and Management of Suicidality (CAMS) to train the ambulance staff in rural areas. They chose this evidence-based training as it is widely recognized for its effectiveness and applicability among a variety of disciplines, including for EMTs and ambulance crews. The State is beginning this project in a select rural area and will expand this approach throughout the State once it is determined that the CAMS-trained ambulance crews deliver crisis services that are effective, timely, and result in better outcomes for the individuals they serve.

**Outcomes**

In 2022, significant flooding in rural Kentucky delayed the implementation of this project. DBHDID is now beginning their work with the selected CMHCs and ambulance crews in rural areas to provide training and working with them to operationalize this new approach to mobile crisis response. Barring another disaster, the State intends to finalize its training in 2023 and begin to monitor outcomes into 2024 to assess any problems with the approach and the quality of using ambulance staff as first responders for individuals in crisis. The State has also begun to reach out to other CMHCs in other rural areas in Kentucky in anticipation of expanding this approach statewide.

**Transformation Transfer**

The State and its partners among the rural CMHCs and ambulance services have committed to continuing this approach post TTI funding and expand it throughout rural Kentucky. The State sought the TTI funding and project to transform how individuals in remote and rural areas receive crisis services given the current staffing of rural CMHCs and the crisis services for large geographic areas.

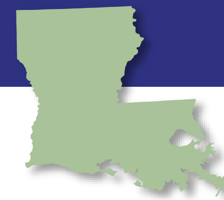
Kentucky, through an innovative use of existing resources, is building knowledge and skills of existing first responders. If successful, this TTI funded approach provides another model to deliver timely crisis response services to people who live in rural and remote areas.

**Strategies for Success**

The SMHA recognized that it had to better understand the regulations governing ambulance services, their staffing, and staff training and funding, to work with them in developing their role in responding to a behavioral health crisis. DBHDID also learned that events external to a project (e.g., a flood or other natural disaster) can significantly affect its implementation. The flooding in Kentucky, both unexpected and destructive, greatly delayed its implementation.

**TTI Contact**

For more information, contact Patti Clark at patti.clark@ky.gov.

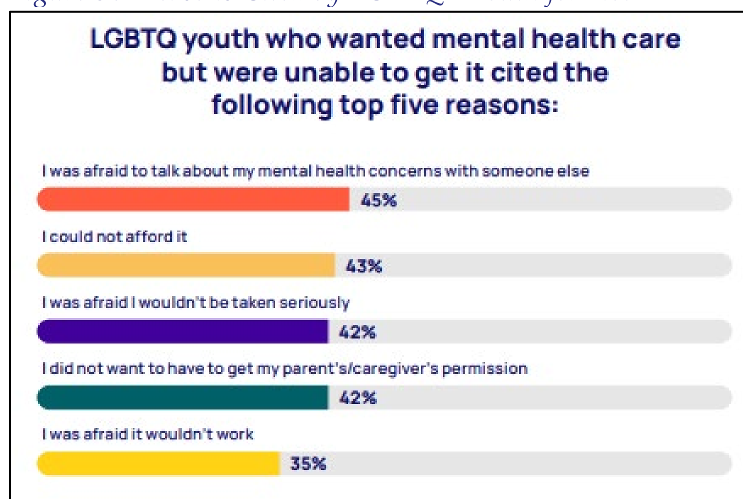


## Louisiana – Special Populations (LGBTQ+)

**Problem/Need**

The Louisiana Office of Behavioral Health (OBH) is undergoing a multiyear expansion of crisis services as a result of 988 and its impact on demand for services across the state. In the year since its inception, the Louisiana 988 system has experienced an 11% increase in crisis calls.[36] To meet this growing demand, in part, OBH established a priority to provide training to staff among the State's child/adolescent and adult providers. While it has developed training programs to assist any Louisianian in crisis, OBH has focused many of its trainings on extremely vulnerable populations, such as LGBTQ+ individuals.[37] This group has experienced disparities in access to crisis services and high rates of suicide and suicidal ideation. Reasons cited by LGBTQ+ youth in a Trevor Project report show they are afraid to talk about their mental health concerns with others, they cannot afford services, a fear of not being taken seriously, not wanting to seek parental permission, and fear that the services would not work (Figure 30).

*Figure 30: Reasons Cited by LGBTQ+ Youth for Not*




**Vision and Approach**

This initiative by OBH is being done in partnership with the Louisiana State University Health Sciences Center, Center for Evidence to Practice, and the Center of Excellence on LGBTQ+ Behavioral Health Equity. Through this partnership, OBH is developing an

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[36] Louisiana Department of Health. (2023). LDH celebrates 1st anniversary of 988 Lifeline with growth, expanded capacity. *Louisiana Department of Health.* https://ldh.la.gov/news/988anniversary

[37] The Trevor Project. (2022). The Trevor Project 2022 national survey on LGBTQ youth mental health by state: Louisiana. https://www.thetrevorproject.org/wp-content/uploads/2022/12/The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Louisiana.pdf

array of trainings for the publicly funded behavioral health provider system to reduce disparities in access to crisis services and improve outcomes of individuals served by the system. The goal of this work is to improve the workforce competencies required for providing behavioral health services to the LGBTQ+ community. To this end, OBH assembled an array of nationally recognized subject matter experts to develop trainings that are person-centered, resolution-focused, and delivered by a system that is coordinated, responsive, and efficient.

### Outcomes

This TTI project has resulted in a series of eight trainings, each of which are available on the Louisiana Evidence-to-Practice website. OBH will continue to provide and improve its training curriculum and expand the number of participants and types of professions represented in each session.

### Transformation Transfer

This TTI project has resulted in a repository of trainings that focus on a historically vulnerable population. These trainings and the ongoing focus of services to this community are making the Louisiana behavioral health system more equitable and inclusive, with the hoped-for outcome of better care for all individuals in need.

> ***"OBH wants to ensure that anyone who seeks crisis services receives care that is person-centered, resolution-focused, and delivered by a system that is coordinated, responsive, and efficient."***
>
> *-Dana Foster, TTI Project Director*

### Strategies for Success

The time to complete the contract procurement process greatly delayed the project, but ultimately did not undermine its implementation and successful outcomes. In the future, OBH will attempt to mitigate these delays with additional planning prior to the project's inception.

### TTI Contact

For more information, contact Dana Foster at dana.foster@la.gov.

## Maryland - Special Populations (LGBTQ+)

**Problem/Need**

Maryland is significantly expanding and changing its crisis service system. With the implementation of 988, Maryland needed to change their crisis service system, including Maryland's statewide crisis number. A crisis system more focused on suicide prevention requires far different levels of funding and staffing compared to a system intended to serve a wide range of crises, including those related to substance use disorders. Since 2020, funding for crisis services has increased from $1 million to $14 million, mostly with increases from State General Funds. Staffing an expanded system requires call center staff to understand suicide prevention, all mental health and substance use concerns, and how to effectively serve all populations across the State. The 2022 TTI project is intended to augment the baseline of knowledge about the LGBTQ+ community and their specific needs and concerns within their crisis call center staff.

**Vision and Approach**

*Figure 31: Training Modules Developed by BHA Under the 2022 TTI Award*

Training Modules Developed
Under TTI Grant:

1. Challenges of living as an LGBTQ+ person
2. How to support LGBTQ+ mental health
3. LGBTQ+ stereotyping and its impact on mental health
4. Gender-inclusive language
5. Local resources for LGBTQ+ mental health
6. Special considerations when working with LGBTQ+ youth

To rapidly expand the crisis workforce and successfully adopt the Crisis Now model of behavioral health crisis care, Maryland's Behavioral Health Administration (BHA) sought to create web-based training content that provides a broader understanding of the types of behavioral health concerns with which callers may present. Without training, call takers may have limited knowledge about the gamut of behavioral health concerns and how to effectively address these concerns across diverse populations. The training is web-based and will be available to

all levels of the crisis care workforce, including direct providers, mobile crisis teams, and paraprofessionals. The selection of training modules was informed by input with the crisis call center managers (Figure 31). The project is ongoing, and as of the end of August 2023, the funds have been allocated but not yet expended. The State has contracted out the creation of the training videos to a production company with whom they have previously worked. The challenge has been identifying subject matter experts to create the content. The State's initial approach, after selecting the training topics, was to contact subject matter experts already known to BHA. This approach was unsuccessful as their initial contacts were unavailable. After following further leads, BHA has gained some traction with the University of Maryland's School of Social Work, which has identified adjunct professors with content expertise who have the time and interest in creating the training content. It is expected that the training videos will be filmed in the fall of 2023.

**Outcomes**

Once developed, the training modules will be available publicly on Maryland's BHA Online Training Portal website. Trainees will be able to rate the content of each module, and the feedback will be used to inform future activities. Maryland is also exploring how successful these training courses are at improving the quality of crisis services their system provides.

**Transformation Transfer**

This TTI project came at a vital time for BHA as the agency rapidly and broadly expands and transforms its crisis service system. The training content created by the project will be used to train staff for years to come.

**Strategies for Success**

Creating training content is difficult. Working within a bureaucratic system can lead to delays. Knowing how to navigate the system is helpful in moving the process forward. However, time should be incorporated into the project timeline to identify and secure appropriate subject matter experts to guide and develop the creation of the project.

**TTI Contact**

For more information, contact Edward Soffe at edward.soffe2@maryland.gov and Christine Milano at christine.milano@maryland.gov.

# Maryland – Workforce

**Problem/Need**

Maryland is expanding and changing its crisis service system. With 988, Maryland needed to change their crisis service system including Maryland's state-wide crisis phone number, which had been in existence for many years. A crisis system more focused on suicide prevention requires far different levels of funding and staffing than a system intended to serve a wide range of crises including those related to substance use disorders. In the last three years funding of crisis services has gone from $1 million to $14 million, mostly coming from state general funds. Staffing an expanded system requires call center staff to know about suicide prevention, all mental health concerns, all substance use disorder concerns, and how to effectively serve all the types of populations in the state. The TTI project is intended to augment the baseline of knowledge within their crisis service call center staff in specific areas. Call center specialists have upwards of 40 hours of training already.

**Vision and Approach**

To rapidly expand their crisis workforce, the adoption of the Crisis Now model, with the expansion of calls, types of calls, and the expansion of call centers from eight to nine, Maryland's Behavioral Health Administration (BHA) sought to create web-based training content that would provide a broader understanding of the types of behavioral health concerns that callers might call about. Without training, you are expecting someone with limited knowledge to know about the gamut of behavioral health concerns and how to effectively address those concerns within a diverse population. The training would be web-based and available to all levels of their crisis care workforce, including direct care workers, mobile crisis teams, and paraprofessionals.

The selection of training module topics was informed by input with their call center managers. The project is ongoing and as of the end of August 2023, the funds have been allocated but not yet spent. Procurement was not a problem. They have contracted out the creation of the videos to a production company that they have previously worked with. The problem has been identifying subject matter experts to create the content. Their initial approach, after selecting the training topics, was to contact subject matter experts already known to BHA. This approach was unsuccessful because their initial

contacts did not have the time to create content. After a process of following further leads, they have gained some traction with the University of Maryland's School of Social Work, who has identified adjunct professors with content expertise who have the time and interest in creating training content. It is expected that the training content will be filmed in the fall of 2023.

### Outcomes

The training content in development will be available (publicly) through the BHA Trainings Portal website (https://bhatrainings.health.maryland.gov). Users will be able to rate the content of each module. These ratings will be used to inform future activities. Maryland is also interested in looking at how successful these training courses are at improving the quality of crisis services their system provides.

### Transformation Transfer

The TTI projects came at a vital time for BHA as they rapidly and broadly expand and transform their crisis service system. The training content created by the project will be used to train staff for years to come.

### Strategies for Success

It is important to have a large pool of subject matter experts to help guide the project.

### TTI Contact

For more information, contact Edward Soffe at edward.soffe2@maryland.gov and Christine Milano at christine.milano@maryland.gov.

## Mississippi – Workforce

### Problem/Need

> "This is a great program that has been able to divert a lot of people from institutionalization to community care."
> -Nena Klein, TTI Project Director

Community mental health centers (CMHCs), law enforcement, corrections, and courts in Mississippi had for many years looked to hospitalization as the only option to stabilize individuals with serious mental illness in crisis. The over-reliance on civil commitment and lack of community-based options resulted in a civil lawsuit against Mississippi's Department of Mental Health (DMH).[38] In response to a court-imposed remedial plan to prevent unnecessary hospitalizations, DMH has expanded core services to include mobile crisis teams, crisis stabilization units, programs of assertive community treatment (PACT), permanent supported housing, supported employment, peer support, and community support services. Using TTI funds, DMH launched a pilot project to take advantage of these expanded services and reduce reliance on state hospitalization by improving how courts, law enforcement, and corrections work together to keep people in the community.

*Figure 31: Goals of Mississippi's TTI-Funded Court Liaison*

**Court Liaison Program** DMH

Goals of the Program:
- 1. To reduce the number of involuntary commitments to state hospitals
- 2. To reduce the amount of time and exposure individuals have with law enforcement, the criminal justice system, and restrictive environments
- 3. To increase the knowledge and usage of community-based services
- 4. To increase collaboration with families, court personnel, and the State Hospital Forensic Unit on behalf of the Community Mental Health Centers and the people they serve

### Vision and Approach

TTI funds were used to support a pilot program to create and staff court liaison positions in four CMHCs that serve areas with high rates of involuntary commitments to hospitalization. The goals of this project, including to reduce involuntary commitments and

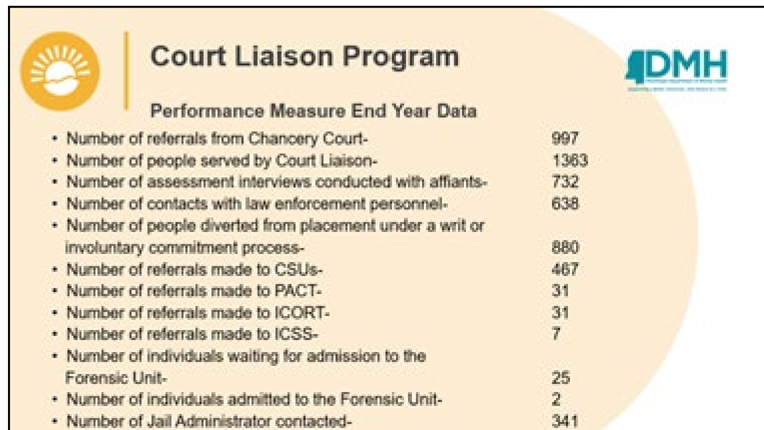
[38]In a lawsuit against the Mississippi Department of Mental Health by the U.S. Department of Justice, the court found that the State has insufficiently complied with the principles of the 1999 Supreme Court Case, *Olmstead v. L.C.* https://www.dmh.ms.gov/news/olmstead

exposure to the criminal justice system for adults with mental illness are listed in Figure 31. The court liaisons work with individuals, families, judges, district attorneys, and law enforcement officers to divert individuals from institutionalization. The liaisons also collaborate with the Mississippi State Hospital to reduce the list of individuals waiting in jail for a forensic evaluation. The National Center for State Courts describes the value of court liaisons, indicating they "provide a vital link to mental and behavioral health service providers during the life of court cases. Liaisons are typically clinically trained and connected with a provider or agency. They are trained to conduct assessments and are adept at providing program and treatment recommendations."[39] In order to redirect individuals in crisis to community-based services, CMHCs engage courts, law enforcement, and often corrections; all of which are critical partners and decision makers in the process of involuntary commitments and competency evaluations. Court liaisons span the boundaries of behavioral health and justice systems that may sometimes conflict to promote the most-effective treatment in the least-restrictive environment.[40]

**Outcomes**

The most important metric for the project is the rate of hospitalizations within the CMHC catchment areas. From this perspective, the installation of court liaisons has been very successful. Figure 32 displays project outcomes including referrals to appropriate treatment settings. The program has been so successful that DMH is funding a minimum of one court liaison position in all 18 CMHCs throughout the state, for a total of 26 court

*Figure 32: Performance Measure End-of-Year Data, 2022, for DMH's TTI-Funded Court Liaison Program*




[39] National Center for State Courts. (2023). *Court Liaison.* Retrieved via https://www.ncsc.org/behavioralhealth/resourcehub/intercept-3/court-liaison

[40] Steadman, H.J. (1992). Boundary spanners: a key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior,* 16(1), 75-87. https://doi.org/10.1007/BF02351050

liaisons. The positions are funded from various sources, including the American Rescue Plan Act (ARPA), and state funds allocated by the Mississippi State Legislature.

**Transformation Transfer**

TTI pilot projects provide states with the flexibility to implement programs, fill gaps, improve collaborations and partnerships, and evaluate results. In its efforts to change its overreliance on hospitalizations, DMH recognized the need to engage critical partners in this process. CMHC directors look forward to developing stronger ties with local courts through court liaisons.

**Strategies for Success**

Through the creation of court liaisons, mental health agencies are engaging partners in the process of changing long-held patterns of treatment. To be successful, CMHCs, newly hired court liaisons, and DMH must exercise both flexibility and persistence to develop trusting and productive collaborations.

**TTI Contact**

For more information, contact Nena Klein at nena.klein@dmh.ms.gov.

## Mississippi – Children and Adolescents

### Problem/Need

Mississippi's Department of Mental Health (DMH) was looking for ways to reduce the frequency of children with serious emotional disorders cycling in-and-out of the state's hospitals. DMH targeted three inflection points in the crisis care system to improve treatment outcomes and reduce dependence on hospitalization to address crises, including 988 call centers, mobile crisis response teams, and crisis residential programs for youth.

### Vision and Approach

TTI funds were used to enhance the Crisis Now service model in Mississippi, including someone to call, someone to respond, and a safe place to be:

- Someone to call: funds were used to develop and provide training to young adult members of Open Up Mississippi, a statewide youth-led advisory council. Once trained, Open Up members can receive calls referred by 988 from youth and young adult callers. The project expands capacity with a cadre of responders that are more relatable to young callers in crisis.
- Someone to respond: mobile crisis response teams and PACT-youth teams received training in the Mobile Response and Stabilization Services (MRSS) model.[41] The purpose of the training is to provide models and approaches that staff can use to keep children in the home, work with the family, and reduce reliance on law enforcement and out-of-home placements to resolve problems.
- Somewhere to go: although the State has two, and will soon have a third, crisis stabilization unit for children; many children are placed in residential programs.

[41] Mobile Response & Stabilization Services is a specific kind of mobile crisis service and stabilization service for children and youth with behavioral health conditions. It is an upstream intervention for children and youth that are beginning to experience an acute behavioral health issue and are in crisis. This evidence-based service can help prevent unnecessary emergency department utilization and hospitalization." https://healthlaw.org/wp-content/uploads/2022/02/Mobile-Response-and-Stabilization-Services-publication.pdf#:~:text=Mobile%20Response%20and%20Stabilization%20Services%20(MRSS)%20is,that%20are%20beginning%20to%20experience%20an%20acute

Staff at the two largest residential care sites received training on TAMAR-Youth[42] to help them better serve children that have been placed with histories of trauma, including trafficking. Staff also received training on the Transition to Independence Program (TIP)[43] model to help them enable young people to move toward greater self-sufficiency and successful achievement of their goals.

**Outcomes**

DMH is collecting the following outcomes related to this project:

- Number of Open Up Mississippi members trained to receive 988 calls.
- Number of staff at the two largest residential facilities in the State that received TAMAR-Y training.
- Number of staff at the two largest residential facilities in the State who received TIP training, as well as the number of participants who also completed train-the-trainer training in TIP.
- Number of individuals served by mobile crisis response and PACT-youth teams that received training in MRSS.

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[42] Trauma, Addictions, Mental Health, and Recovery for Youth. The original TAMAR intervention was customized for Maryland DJS, in concert with youth, families, and DJS staff, to create TAMAR-Y. This clinical intervention combines psychoeducation about trauma and its impact with concrete techniques designed to help participants identify their triggers and learn and practice skills to self-regulate trauma symptoms. The training incorporates the use of expressive arts therapies, an approach that successfully engages youth in age-appropriate, meaningful ways.

[43] The Transition to Independence Process (TIP) Model was developed for working with youth and young adults (14-29 years old) with emotional/behavioral difficulties (EBD) to: a) engage them in their own futures planning process; b) provide them with developmentally-appropriate, non-stigmatizing, culturally-competent, trauma-informed, and appealing services and supports; c) involve the young people, their families, and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals.

**Transformation Transfer**

Training staff at these critical inflection points not only offers staff alternatives to hospitalization; it also sparks interest in other agencies to identify resources, including housing, employment, and education to support the transition of young people to adulthood.

> ***"Providers are learning more effective ways to address complex, multi-system problems without relying on hospitalization."***
> *-Lynda Stewart, TTI Project Director*

**Strategies for Success**

Providers continue to change and grow in how they deliver services. State agencies have a significant role to ensure that growth is aligned with the State's mission and goals.

**TTI Contact**

For more information, contact Lynda Stewart at lynda.stewart@dmh.ms.gov.

## Nevada – Children and Adolescents

**Problem/Need**

The Nevada Division of Public and Behavioral Health (DPBH) had undertaken a geo-mapping of crisis services in Nevada to determine the distribution of crisis resources throughout the State. This was done to better understand the Division's capacity to respond effectively to crises. This proved to be valuable information for DPBH in its management of adult services. An important revelation to DPBH of the mapping of adult crisis services was that crisis response resources tended to be concentrated in the State's largest cities with few and fragmented services offered in Nevada's vast rural territory.

However, this initial mapping did not include crisis services for children, adolescents, and their families. DPBH determined that it would need to undertake a child/adolescent crisis services geo-mapping process, like that conducted for adult services and thus have data that could be used to better understand the distribution and capacity of crisis services for children and adolescents.

A second and related project was a study that evaluated the knowledge of rural communities regarding crisis services and how to access these services. The report concluded that much of rural Nevada was not aware of the existence of services for individuals experiencing a behavioral health crisis or whom to contact when such a crisis arose.

**Vision and Approach**

DPBH's Strategic Plan has the goal of increasing services for children and adolescents in crisis throughout the State. DPBH believes that this TTI project's focus on crisis mapping and a media campaign regarding crisis services in rural areas will assist the State in meeting this goal. The mapping component has not yet begun due to several delays in the procurement process. However, DPBH is continuing with its procurement of a contractor skilled in the required geo-mapping. The Media campaign has begun with the State purchasing ads on billboards, television, and other materials such as brochures. The approach targets rural areas with all these resources with the hope that rural residents will better understand the resources that are available in the event of a behavioral health crisis. DPBH has also presented information to rural communities

directly in town-hall type meetings and has designed a web portal for the public to gain a better understanding of behavioral health resources, particularly for those in crisis.

**Outcomes**

The DPBH Mobile Crisis Response Team website is operational. It provides an overview of available services for those in crisis and contact information for a mobile crisis response. An important feature of the website that is in the development phase is an interactive portal, allowing individuals to request services, complete preliminary documentation (e.g., consents) and provide information via surveys to the State. The web portal will be used in conjunction with other data (e.g., geo-mapping) to monitor and improve delivery of crisis services to children and adolescents.

DPBH has secured funding to continue their media campaign and believes, through anecdotal evidence, that the campaign is reaching individuals in targeted rural areas. DPBH will continue to provide outreach to rural areas as part of their strategy to inform all Nevada citizens about the availability of crisis resources. While the geo-mapping has not yet commenced, DPBH believes that it will eventually provide essential data regarding gaps in services, information that will be used to further develop rural crisis services and service capacity.

**Transformation Transfer**

The Nevada Department is committed to developing a crisis system that is responsive to all ages and that is accessible in rural and urban areas throughout the State. The TTI project assisted in this endeavor by increasing the focus of resources in underserved rural areas for children, adolescents, and their families. This is a significant development for Nevada given its historic focus on the more densely populated urban areas of the State.

**Strategies for Success**

The main lesson learned for DPBH was that their procurement process for the various elements of this project, including the work related to information technology (IT - geo-mapping, web site development) took longer than anticipated. They have suggested that in the future they will begin to prepare for procurement and other administrative requirements earlier in the process.

**TTI Contact**

For more information, contact Michelle Sandoval at mvsandoval@health.nv.gov.

## New York - Special Populations (LGBTQ+)

**Problem/Need**

In anticipation of implementing the 988 Suicide and Crisis Lifeline, the New York State Office of Mental Health (OMH) prepared an extensive description to the Governor and Legislature on the suicide prevention programs and activities it oversaw across the State. Members of the LGBTQ+ community were identified among the populations at higher risk of suicide compared to the general population. Based on its assessment, OMH determined that it needed to develop additional resources to ensure equitable access and services for these individuals. OMH used TTI funds to develop these resources. The process began prior to March 2023 when Vibrant Emotional Health launched an LGBTQ+-specific line.

**Vision and Approach**

OMH developed a comprehensive crisis response plan and system to provide crisis services and supports to individuals in need. This plan has specific foci on the most vulnerable populations, including the LGBTQ+ community. OMH's approach is to develop population-specific training courses for its workforce, so that it can provide effective services to anyone seeking assistance. OMH has devised an approach that tailors their crisis encounters to the needs of the individual rather than a "one-size-fits-all" generic approach. This strategy focuses on the entire lifespan, with trainings and resources developed for specific age cohorts. To develop the training curriculum and related resources, OMH worked with the Sexual Orientation, Gender Identity, and Expression Center (SOGIE Center). See Figure 33 for an example of the resources produced through this project.

OMH plans, as part of the TTI project, to distribute the training curriculum to crisis staff throughout the State via a secure online, e-learning platform. This platform will simplify and expedite the distribution of these materials, as well as future training materials, and will provide a means for monitoring and evaluating the training content.

## Outcomes

With the TTI funds, as of August 2023, OMH has already developed four tip sheets for 988 crisis counselors, which will be presented to 988 crisis staff once the online e-learning platform is operational. Once in use, OMH will begin to assess the performance of the trainings and related curriculums. The goal in doing this is to identify any gaps in knowledge and to inform development of future products to fill those gaps.

*Figure 33: Tip Sheet for Providers on how to Support Family Members of LGBTQ+ Individuals*

SUPPORTING FAMILY MEMBERS OF LGBTQ+ PEOPLE

NEW YORK STATE'S OFFICE OF MENTAL HEALTH TIP SHEET FOR 988 CRISIS COUNSELORS

As a 988 Crisis Counselor, you may talk to family members in distress or experiencing conflict over their loved one's LGBTQ+ identity. It is important that you know how to support families through discussions about their experiences, worries, and questions. Research has shown that when families support and affirm their LGBTQ+ loved ones, it reduces anxiety, depression, suicidal ideation, harmful substance use, and other negative life and health outcomes for the LGBTQ+ person. It is imperative that we provide non-judgmental spaces for families to seek support and a listening ear, while also offering them resources that will further their learning and understanding of how to affirm their LGBTQ+ family member.Here are some helpful tips to keep in mind:

#1 Try to build some rapport. Often times, family members are struggling to reconcile their love for their LGBTQ+ family member with things they have learned through media, their faith community, or cultural teachings. It is important to build rapport and trust when having discussions about these topics.

#2 Engage the family in a caring and non-judgmental way. This means practicing active listening skills and not correcting the terminology they use when you are first engaging with them. Give family members the space to make mistakes and, if needed, approach corrections with kindness and with the caller's goals in mind.

#3 Ask them what they know about LGBTQ+ people and where they learned the information. Many people hear inaccurate stereotypes early in life from the media or broader community. Sometimes asking this question can lead to an acknowledgment that some information they hear can be inaccurate. They may even discuss how their early learning about LGBTQ+ identities have shaped their misconceptions.

#4 Listen actively for cues that they want more information. They may say something like, "I don't even know what that is," or, "I am not sure what I am supposed to do." When you hear these cues, ask them if they are open to learning more and connect them to relevant resources.

## Transformation Transfer

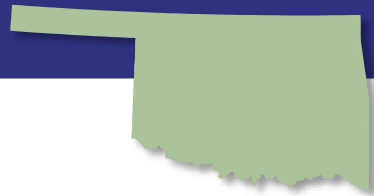
OMH is committed to providing their 988 Suicide and Crisis Lifeline staff the training and support required to provide quality services to all in need, regardless of gender or sexual orientation. The development of the LGBTQ+ training materials and the e-learning platform to disseminate these and other pertinent curricula will provide staff essential information to accomplish this transformational goal of reducing suicide among LGBTQ+ individuals. OMH will monitor and update training materials on the e-learning platform as they are used to continually improve this training and caller outcomes.

## Strategies for Success

OMH has two primary lessons from this TTI project that may benefit others: 1) the procurement process can be long and complex, and states should consider this as they develop their plans; and 2) OMH highly recommends the SOGIE Center to provide subject matter expertise in the development of training and supports to improve services to the LGBTQ+ community.

**TTI Contact**

For more information, contact Denise Balzer at denise.balzer@omh.ny.gov and Katerina Gaylord at katerina.gaylord@omh.ny.gov.



# Oklahoma – Workforce I

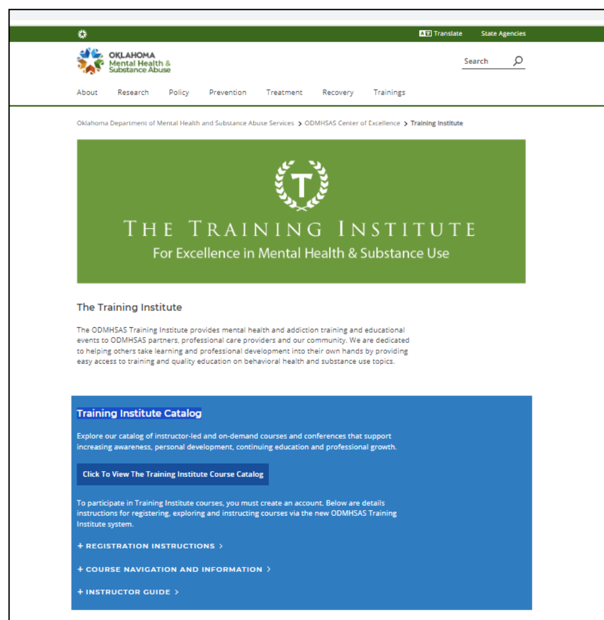
**Problem/Need**

Like many states, Oklahoma is facing an increasing behavioral healthcare workforce shortage. Such workforce shortages are not new to the State, but several recent developments have increased this problem: the advent in 2022 of the 988-crisis line and an expansion of crisis response services (e.g., mobile crisis services, crisis recovery/urgent recovery centers); and the expansion of Certified Community Behavioral Health Clinics (CCBHCs) in the State.[44] The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) anticipates that its behavioral healthcare workforce will need to double in size to continue to meet increases in services and service demand. ODMHSAS sees this expansion as an opportunity to develop the resources needed to train and support its new and growing workforce.

**Vision and Approach**

To meet the training needs of its workforce, the ODMHSAS Strategic Plan has a major initiative to develop and establish the Clinical Center of Excellence. See Figure 34. This center provides a single-entry access point for all behavioral healthcare trainings; maintains training resources; conducts assessments of the workforce and the behavioral healthcare field to determine training needs; and develops and maintains a comprehensive course catalog and event calendar.

*Figure 34: The Training Institute for Excellence in Mental Health and Substance Use*




ODMHSAS used funding to convene stakeholders in the planning, development, and implementation of the

[44] ODMHSAS. (2023). Certified community behavioral health clinics. *ODMHSAS.* https://oklahoma.gov/odmhsas/treatment/ccbhc.html

Clinical Center of Excellence. Partners included senior staff of ODMHSAS across mental health, prevention, and substance use services as well as the Departments HR/Training staff, clinical leaders, and staff from provider organizations.

**Outcomes**

Through this project ODMHSAS:

Issued a course catalog and implemented a consistent process for scheduling training to behavioral health providers.

Established specialized training sectors or tracts such as those for crisis workers.

Conducted an initial assessment of provider training needs including two surveys sent to all individuals who had accessed trainings, and interviews with representatives of the State's provider organizations.

Developed a data plan to be used in assessing training and knowledge needs of the workforce.

Held a 2-day summit with leadership to identify 50 trainings needed based on the data.

Completed a gap analysis of all existing contracts, policies, and required trainings to ensure that the identified trainings and training priorities were addressed including 13 potential e-Learning curriculums.

ODMHSAS plans to continue the development of the Clinical Center of Excellence

**Transformation Transfer**

TTI funding permitted the State to plan, develop, and operationalize a well-organized training resource that supports its growing workforce, as well as the expansion of crisis services, including the implementation of 988, and the expansion of its CCBHC network to deliver evidence-based quality care.

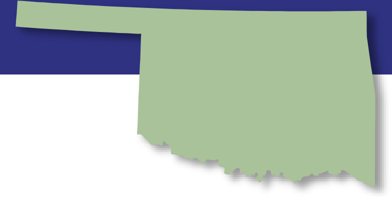
**Strategies for Success**

If a state is going to undertake a major project such as the development of the ODMHSAS Clinical Center of Excellence, it should first assess its readiness for the project's work. In other words, does the state have the necessary infrastructure and

organizational resources required to tackle the project? Through such an assessment, ODMHSAS determined that it needed additional staffing, organizational structural changes, a data assessment process, and other resources all finalized prior to beginning work on the TTI project.

**TTI Contact**

For more information, contact Jennifer Benefiel at jennifer.benefiel@odmhsas.org.



## Oklahoma – Workforce II

### Problem/Need

Oklahoma is facing an increasing shortage of licensed professional counselors (LPC) in the State due to the growing demand for these professionals. Several recent developments have driven this demand: the advent in 2022 of the 988-crisis line and related crisis response services (e.g., mobile crisis services, crisis recovery/urgent recovery centers); the development of Certified Community Behavioral Health Clinics (CCBHC) in the state; and competition with the private sector for LPCs.

### Vision and Approach

The ODMHSAS Strategic Plan has a main goal regarding the support of workforce development with four strategies to achieve and sustain this goal. These are 1) to develop partnerships with colleges (4- and two-year programs) and universities to increase interest in pursuing a career in behavioral health, principally case management services; 2) to build relationships between the schools and community providers as a way to improve hiring of graduates, 3) to implement an e-learning platform that simplifies case management training and certification, and 4) modifying current certification standards in a manner that may increase interest in the behavioral healthcare field.[45]

### Outcomes

> ***"The success of ODMHSAS school collaborations ultimately depends on the school having a champion, someone who believes in the project."***
> *-Michael Dickerson, ODMHSAS*

ODMHSAS has developed strong working relationships with several schools including Oklahoma State University-Oklahoma City, Southwestern Oklahoma State University and The University of Oklahoma. These collaborations have fostered increased outreach to potential behavioral health professionals and developed relationships between the

[45] ODMHSAS. (2023). Behavioral health case management. *ODMHSAS.* https://oklahoma.gov/odmhsas/recovery/bhcm.html

schools and behavioral health employers to foster a “pipeline” from education to employment.

ODMHSAS has begun the development of an e-learning platform that will simplify access to training and ultimately certifications. The Department expects this platform to be completed and operational by the end of the current year.

An ongoing and related outcome is to modify current certification standards to increase the pool of individuals who can be certified and authorized to bill for services (i.e., reverting to previous standards that required a two rather than a four-year degree for certification and expanding the educational majors that qualify for certification). The process to modify these standards is currently underway by ODMHSAS with input from the state Medicaid office, the involved schools and behavioral health providers.

ODMHSAS believes that these strategies (i.e., collaboration, e-learning, and revised certification standards) will shorten the time required for individuals to become eligible for hire by community providers and expand the pool of eligible certified individuals.

**Transformation Transfer**

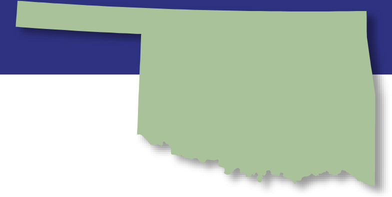
This TTI project has transformed the relationship between the ODMHSAS, institutions of higher education and community behavioral providers. It has created a mutually beneficial relationship among these three partners. These benefits ease workforce shortages, placement assistance to students with post-graduation employment and expanding the pool of qualified candidates for provider agencies that can meet certification standards.

**Strategies for Success**

The success of school collaborations depended significantly on the schools having their own “champion”, a school representative that believed in the project, and its value to the school, students, and the community. These champions were a necessary component of the successful partnerships with schools.

**TTI Contact**

For more information, contact Jennifer Benefiel at jennifer.benefiel@odmhsas.org.

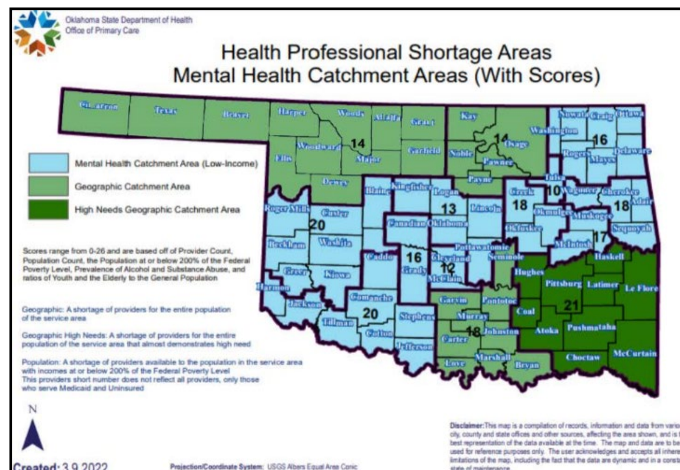


## Oklahoma – Workforce III

**Problem/Need**

For several years, Oklahoma's Department of Mental Health and Substance Abuse Services (ODMHSAS) has observed a decline in recruitment and retention of behavioral health staff at its community mental health centers. Workforce shortages often result in treatment delays and overburdened staff that impact the timeliness and quality of behavioral health care. The situation became more acute as demand has increased due to Medicaid expansion and the launch of 988 and accompanying expansion of crisis services. The need is even more dire in remote and frontier areas of the State. Figure 35 shows the mental health workforce shortage areas of Oklahoma in green and high need shortage areas in dark green. Using TTI funds, DMHSAS re-established a promising practice to offer scholarships and training to existing bachelor's level DMHSAS staff to become licensed professional counselors.

*Figure 35: Mental Health Professional Shortage Areas*




**Vision and Approach**

To improve the availability of clinical staff and reduce vacancies, ODMHSAS invited community mental health center directors in rural areas of the state to recommend their current bachelor level staff to participate in a scholarship program. Within 3 years, program participants would become licensed professional counselors providing quality care and reducing the workforce shortage. TTI funded 10 participants, nominated by their center directors to participate while they continued to work at their mental health centers.

To accommodate their work schedules and lengthy travel from home communities, ODMHSAS developed a partnership with the University of Oklahoma to modify typical weekly class schedules. Under this program, students travel from their home

communities and stay at the universities for two intensive long weekends of classes each month. Participants who complete educational requirements receive a master's degree in human relations; are eligible to provide clinical services under supervision from their home community mental health centers; and qualify to obtain a license to practice as a licensed professional counselor. The entire process of obtaining educational credits and required practicum takes about 3 years. To complete their obligation, participants must continue employment for DMHSAS for five years from beginning classes. Participants who do not finish the program must reimburse ODMHSAS a prorated amount.

**Outcomes**

Of the ten participants that began in August 2022, nine continue one year later. Based on the previous cohort, no further attrition is expected. The Oklahoma legislature has authorized the continuation of this and similar scholarship programs to address workforce shortages. ODMHSAS is awaiting appropriation of funds to launch new cohorts.

**Transformation Transfer**

Over 60 percent of rural Americans live in designated mental health provider shortage areas. The scholarship model that ODMHSAS has designed takes advantage of the local knowledge and cultural competence of existing staff, provides avenues for advancement, and directs resources to the most underserved areas of the State. ODMHSAS is experienced and prepared to implement more scholarship programs when the State legislature appropriates funds.

**Strategies for Success**

***To develop the workforce we need, we grew our own."***

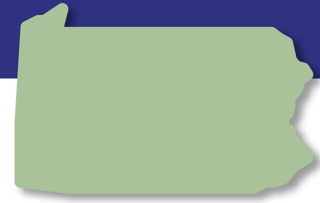
*-Pam Mulvaney, TTI Project Director*

There are many hurdles to overcome for program participants as they continue full time jobs, travel long distances, study for a master's degree, and spend extended weekends away from their families and friends. The success of programs like this begins with selecting staff who are capable and ready to take this journey. Project staff underscore the importance of establishing strong relationships between the participants, the mental health center directors who nominated them, the universities

that educate them, and the ODMHSAS staff that administers the program. Each partner must actively support program participants particularly during personal challenges.

**TTI Contact**

For more information, contact Pam Mulvaney at pmulvaney@odmhsas.org.



## Pennsylvania – Children and Adolescents

**Problem/Need**

As the State prepared to implement 988 and integrate a comprehensive crisis system, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) saw the opportunity to develop crisis services for children, youth, and young adults (CYYA) that are specifically designated to achieve the best outcomes. OMHSAS used TTI funds to engage in peer learning collaborative opportunities and investigate potential crisis models that can be implemented in a county-based system; engage advisory and planning structures that include youth voices; assess current strengths and needs related to crisis services for children and adolescents; and develop standards for the delivery of crisis services in all counties of the Commonwealth.

**Vision and Approach**

> ***We want children's crisis services to be kid-specific, rather than rolled into a broader crisis care model."***
>
> *-Courtney Malecki, TTI Project Director*

Through TTI TA resources, the project participated in NASMHPD's Mobile Response and Stabilization Services (MRSS) Quality Learning Collaborative. This learning collaborative focuses on the structural changes that states need to fully implement a comprehensive crisis system. Through the collaborative, OMHSAS is conferring with other county-based states to learn from their experiences and acquire subject matter expertise on the implementation of best practices. While every county in Pennsylvania has crisis services, access to and quality of these services vary, particularly for crisis services delivered to the CYYA population. OMHSAS also reached out to State partners about their experiences with CYYA in crisis. OMHSAS learned that crisis call centers overall do not have specific training on the needs of youth who are involuntarily committed to inpatient care. The EDs that responded indicated they are experiencing an increase in CYYA in crisis. The next step in the process is to assess readiness across counties to implement crisis services for CYYA. Following the collection of this information, OMHSAS will design guidance documents in consultation with stakeholders that will establish standards for access and quality for CYYA crisis services. To address school-

based crisis prevention and response training needs, OMHSAS acquired train-the-trainer instruction for many of its staff on the PREPaRE model.[46]

**Outcomes**

The project experienced a number of external delays that disrupted progress, including a change in senior leadership, budgetary freeze, and staffing availability. Despite these delays, the project:

- Began training PREPaRE trainers. Three staff from OMHSAS and an additional 35 individuals have been certified as trainers and have provided training to more than 900 staff.
- Engaged subject matter experts at Case Western University to assess readiness for MRSS implementation.

A significant outcome of this learning process has led to the creation of a new position within OMHSAS to coordinate the development of crisis care for CYYA and provide clinical consultation and TA to crisis services in Pennsylvania.

**Transformation Transfer**

Through this project, OMHSAS is bringing recognition of the specific needs of youth and their families in crisis to local crisis response planning efforts. Given the current system stressors, the success of any youth crisis initiatives will rely on both ensuring that necessary resources exist and substantiate the benefits of youth-specific approaches. In the next phase of the project, OMHSAS is aligning those resources (including OMHSAS's position described above), establishing standards and benchmarks, identifying data, and data collection efforts that will demonstrate the value of a child and youth-specific crisis response system.

**Strategies for Success**

While delays can be frustrating, they can sometimes work to a project's advantage. In this case, the Director of OMHSAS's Bureau of Children's Behavioral Health Services is a member of the OMHSAS executive committee, which is tasked with 988

[46] The PREPaRE curriculum has been developed by the National Association of School Psychologists (NASP) as part of NASP's decade-long leadership in providing evidence-based resources and consultation related to school crisis prevention and response. PREPaRE training is ideal for schools committed to improving and strengthening their school safety and crisis management plans and emergency response.

implementation, crisis regulation development and implementation, developing TA to counties, and is able to influence the development of children and youth-specific crisis services with the knowledge gained from this project.

**TTI Contact**

For more information, contact Courtney Malecki at cmalecki@pa.gov.

## Rhode Island – Special Populations (Multiple, Incl. LGBTQ+), and Children and Adolescents

**Problem/Need**

Rhode Island's Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (DBHDDH) received a 988 Planning Grant from Vibrant Emotional Health. Statewide collaboration among primary provider agencies and diverse stakeholders have been planning for the implementation of 988 and coordinating across all crisis services providers, treatment providers, and first responder agencies in the State. The Vibrant project sought to establish cross-agency protocols to ensure individuals get the help they need, no matter who or how they reach out for help. As the group developed a plan to guide the implementation of 988, three critical actions were identified as areas of need:

1. Establishing standardized training and protocols for the crisis response workforce.
2. Coordinating with state 911 and local Public Safety Answering Points (PSAPs) to refer calls to 988.
3. Integrating with the State's behavioral health triage and referral line for children, Kids' Link RI™, run by Bradley Hospital, and Behavioral Health Link's 414-LINK, a statewide crisis line for those aged 18 and older and overseen by Horizon Healthcare Partners.

**Vision and Approach**

Training topics are organized into three phases: Phase 1: Training and Observation, Phase 2: Answering with Support, and Phase 3: Independent Learning. Phase 1 incorporates the fundamental Lifeline training topics designed by Vibrant Emotional Health. Crucial to implementing a successful transition

> ***Know who your local experts are, because even though training on specific populations may be universal and widely available, local knowledge of resources for referral is just as important."***
> *-Christine Ure, TTI Project Director*

to 988, stakeholders agree that there is a need to focus on the development of shared protocols that allow for structured decision making. Phase 2 incorporates training topics that are designed to help providers determine the most appropriate response for different levels of crises, including which assets should be deployed and the type of follow-up needed. Phase 3 combines training topics identified by the planning group on special needs and populations, such as children and families, deaf and hard of hearing (American Sign Language as a first language), elder populations, individuals with intellectual and developmental disabilities (IDD), immigrant and undocumented individuals, LGBTQ+ individuals, restorative and transformative justice, unhoused and the housing insecure, veterans, victims of trafficking, and indigenous communities. To ensure that training is relatable and relevant to the state, DBHDDH used local subject matter experts to integrate nationally available best practices on these training topics into local application and to build shared understanding and relationships between collateral agencies.

**Outcomes**

Training is provided through a variety of modalities, including live, in-person; live, virtual; recorded virtual events, and pre-recorded webinars. Participants may also view and review training courses through the project web portal. For the 18 live, virtual trainings created by the State's local subject matter experts, a total of 98 attendees participated, including 62 Lifeline staffers. The trainings were recorded and are accessible to 988 crisis counselors and their supervisors who will document their trainings.

**Transformation Transfer**

The training library was completed in June 2023, and 988 protocols are being finalized as of August 2023. As in other states, DBHDDH is seeking to grow the number of clinics that are Certified Community Behavioral Health Clinics (CCBHCs) and are establishing protocols for their coordination with 988. DBHDDH interacts weekly with the organization that operates 988 to ensure that work stays on track. The State's 988 Lifeline tracks the number of people receiving training as well as when supervisors document the training as completed.

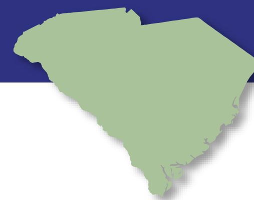
**Strategies for Success**

One of the project's guiding tenets has been to use the best-in-class training already available and to integrate local subject matter experts to create training that meets local needs and resources. Local subject matter experts are also known to many stakeholders and have already established trust.

As noted by other projects, there are significant and often unanticipated delays in the state procurement process. To avoid further interruptions with multiple consulting contracts, DBHDDH initiated a single-source contract with the 988 Lifeline Center. While waiting for the contract to be executed, the 988 Lifeline Center convened planning meetings.

**TTI Contact**

For more information, contact Christine Ure at christine.ure.ctr@bhddh.ri.gov.



## South Carolina – Children and Adolescents

**Problem/Need**

The South Carolina Department of Mental Health (DMH) observed several disturbing trends among youth and young adults in the Santee-Wateree region of the State. These included increases in the number (60 percent) of youth with mental illness severing behavioral health services when they transitioned from adolescents to adult and a simultaneous rise in these and other youth and young adults with behavioral health disorders becoming involved in the justice system. The Santee-Wateree Community Mental Health Center (CMHC) had already established its Roads to Independence (ROI) program to deliver a comprehensive array of services focused on preventing young offenders, ages 15-25, from escalating into chronic and habitual criminality and improving access to behavioral health intervention, routine treatment, and other support services.

**Vision and Approach**

ROI reaches out to young adults with mental health conditions to engage them in treatment. Early intervention strategies reduce the risk for academic underachievement, unemployment, and loss of social supports. TTI funds were used to expand upon the existing program by adding a clinician and peer support specialists. The program depends upon community partners to make referrals and provide comprehensive services and supports including housing, employment, education, and community integration. Most referrals are made by the County's Solicitor's Office, the Public Defender's Office, the Department of Juvenile Justice, Probation, Pardon and Parole, the Sumter County Sherriff's Office, and the Sumter County Police Department. ROI takes an innovative approach to engaging clients by creating social engagement opportunities on a weekly basis and youth specific peer support often at the drop-in Center (Figure 36).

*Figure 36: ROI Drop-In Center*

**Outcomes**

Both staff were initially hired using TTI funds and are employed by the DMH in full-time permanent positions. When TTI funding is expended, the Santee-Wateree CMHC will continue their charge of serving ROI clients. Outcomes the project is monitoring include:

- Increased access to mental health services and supports to youth and young adults whose behavior puts them in direct contact with the justice system.
- Number of offenders referred to access mental health and/or related services within the year.
- Of those youth and young adults who enroll in the ROI program, the percentage that have improved in functioning.
- Percentage of youth and young adults who complete a transition plan from youth to adulthood and self-sufficiency that addresses tasks of adulthood (e.g., employment, education, housing) within 30 days of admission.
- Number diverted from youth detention or young adult incarceration to community services.
- Percentage of program participants that have not been arrested or re-arrested during their participation in the program.
- Percentage by which out-of-home placements have reduced.
- Number of trained law enforcement professionals and other stakeholders on Mental Health First Aid, Cultural Competency, and/or Trauma-Informed Care practices.
- Number of partnerships formed through the ROI initiative.

**Transformation Transfer**

Partners that participate either in making referrals, providing services, or both, have grown significantly. They are grateful for community-based alternatives to detention and value the opportunity to stop involved youth from escalating into chronic and habitual criminality.

***The ROI program prevents crises from happening instead of having to backtrack to fix the damage caused by crisis."***

*-Andrea Darden, ROI Program Director*

**Strategies for Success**

Justice, law enforcement, and corrections agencies have been very supportive of the ROI initiative. Developing protocols to streamline referrals and admissions to the program has required a strong relationship with those agencies as well as a clear understanding of their processes and practices.

Engaging young people with involvement in the justice system requires creativity and innovation.

**TTI Contact**

For more information, contact Keisha White at keisha.white@scdmh.org.

## Tennessee – Workforce

**Problem/Need**

The Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) was struggling to attract and keep its behavioral healthcare workforce. They examined the problem and undertook a study to determine both the causes of the shortage and possible solutions. A finding of the study was that the State could achieve, at least in part, its goal of attracting more individuals to the behavioral healthcare workforce by providing high school students with information about the nature of behavioral healthcare work and the educational and professional paths to entering this workforce. DMHSAS's plan focused on this age group with the belief that providing this type of information earlier in an individual's life would lead to better outcomes for the State (i.e., an increase in the number of young adults entering behavioral healthcare careers).

**Vision and Approach**

The immediate and long-term needs and direction of the DMHSAS and its provider network require a reliable and sufficient workforce. The TTI project has the goal of assisting in meeting this requirement. DMHSAS chose to approach this project with a sustained media campaign created for and directed at young individuals in high schools. The project began as a pilot project in a limited number of schools, but the State now hopes to expand this further.

**Outcomes**

> ***"We learned that there are many behavioral health professionals who are excited and willing to share details regarding the work that they do, as well as inform students about the field."***
> *-Jessica Youngblom, TTI Project Director*

Ultimately, the goal of this project is to entice high school students into entering a career/career path leading to employment in the behavioral health care field. It is hoped that this employment "pipeline", beginning early in a student's education, would lead to an increase in interest among young adults in behavioral healthcare, something the State

believes is less likely if young adults are not exposed to this work later in their lives and education.

To date, the project has reached over 150 students and conducted behavioral health career-days at four high schools. These events included college and university "ambassadors" who provided the high school students information about education and a career in behavioral health care. The State found the use of these "ambassadors" greatly enhanced the effectiveness of the program.

DMHSAS has also created "reflection materials" (i.e., career reference materials to assist students in choosing careers in behavioral healthcare). The project is also supported by social media resources including a YouTube channel and an Instagram page.

**Transformation Transfer**

The initial phase of the project is complete, but the work is ongoing and was conceived to be an ongoing strategy given that its goal is to influence students' career decisions for the foreseeable future. They have appropriate dollars to expand the program and increased the area of the State that is the focus of these efforts. In addition, the State has now invested additional funding to sustain these efforts. The project has also resulted in a train-the-trainer for providing students with more targeted information about a career in behavioral healthcare. In addition, the State has expanded its investment into behavioral healthcare interns; this was not part of the original TTI project but was seen by the state as an important adjunct to the work begun by the project. There is a growing demand among community-based providers for interns, so these efforts fit well into the goals of the TTI project. The project also focused heavily on the role of technical schools as TN has invested heavily in the 2-year programs primarily provided through these schools.

**Strategies for Success**

A major lesson learned from this project was the lack of anticipation of the many factors that would delay its implementation. The creation of media content took longer than anticipated and the project itself needed to operate in concert with the academic calendar. In addition, there was a school shooting that impacted access to schools and thus its implementation.

An important lesson learned was that this type of project needed to focus on students as young as eighth grade to have a better chance of influencing the students' decisions about career choices.

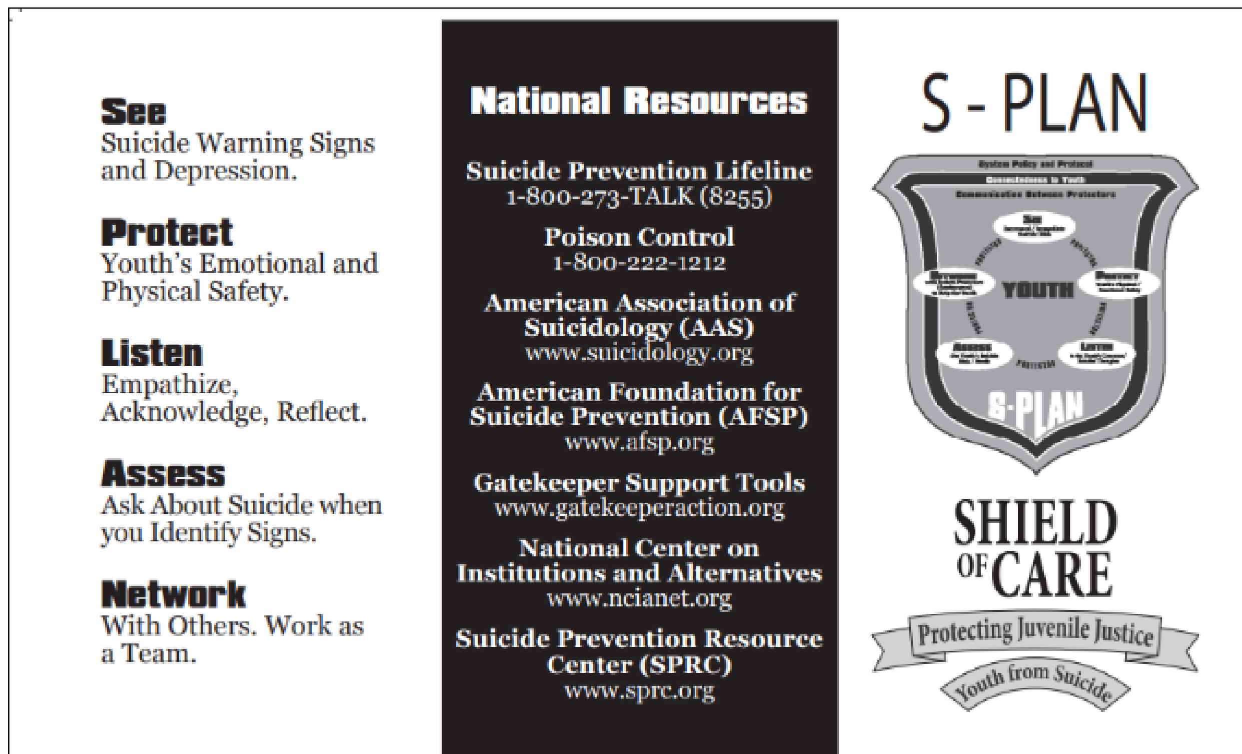
**TTI Contact**

For more information, contact Jessica Youngblom at jessica.youngblom@tn.gov.

**Problem/Need**

As attention to suicide has grown over the past decade, The Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) is concerned about the risk of suicide among children and youth in detention centers. Nationwide, incarcerated youth die by suicide at a rate two to three times higher than that of youth in the general population according to a Department of Justice report[47]. The 2022 TTI's focus on children and youth in crisis provided TDMHSAS the opportunity to reduce the risk of suicide in detention facilities by improving suicide prevention skills of the correction officers who care for them. The 22 detention centers in the State are comprised of county and private facilities without a statewide data collection system.

*Figure 37: Shield of Care List of National Resources*




[47] U.S. Department of Justice, Office of Justice Programs. (2009). Juvenile Suicide in Confinement, A National Survey. https://www.ojp.gov/pdffiles1/ojjdp/213691.pdf

### Vision and Approach

The project sought to reduce suicide attempts and completions in detention facilities by improving the training that correction officers receive. TDMHSAS developed its Shield of Care™ suicide prevention curriculum specifically for staff in juvenile justice settings. The curriculum is based on evaluation data, best practice literature, and the input of juvenile justice staff, and many partners including Youth Villages, contracted to deliver the training. The Shield of Care website contains trainer and participant manuals, evaluation forms, a wallet card (shown above in Figure 37) and other materials that are publicly available.

### Outcomes

Beginning in September 2022, Youth Villages conducted 51 sessions to train 353 staff and providers. Trainings were hosted by 18 of the 22 youth detention facilities or conducted in community settings nearby to detention facilities that did not host training. Seven of the sessions were Train-the-Trainer (TTT) delivered to detention staff who expressed interest in improving skills and expanding access in their facilities. The TTTs extend the number of personnel trained and are particularly useful due to high detention staff turnover. Pre- and post-training evaluations were distributed to participants to measure knowledge and skills acquired as well as attitudinal shifts.

### Transformation Transfer

TDMHSAS has improved the knowledge and skills of correctional officers responsible for the welfare of youth who are at high risk of suicide. Due to the success of the project, TDMHSAS will fund continued training of juvenile detention facility staff on suicide prevention. TDMHSAS is also considering expanding training topics to include Trauma-Informed Care and Adverse Childhood Experiences (ACES).

### Strategies for Success

Correction officers were interested in improving their skills in suicide prevention training and many wanted to receive additional training on mental health topics. Shield of

> ***"Correction officers who received suicide prevention training want more training on mental health topics, including adverse childhood experiences (ACES) and trauma-informed care."***
>
> *-Elizabeth Reeve, TTI Project Director*

Care training provided a “foot in the door” for TDMHSAS to expand training on issues that will reduce the isolation, trauma, and risk of suicide among children and youth in detention settings.

**TTI Contact**

For more information, contact Elizabeth Reeve at elizabeth.reeve@tn.gov.

## Tennessee – Children and Adolescents II

### Problem/Need

Similar to many states, families and hospitals alike in Tennessee complain about lengthy wait times to secure treatment beds for children and adolescents in a behavioral health crisis. Once a child is examined in the emergency department of a hospital and determined to need a more structured and intensive treatment environment to stabilize their condition, the emergency department must hold the child and transfer them to a treatment bed in a behavioral health hospital or unit in a general hospital. Known as boarding, patients can wait hours and days, even weeks while hospital staff seek an opening. Not only is this a problem for hospital staff, but the Children's Hospital Association also observed that "While boarding keeps vulnerable patients physically safe from injury, waiting in an emergency department does not provide the specialized mental health treatment kids need to help them recover. In addition to delaying treatment and recovery, prolonged boarding also means extended absences from schools and communities and puts undue stress on both kids and their caregivers." Tennessee's Department of Mental Health and Substance Abuse Services (DMHSAS) used TTI funds to pilot an innovative project to reduce boarding in two regions of the State.

### Vision and Approach

> ***"Many families are unaware of community services and supports, and these teams allow families to get what they need in a crisis while freeing up ED staff to focus on medical trauma and other patients."***
> *-Keri Virgo, TTI Project Director*

DMHSAS partnered with the Tennessee Children's Hospital Alliance to co-locate mental health clinicians and certified family support specialists at two hospital emergency departments. Clinicians may assist the hospital's psychiatric staff to conduct the evaluation and suggest resources and non-hospital alternatives for staff to consider for placement. Certified family support specialists are particularly adept at helping families navigate the complex systems of care and acquiring appropriate community services that may prevent future behavioral health crises or

seek help from non-hospital resources such as the State's recently launched children's crisis stabilization unit to resolve crises when they arise.

### Outcomes

The project, which began in 2022, was able to establish workflow at both sites to better track diversions from a higher level of care due to psychiatric consultations from the embedded clinicians and support specialists. Figure shows data from East Tennessee Children's Hospital (ETCH), one of the two project locations, reflecting a significant reduction in emergency room boarding times from an average of 42.53 hours to 33.42 during the review period.

By engaging children in crisis and their families in treatment and support, the sole reliance on ED visits and prolonged boarding can be reduced. At the second project site, the Emergency Department at Monroe Carrell Jr. Children's Hospital at Vanderbilt, project clinicians and family support specialists assessed 311 children/youth and completed 268 follow-ups with them and their families over a ten-month period. One hundred twenty-three of those families began to or planned to engage in ongoing care. Of those assessed, 3% returned to the emergency department for services within one month after discharge.

### Transformation Transfer

TTI funds provided an opportunity to pilot an innovative solution to reduce hospital boarding and to collect data that supports implementation in other areas of the State.

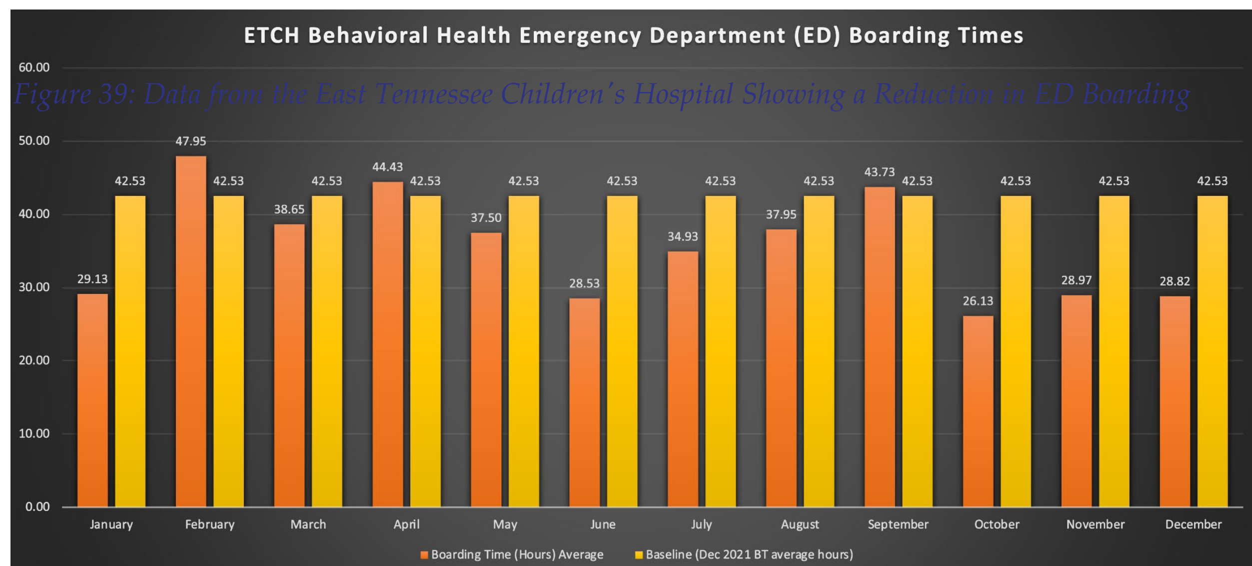



*Figure 39: Data from the East Tennessee Children's Hospital Showing a Reduction in ED Boarding*

Through collaboration between the State and the hospitals, the project successfully implemented an approach that reduced boarding time of children in a behavioral health crisis, provides support and guidance to their families, and engages them in treatment. Both pilot sites will continue to operate through a combination of state and hospital funds.

**Strategies for Success**

Colocation of services requires collaboration at multiple levels and the development of clear workflow. Successful implementation requires hospital emergency department staff to be oriented to the project including its goals, mission, and staff roles. Staff also include information technology to support integrating electronic health systems between DMHSAS and hospitals.

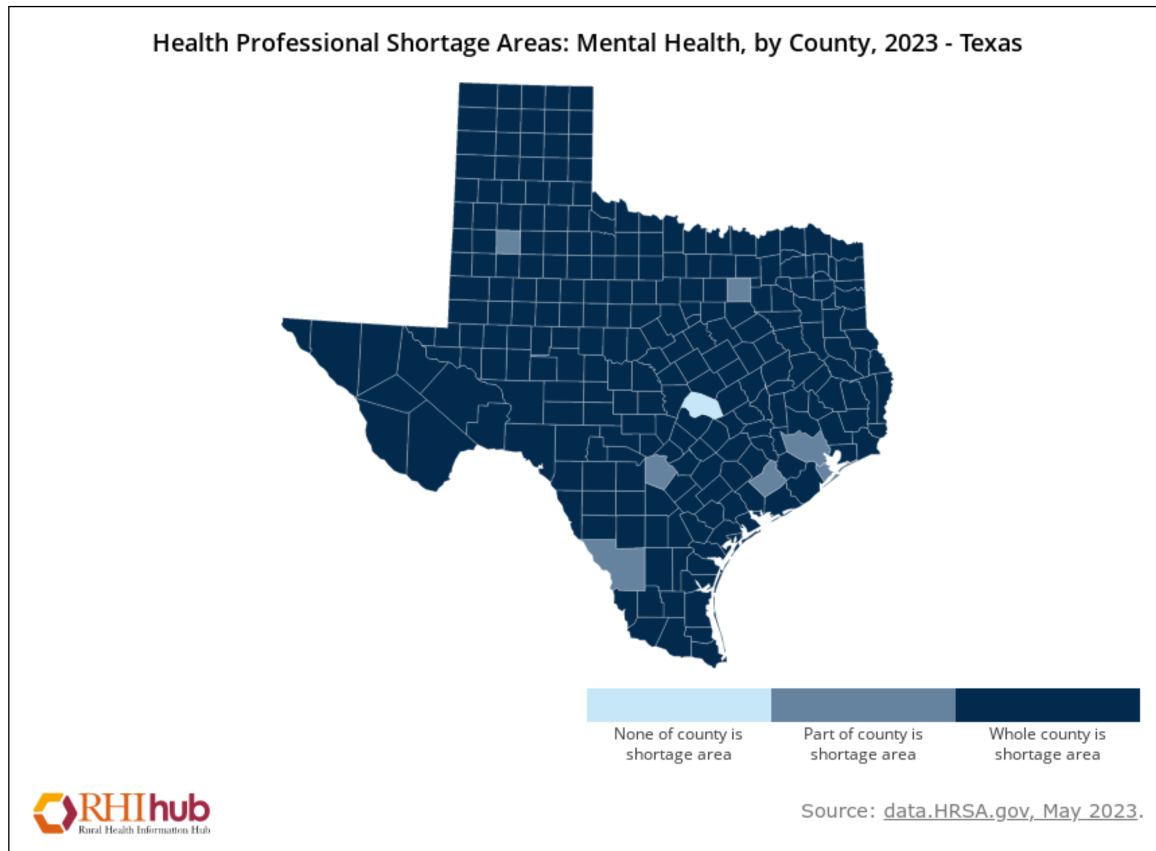
**TTI Contact**

For more information, contact Keri Virgo at keri.virgo@tn.gov.

**Problem/Need**

More than 80 percent of Texas's 254 counties were designated as Mental Health Professional Shortage Areas in 2016, defined as more than 30,000 residents per clinician. Access to behavioral health professionals has only grown worse since then with the COVID pandemic further exacerbating shortages and limited access. In 2023 that number has risen, as indicated in Figure 40. Texas Health and Human Services Commission (HHSC) used its TTI award to implement learning collaboratives for community mental health centers to address behavioral health workforce challenges related to 988 implementation and sustainability. The learning collaborative conducted training sessions on strategies to address key workforce issues, fostered peer-to-peer learning, and provided expert consultation to address specific challenges experienced by rural and urban communities across the State. In addition, trauma-informed care

*Figure 38: Mental Health Professional Shortage Areas in Texas, 2023*



training courses were provided to create a healthy workplace environment, improving both access and quality of care to Texas communities.

**Vision and Approach**

HHSC partnered with the University of Texas Health San Antonio to refocus the existing training platform from clinical practice to organizational development and reach human resource and executive leaders of numerous behavioral health agencies throughout the State. The effort to establish a healthier workplace starts at the human resources level to create healthier work environments, less turnover, and fewer vacancies. The project developed a series of webinars and consultation sessions to identify and deliver recommendations to overcome workforce challenges through organizational change. All training topics were based on a survey of LMHAs and LBHAs to seek their input on key topics and included: effective interviewing, edits to job postings, and reimagined retention incentives (financial, wellness, and otherwise) that may pave the way to be a long-term strategy to Texas's workforce challenges.

**Outcomes**

Beginning in September 2022, HHSC delivered webinars on various aspects of trauma-informed care. In January 2023, organizational subjects that contribute to healthier workplaces (e.g., retention strategies, onboarding strategies, etc.) were integrated into the schedule, delivered every other week. Following each webinar, participants are invited to schedule themselves for a private, one-hour consultation call with the subject matter expert who delivered the webinar.

The webinars are recorded, archived, and made available to the network of behavioral health agencies in Texas. The project also maps geographic locations of those who have participated in calls in relation to rural versus urban and health professional shortage areas to determine if they are engaging the clinics most in need of assistance.

Attendance of webinars has grown steadily from the initial 15 attendees to 69 and up to 18 scheduled individual consultations following each webinar. Based on attendance so far, the project estimates 741 participants representing 67 community mental health centers when the series ends later this year. Webinar topics included:

- Trauma-informed care: implementation practicalities
- Trauma-informed care implementation practicalities: focus on policy

- Trauma-informed care implementation practicalities: focus on your team
- Trauma-informed care implementation practicalities: focus on environment
- Critical incidence response training
- Handling abusive callers
- Navigating challenges with pay and pay equity
- Strategies for effective recruiting
- Alternative recruitment strategies: maximizing your network
- Recruitment: interviewing strategies
- Work/Life balance
- Management: training new team managers
- Retention strategies
- Effective strategies for staff onboarding
- Recruiting and managing peer support specialists
- Grant writing
- Program sustainability
- Strategies to compete in today's job market

Four interactive workshops were conducted with 56 center executives and human-resource leadership. The average evaluation score was 4.7 on a five-point-scale. Workshop topics include:

- Putting trauma-informed care into action in your work
- Trauma-informed supervision: what is trauma-informed supervision and why it matters
- Supporting supervisees with secondary/vicarious trauma
- Putting trauma-informed supervision into practice

**Transformation Transfer**

The project is creating a positive "ripple effect," where the thousands of clients served in Texas can receive quality behavioral health care delivered by a healthier and less-overwhelmed workforce. The ripple effect:

- Empowered agencies with tools to move away from the "sink-or-swim" staffing approach, to one that addresses workforce shortages and improves retention.
- Introduced the trauma-informed care approach to agencies that may not have been familiar with the practice or how to implement it. Eight local mental health authorities have asked about the TICOMETER to evaluate needs and progress in implementing trauma-informed care and ensuring its sustainability.

**Strategies for Success**

The initial survey results of community mental health centers were different than what was expected. They stimulated a new approach to the training curricula that interwove the trauma-informed care approach with the concept of a healthy workforce and with concrete actions to improve recruitment and retention.

> ***In a period of widespread workforce shortage, clinics must move beyond the 'sink or swim' approach to orienting and keeping staff."***
>
> *-Cynthia Sierra, Sr., Project Manager, UT Health San Antonio*

The project also gained new ideas and understanding from participation in the TTI learning collaborative. Through collaborations with SAMHSA and NASMHPD, states share ideas, data, and outcomes to improve recruitment and retention and to make policy recommendations that can address workforce shortages.

**TTI Contact**

For more information, contact Kathleen Manuel at kathleen.manuel@hhs.texas.gov.

## Washington - Special Populations (AI/AN)

**Problem/Need**

Following the launch of 988 and comprehensive crisis services statewide, the Washington State Health Care Authority (HCA) and many Washington State tribal, state agency, and legislative partners worked diligently in partnership to develop a first-in-the-nation dedicated crisis call line for American Indian and Alaska Native people. The CDC reports that American Indians/Alaska Natives (AI/AN) have the highest rates of suicide of any group in the United States.[48] In response to high rates of suicide among American Indians in the state, the Native and Strong Lifeline was launched in November 2022. Callers are greeted by crisis counselors that identify their affiliation as tribal members and descendants. Tribal sovereignty, culture, entitled services, as well as eligibility are complex in Indian County and require general and specific knowledge about the availability of resources. The Medicaid and CHIP Payment and Access Commission (MACPAC) reports that AI/AN people are more likely to avoid or delay medical care due to cost or other reasons, and "face barriers to care, such as living in remote rural areas, lack of transportation, and cultural and language barriers."[49] To help crisis counselors navigate the maze of Indian and non-Indian resources and connect callers with follow-up care, the Tribal-Centric Behavioral Health Advisory Board, along with the American Indian Health Commission and the HCA established the Tribal Resource Hub/Indian Behavioral Health Hub (the "Hub"). The Hub is staffed by Natives who can direct callers to the most proximate and available resources to meet their needs. TTI funds were used to expand the Hub's staffing capacity, build its electronic resource library, and develop training resources for all Lifeline crisis counselors and future behavioral health aides on how to use Hub resources, as well as considerations for working with Native individuals and tribal communities.

[48] CDC. (2023). Suicide data and statistics. *Centers for Disease Control and Prevention.* *https://www.cdc.gov/suicide/suicide-data-statistics.html*

[49] MACPAC. (2021). Medicaid's role in health care for American Indians and Alaska Natives: Issue brief. *MACPAC.* https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf

### Vision and Approach

Much of the design of the Native and Strong Lifeline and the Hub have been informed by the Tribal-Centric Behavioral Health Advisory Board. While the Native and Strong Lifeline provides immediate support to individuals experiencing a crisis, the Hub provides the connection to ongoing follow-up care to help prevent future crises. Lifeline counselors can refer callers to the Hub, as reflected in Figure 39 screenshot from the Hub website. The Hub staff, for example, maintain a census of crisis bed resources from across the State, updated twice per day. In addition to increasing the number of hours of operation, TTI funds were used to convert existing spreadsheets of resources into an electronic database, allowing for quicker access and updating of information. Volunteers of America (VOA), who operate the Lifeline and the Hub, are in the process of creating training for its crisis counselors, behavioral health aides, and those of other health care entities, including Indian Health Care Providers, to take full advantage of the Hub.

*Figure 39: Screenshot from the Hub Website*

Contact Us

If this is a life-threatening emergency, dial 911.

If you or someone you know are in crisis or considering suicide, call 988. Counselors are available 24 hours a day.

Our Tribal Hub staff is available during normal business hours for support or to answer questions. Simply fill out the contact form or give us a call at 1-866-491-1683.

First Name*

Enter your message or comments here.

### Outcomes

The project created an electronic database of resources and has begun training Lifeline crisis counselors. HCA staff receive anecdotal reports that tribal members are receiving the behavioral health care that they need from the Hub. Costs to maintain the database and train new Lifeline crisis counselors are minimal and will be absorbed with other funding resources once the TTI funds are exhausted. VOA has developed datapoints to measure the volume and frequency of calls and referrals to the Hub per state

requirements and in consultation with the Tribal-Centric Behavioral Health Advisory Board. Data points being collected include:

- Caller demographics:
    - Age, tribal affiliation, county of residence
    - Type of resources requested from the Hub
    - Type of resources provided by the Hub
    - How did you hear about us? (with a drop-down menu)
- Service data:
    - Number of clients served
    - Number of calls received to the Hub
    - Number of email requests received by the Hub
    - Number of individuals calling on their own behalf
    - Number of professionals calling on behalf of others
    - Number of 211 referrals
    - Number of crisis line transfers
    - Number of resource-seeking only calls (for professionals/tribes)
- Outreach:
    - Service providers contacted to update resources
    - Number of in-persons at community outreach events attended
    - Number of virtual outreach meetings to learn about service providers in the state

**Transformation Transfer**

Providing immediate access to help when people are most in need is critical to saving lives and turning crises into opportunities. If behavioral health systems want to prevent crises, they must continuously look to improve their ability to engage the people they

seek to serve. The Hub serves to connect AI/ANs in Washington to services that surmount the geographic, transportation, and cultural and linguistic barriers to care. The Hub also serves to support Indian Healthcare Providers in supporting their patients with access to the behavioral health system and will expand to increase resources available to serve Native people.

**Strategies for Success**

The consistent advocacy of tribes for tribal-centric services in the State and true tribal-state partnerships has been effective and led to funding for dedicated services like the Native and Strong Lifeline, and dedicated funding for crisis services. Their consultation and support have been crucial to expanding the Hub.

**TTI Contact**

For more information, contact Lucilla Mendoza at lucilla.mendoza@hca.wa.gov and Rochelle Williams at rwilliams@voaww.org.

## Washington – Children and Adolescents

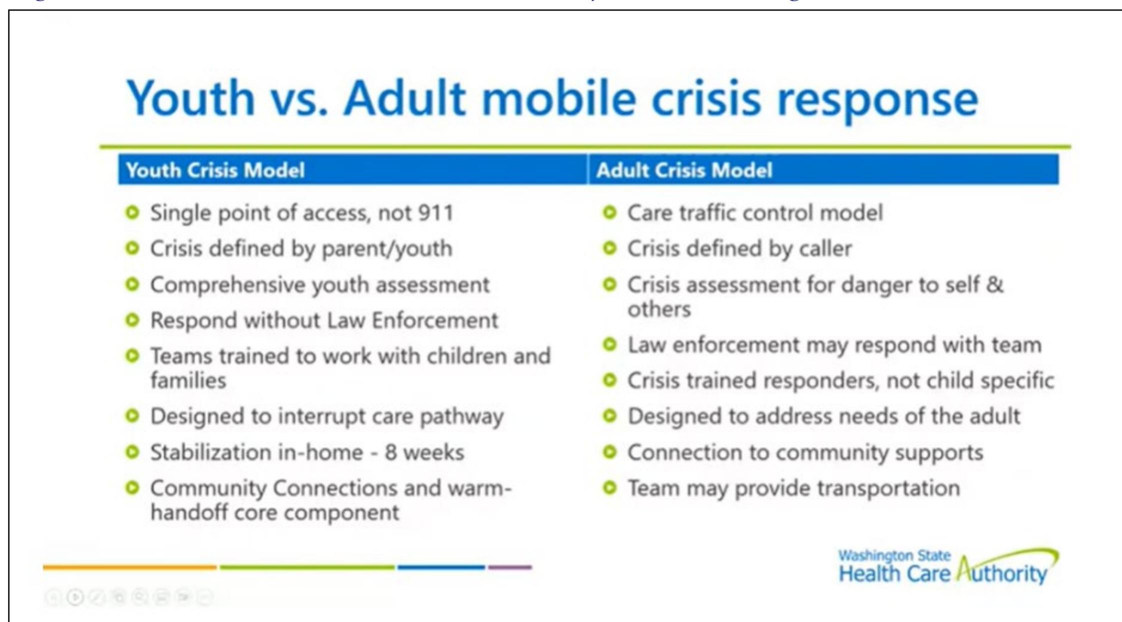
**Problem/Need**

The launch of 988 highlighted the need to develop and implement a comprehensive crisis response system for children, adolescents, and their families, providing upstream intervention and stabilization to prevent more intensive interventions later on. In July 2022, the Washington state legislature tasked the Washington State Health Care Authority (HCA) with implementing specialized crisis teams focused on children, youth, and families in each of their regions. HCA selected the Mobile Response and Stabilization Services (MRSS) as the best-practice model to deliver a response capacity designed specifically for children and their families. TTI funds were used to participate in a state peer-to-peer MRSS Quality Learning Collaborative (QLC). Funds went towards purchasing QLC access, technical assistance, and establishing partnerships with agencies and community organizations throughout the State.

**Vision and Approach**

After investigating different children and youth-oriented crisis response approaches, the project adopted the MRSS. HCA invited crisis service providers (crisis services teams are contracted through Behavioral Health Administrative Service Organizations)

*Figure 40: Youth versus Adult Mobile Crisis Response in Washington State*



to participate with them in the QLC. Participants are provided monthly coaching calls, facilitated peer-to-peer learning opportunities, data collection activities, and access to resources and tools to support design and implementation of mobile response teams. In addition to informing best-practice guidance and community building activities, participation has informed program standards and the respective contract language required to implement, measure, and hold accountable providers to those standards. The project is developing best practice guidance and outreaching to communities to explain MRSS and its plans for future crisis services. Figure 40 displays a slide from a presentation made by HCA on the differences between MRSS and adult mobile crisis response models.

The project is advised by key stakeholders committed to the roll-out of MRSS statewide. They include youth and families with lived experience and their organizations, the State's Office of Tribal Affairs, Office of the Superintendent of Schools, and Department of Children, Youth, and Families, behavioral health providers, Seattle Children's Hospital, and Managed Care Organizations and BH-ASOs.

**Outcomes**

As a result of this work, parents with lived experience and their organizations are now represented on the Crisis Response Improvement Strategy (CRIS) committee's Lived Experience subgroup (a statewide advisory group established in legislation). Staff from many agencies and partners attend and actively engage with QLC events. Meeting data collection and reporting requirements of the QLC has brought attention to these measures and their tracking for long-term systems evaluation.

**Transformation Transfer**

> ***"We wanted a crisis response system that wasn't just a watered-down version of the adult one. We were able to set the goal posts high with MRSS as the best practice."***
>
> *-Elizabeth Venuto, Project Director*

One of the major accomplishments of the project has been the alignment of perspective across sections within Health Care Authority and with the larger workgroups dedicated to the implementation of 988. The commitment to the MRSS model

was rooted in a small pocket of work, brought to the community, and supported by individuals with lived experience in

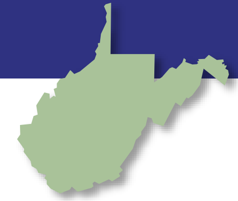
the system. The model is very different than the current, adult-oriented system and it took time and dedication to cultivate alignment.

**Strategies for Success**

The flexibility of TTI funds allowed the project to utilize technical assistance to identify system needs and pivot to the MRSS model as the best model to meet those needs.

**TTI Contact**

For more information, contact Elizabeth Venuto at liz.venuto@hca.wa.gov.



## West Virginia – Children and Adolescents

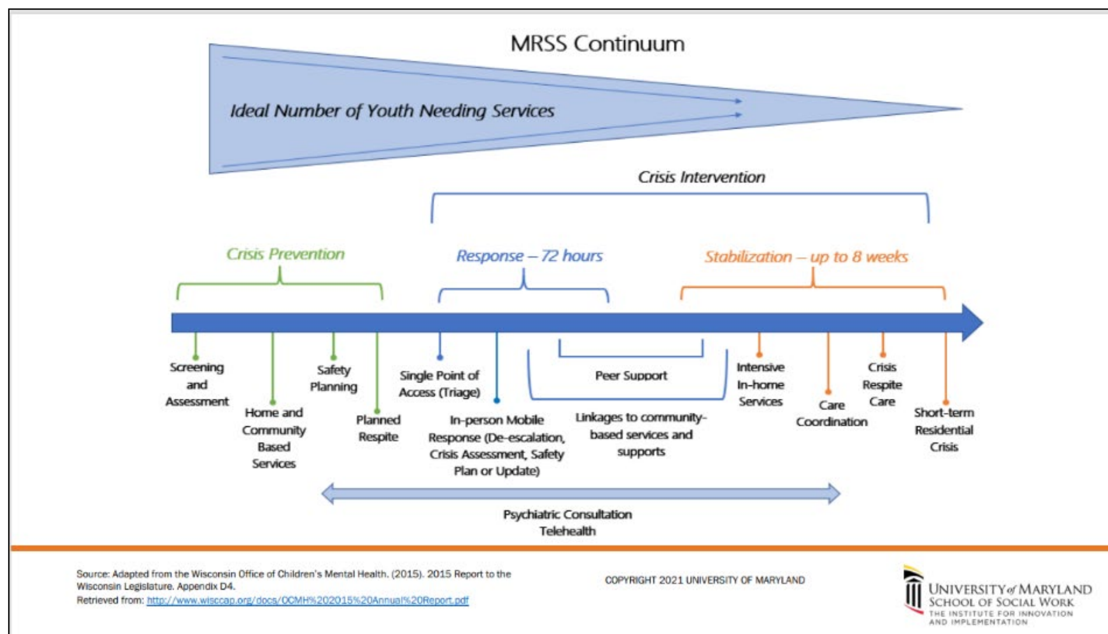
### Problem/Need

West Virginia's Bureau for Behavioral Health's Office of Children, Youth, and Families (BBH) is using the 2022 TTI funds to undertake two new efforts to expand and improve crisis care for all children and their families in the State. Various state and national sources (e.g., Trevor Project National Survey and Results from the 2021 National Survey on Drug Use and Health) have reported on disparities in access to behavioral health services for some groups, particularly youth identifying as LGBTQ+, as well as individuals who are black, indigenous, and people of color (BIPOC). To address these disparities, BBH (1) participated in NASMHPD's Mobile Response and Stabilization Services (MRSS) Quality Learning Collaborative, and (2) reached out to organizations of and for LGBTQ+ and BIPOC communities to encourage and support their participation in oversight of behavioral health services.

### Vision and Approach

The MRSS Quality Learning Collaborative focuses on the structural changes that states need to make to fully implement a comprehensive crisis system as displayed in Figure 41. The collaborative facilitates peer-to-peer learning among state leaders and addresses

*Figure 41: Mobile Response and Stabilization Services Crisis Continuum from the University of*



leadership, finance, policy, and workforce. During the collaborative, participants receive presentations, facilitated discussions, monthly coaching, and access to resources and tools on service delivery, data collection, and data analysis. BBH recognized that effective mobile crisis and stabilization services can reduce reliance on law enforcement, prevent future crises by connecting families with on-going community-based care and maintaining children safely at home and in the community. Data collection and analysis was particularly relevant as BBHs move toward more evidence-based decision making informed by service utilization reports (e.g., geographic area, demographics, and variations in volume) as well as response times and outcomes of crisis care resources.

BBH recognized that participation in its boards, committees, and other oversight structures did not include representation of underserved populations, particularly BIPOC and LGBTQ+ youth. The project sought to solicit input and encourage participation in boards and committees by developing relationships with organizations that represent and serve people who are LGBTQ+ and BIPOC, such as Fairness WV, Rainbow Pride of WV, Keep Your Faith Corporation, and Youth MOVE chapters throughout the State. Beginning in the fall of 2023, BBH will distribute limited funds to several of these organizations to support their members' participation in BBH and to conduct surveys on barriers to access, and disparities in service quality and outcomes.

**Outcomes**

Collaboration with organizations that serve BIPOC and LGBTQ+ youth are unlikely to produce quantitative data; however, they will yield important qualitative information as the project begins difficult discussions with new partners. Through participation in the MRSS Quality Learning Collaborative, BBH is planning to develop a data strategy on crisis care that includes the selection of available and meaningful measures and how they can be used to expand crisis are to all West Virginians and improve outcomes.

***Be prepared to have important, but sometimes uncomfortable, conversations."***

*-Nikki Tennis, TTI Project Director*

**Transformation Transfer**

Bringing new voices to BBH boards and committees can have a transformative effect on behavioral health services. The inclusion of underserved youth in policy, training, and

program design decisions may bring positive and lasting change to West Virginia's crisis system of care. BBH is committed to engaging BIPOC and LGBTQ+ youth in program design and implementation and is including outreach and engagement of underserved populations in federal grant proposals and submissions.

**Strategies for Success**

Raising issues of inequity because of race, sexual orientation, or other differences can raise distrust and discomfort. Projects must be prepared to engage in difficult discussions and commit to addressing disparities.

**TTI Contact**

For more information, contact Nikki Tennis at nikki.a.tennis@wv.gov (outreach and engagement) and Cassandra Toliver at cassandra.l.toliver@wv.gov (MRSS Quality Learning Collaborative).