988

Convening Playbook

Mental Health and Substance Use Disorder Providers

Acknowledgements

Many organizations contributed their time and expertise to the development of this document, including:

Advocates (Massachusetts)

American Paramedic Association

Arlington Department of Human Services (Virginia)

Brave Health

Burrell Center (Missouri)

CASES (New York)

Compass Health Network

Connections Health Solutions (Arizona)

Family & Child Services (Oklahoma)

Family Run Executive Director Leadership Association (FREDLA)

Georgia Department of Behavioral Health and Developmental Disabilities

McKinsey Health Institute

Mental Health America (MHA)

National Action Alliance / Education Development Center (EDC)

National Alliance on Mental Illness (NAMI)

National Association for Behavioral Healthcare

National Coalition for Mental Health Recovery (NCMHR)

National Council for Mental Wellbeing

NRI, Inc.

People-USA (New York)

PRA, Inc.

RI International

Solari (Arizona)

State of Connecticut, Department of Children and Families

Technical Assistance Collaborative

Vibrant Emotional Health

988 Convening Playbook Mental Health (MH) and Substance Use Disorder (SUD) Providers

Overview

Goal. The document sets out to help MH & SUD providers ("providers")
- Articulate the need for operational readiness for 988
- Prepare for the 988 transition (not a specific mandate for them)
- Explain how to make progress on the criteria that are central to 988 readiness
- Identify best practices and examples seen in the field today

Audience. The document is written for executive leadership (e.g., CEO and/or Chief Clinical Officer) of a community behavioral health provider (e.g., Certified Community Behavioral Health Clinics (CCBHCs), Community Mental Health Centers (CMHCs), or similar) that provide MH and/or SUD services and treatments. These organizations may provide a range of services including mobile crisis services, crisis receiving and stabilization services, psychiatric emergency / urgent care facilities, SUD services, and/or outpatient facilities.

Structure. The document is structured in three sections:
- I. Operational readiness self-assessment
- II. Playbook with five sub-sections:
    - a. Linkages to Lifeline contact centers
    - b. Linkages to crisis care continuum
    - c. Crisis care practices
    - d. Access
    - e. Capacity
- III. Additional resources

Notes:
- *Equity:* The playbook aims to highlight equity considerations across topics, including how equity needs to be considered across all areas of readiness
- *Case studies and examples:* The playbook includes many case studies and examples from individual providers. Examples will not be applicable to all providers

Table of Contents

I. 988 operational readiness self-assessment for providers

Introduction and purpose of the operational readiness self-assessment

The self-assessment tool is intended to assist providers in assessing their readiness for the July 2022 988 transition and prioritizing areas of focus moving forward.

The tool is <u>not</u> intended to be evaluative, and no responses will be collected or aggregated. There is neither a *perfect score* nor a *right answer*. The intent is solely to help providers determine where they might focus efforts both ahead of July 2022 and beyond as the country moves toward integrated crisis care.

In addition, there is no time expectation associated with the self-assessment tool. Providers are working in different contexts, and all have different priorities and needs related to 988 and integrated crisis care. The goal of this self-assessment tool is to help providers define an aspiration unique to their locality, not prescribe any activities on a specific timeline.

Self-assessment levels

The self-assessment tool lays out a series of criteria within specific readiness categories that are aimed at holistically capturing components of readiness to realize the full potential of 988. For each criterion, three distinct levels can be selected. Providers are asked to select the level that best approximates their current state.

- Beginning: Work in this area has not yet started
- Emerging: Work in this area is underway but not yet complete
- Solidified: Objectives in this area are fully or almost fully met

Some criteria reference specific services (e.g., 24/7 crisis call operations, mobile crisis services, crisis receiving services, outpatient services) that may not apply to every organization. Each organization can choose to focus on the criteria that are most relevant for them.

Link to playbooks

The self-assessment categories match categories of information contained in the rest of the playbook document. The results of the self-assessment can be used to determine which areas of the playbook to consider focusing on in the immediate term.

For example, providers who are "beginning" work within specific categories that they believe are important can use information contained in the playbook to chart a path to initiate activities aimed at achieving "emerging" readiness. Providers that are already "emerging" in certain categories can use information in the playbook to fully solidify their readiness in those categories.

Criteria

Criteria	Beginning	Emerging	Solidified
Linkages to Lifeline contact centers ("centers"): Does the organization have relationships with nearby centers?			
To what extent does the organization have an **existing relationship with nearby centers**?	Limited to no existing relationship with centers. Infrequent individual referrals and warm transfers from centers	Informal relationship with centers. Occasional individual referrals and warm transfers Generally, centers cannot make appointments directly, but an informal arrangement may exist to set up appointments	Formal relationship and memo of understanding with centers, with active encouragement of centers to refer individuals in crisis for services Always accept transfers from centers, which can make appointments or arrangements for treatment with organizations directly through an online system with real-time availability
To what extent does the organization **receive data and information on referred individuals (e.g., call records) from centers** when available (when individuals provide consent)?	Never or infrequently receives data or information on referred individuals from centers	Occasionally receives data and information on referred individuals from centers, but this process is not standardized or consistent	Systematically receives data and information on referred individuals from centers, ideally including full records in an interoperable format consistent with ONC requirements; transfer includes information about current crisis episode, prior history (including previous crisis episodes and contacts), any safety related information, and any medications previously dispensed)
2. Linkages to crisis care continuum: Can the organization accept all referrals and provide / connect individuals in crisis to care in real time?			
To what extent does the organization **accept referrals of individuals in crisis**, including from local mobile crisis teams, crisis receiving and stabilization facilities, and emergency departments (EDs)?	Limited or no ability to accept individuals in crisis referred from other crisis service providers	Ability to accept some but not all individuals in crisis referred from other crisis service providers	Ability to accept all individuals in crisis referred from other crisis service providers
To what extent does the organization **accept routine referrals from other providers,** including from local mobile crisis teams, crisis receiving and stabilization facilities, and EDs?	Limited or no ability to accept routine referrals from other providers	Ability to accept some but not all routine referrals from other providers	Ability to accept all routine referrals (individuals) from other providers

Criteria	Beginning	Emerging	Solidified
To what extent does the organization **share individual data and information (e.g., electronic health records) with other providers?**	Limited to no sending or receiving of electronic health records on individuals	Some sending or receiving of individual electronic health records but not via a standardized or consistent processes	Consistent sending and receiving of individual electronic health records via standardized and consistent processes, including full records in an interoperable format consistent with Office of the National Coordinator for Health Information Technology (ONC) requirements; this includes information about current crisis episode, prior history (incl. previous crisis episodes and contacts), any safety related information, and any medications previously dispensed)
To what extent does the organization have **defined policies or procedures to follow up** on individuals in crisis after the crisis episode, as appropriate?	Generally, no follow-up provided or coordinated	Follow-up provided or coordinated for some individuals in crisis	Follow-up provided and coordinated for all individuals in crisis

3. Crisis care practices:
Do the organization's crisis care practices follow the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Guidelines?
Note: Crisis care best practices address all populations throughout their lifespans, as stated in the National Guidelines.[1] The playbooks will address in more detail the unique needs of groups at higher risk of experiencing crises related to MH and/or SUD.

Criteria	Beginning	Emerging	Solidified
To what extent do the organization's **crisis care practices follow SAMHSA's National Guidelines,** such as practices that: • are trauma-informed • support safety and security for staff and individuals in crisis • address the recovery needs of individuals • address the recovery needs of families	Team members are not trained on trauma-informed care and trauma is not regularly evaluated Limited to no safety measures are in place, incidents of seclusion and restraint are not regularly monitored or reviewed, and no commitment to a no-force-first approach to care exists	*All of the following are true:* Team members receive limited training on trauma-informed care principles and practices Some safety measures in place including an existing commitment to a no-force-first approach to care, but incidents of seclusion and restraint are not regularly monitored or reviewed	*All of the following are true:* Most to all team members are trained on trauma-informed care, and trauma is regularly evaluated as part of care Substantial safety measures in place including an existing commitment to a no-force-first approach to care and incidents of seclusion and restraint are regularly monitored and reviewed

---

1 Substance Abuse and Mental Health Services Administration, "National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit," pg. 42, 2020, https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.

Criteria	Beginning	Emerging	Solidified
	Limited engagement and collaboration with individuals to align actions to their preferences Limited engagement and collaboration with families to align actions to their preferences	Some engagement and collaboration with individuals, but care is not fully recovery-oriented Some engagement and collaboration with families, but care is not fully recovery-oriented	Care is fully recovery-oriented, with individuals and families engaging and collaborating in their care as well as care plans that fully align with their needs and preferences
What is the commitment to the **Zero Suicide framework** or a similar universal suicide assessment framework?[2]	Elements of the framework are not met, and there is no formal commitment Suicide risk screening, assessment, and planning processes are not standard practice	Elements of the framework are met to some degree and there is some commitment Suicide risk screening, assessment, and planning processes may take place but are not standard practice	Elements of the framework are met, and there is full commitment to it Suicide risk screening, assessment, and planning processes are standard practice
What **role do peers (such as Peer Support Specialists, Recovery Coaches, and/or Youth and Family Peer Support Specialists) with lived experience play** in crisis response across service delivery, training, and evaluation of services?	Limited to no peers with lived experience engaged in services	Some peers with lived experience engaged in services, but they are not consistently integrated in crisis response	Many peers with lived experience are on staff and/or routinely engaged in services. Peers play a vital part in crisis response, as appropriate
How are **social determinants of health (SDOH) considered** as part of an individual's screening (e.g., evaluating an individual's environment and living conditions)?[3]	Limited to no screening for SDOH or referral of individuals to social services, as appropriate	Inconsistent screening for SDOH and referral of individuals to social services, as appropriate	Consistent screening for SDOH and referral of individuals to social services, as appropriate

---

2 Zero Suicide is a continuous quality improvement framework that shows health and behavioral health care systems how to transform care for individuals at risk for suicide. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving safety of individuals in crisis, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. Source: "Zero Suicide Framework," Zero Suicide, Education Development Center Zero Suicide Institute, accessed Jan 31, 2022, https://zerosuicide.edc.org/about/framework.

3 The social determinants of health (SDOH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Source: "Social determinants of health," World Health Organization (WHO) Health Topics, accessed Jan 31, 2022, https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.

Criteria	Beginning	Emerging	Solidified
To what extent is **cultural competence and humility embedded into the organization?**[4] Do the services provided respect and respond to the cultural, linguistic, and other social and environmental needs of the individual, such as: • a needs assessment that includes cultural, linguistic, and treatment needs • screening tools and services that are culturally and linguistically appropriate, and tools / approaches that accommodate disabilities, when appropriate • training plan(s) that addresses cultural competence	Limited to no focus on cultural competence in practice, trainings, and tools Few if any staff are representative of the community and no proactive hiring plan exists to recruit from community	Some focus on cultural competence in practice, trainings, and tools Some staff are representative of the community and/or a proactive hiring plan exists to recruit from community	Significant focus on cultural competency at the executive level and across the organization in practice, trainings, and tools Cultural competency is embedded into all relevant services, needs assessments, screening tools, and trainings Multiple team members on staff are representative of the community and a proactive hiring plan exists to recruit from community

4. Access:
Does the organization provide services to any individual in crisis seeking help?

Criteria	Beginning	Emerging	Solidified
To what extent are **services provided to everyone regardless of the ability to pay**?	Serve only currently reimbursable and required populations	Serve currently reimbursable and required populations and some other individuals	Serve nearly all individuals, including those outside the currently reimbursable and required populations
To what extent does the organization **offer 24/7 call service**?	Limited to no 24/7 access	24/7 access to an answering service and callback, but no direct response from a real person	24/7 access to a trained clinician and/or behavioral health specialist who can answer questions
To what extent does the organization **offer tailored services to groups with unique needs and/or at higher risk of experiencing a crisis related to MH and/or SUD** (e.g., veterans, lesbian, gay, bisexual, transgender, or queer / questioning (LGBTQ), American Indian and Alaska Native, non-English speakers, and youth)?	Offers few or no tailored services	Offers some tailored services for some populations but often refers individuals to other providers for tailored services	Offers a comprehensive suite of tailored services for groups with unique needs or at higher risk, including offering to coordinate care

---

4 "CCBHCs and Cultural Competence," Substance Abuse and Mental Health Services Administration, accessed Jan 31, 2022, https://www.samhsa.gov/section-223/cultural-competency.

Criteria	Beginning	Emerging	Solidified
5. Capacity: Can the organization accommodate a potential increase in demand for services?			
To what extent can the organization **accommodate an increase in demand for Mobile Crisis** (MCT) services for all individuals in crisis (i.e., respond to requests with urgent need in **one hour in urban areas** or **two hours in rural areas**), if relevant for the organization?	Limited to no ability to increase capacity with no defined plan to provide and accommodate potential increases in future demand	Limited ability to increase capacity currently, but with plan in place to provide these services in the future and accommodate potential increases in demand	Ability to handle an increased demand for services for all individuals (including adults, youth, and parents / caregivers with children)
To what extent can the organization **accommodate an increase in demand for crisis receiving and stabilization services** for all individuals in crisis, if relevant for the organization?	Limited to no ability to increase capacity with no defined plan to provide and accommodate potential increases in future demand	Limited ability to increase capacity currently, but with plan in place to provide these services in the future and accommodate potential increases in demand	Ability to handle an increased demand for services for all individuals (including adults, youth, and parents / caregivers with children)
To what extent can the organization **accommodate increased demand for urgent (within 48 hours) outpatient care services** for all individuals in need, if relevant for the organization?	Limited to no ability to increase capacity with no defined plan to provide and accommodate potential increases in future demand	Limited ability to increase capacity currently, but with plan in place to provide these services in the future and accommodate potential increases in demand	Ability to handle an increased demand for urgent services
To what extent can the organization **accommodate an increase in demand for routine (within five days) outpatient care services** for all individuals in need, if relevant to the organization?	Limited to no ability to increase capacity with no defined plan to provide and accommodate potential increases in future demand	Limited ability to increase capacity currently, but with plan in place to provide these services in the future and accommodate potential increases in demand	Ability to handle increases in demand for routine services
To what extent does the organization provide **real-time service availability and capacity such as a bed registry or same-day-scheduling capabilities?**	Limited to no ability to report service availability and capacity	No current ability to report service availability and capacity in real time, but a plan is in place to do so in the future	Currently reporting service availability and capacity in real time. Reporting is accessible to Lifeline contact centers and other crisis providers

II. Playbook

1. Linkages to Lifeline contact centers

As an organization, building and/or strengthening relationships with nearby Lifeline contact centers is a key element of readiness for 988. Lifeline contact centers answer calls for the Lifeline as well as other local helplines and offer other resources such as text, chat, and mobile services.[5] Building relationships with these Lifeline contact centers is an important step toward being able to accept transfers from contact centers as needed.

Some CCBHCs may currently have no relationship with their local Lifeline contact centers, while others may be informally engaged with Lifeline contact centers but lack formal agreements. Some CCBHCs themselves may also function as Lifeline contact centers. Based on the maturity of existing relationships with Lifeline contact centers, priorities for developing linkages to Lifeline contact centers will vary.

This section describes:
- Approaches to establishing relationships with Lifeline contact centers
- Resources to build / integrate mobile dispatch technology

Approaches to establishing relationships with Lifeline contact centers

Establishing informal relationships. If the organization does not have an existing relationship with contact centers it can take several steps, including:
- Reaching out to local Lifeline contact centers: Locations and websites for the ~200 centers can be found in the *Find Your Center* tool on Vibrant Emotional Health's website (https://suicidepreventionlifeline.org/our-crisis-centers/)[6]
- Maintaining a close relationship with the center by regularly checking in with contact center leadership / point of contact
- Actively encouraging contact centers to refer callers for services, as appropriate

Establishing formal relationships. Formal relationships between an organization and contact centers are preferred, where possible. Steps to build formal relationships include:
- Building a formal relationship such as entering into a memo of understanding (MOU) or Business Associate Agreement (BAA). A formal agreement would ideally set up the process and rules around systematically receiving data and information on referred individuals from crisis centers
- Setting up processes, ideally using automated technology, that allow contact centers to make appointments or arrangements for treatment with the organization directly through an online system with real-time availability

---

[5] "Our Crisis Centers," National Suicide Prevention Lifeline, Vibrant Emotional Health, accessed Feb. 7, 2022, https://suicidepreventionlifeline.org/our-crisis-centers/.
[6] "Our Crisis Centers," accessed Feb. 7, 2022.

Case study: Family and Children's Services (F&CS) (Oklahoma) [7]

A provider of crisis services in Tulsa for the past 22 years, F&CS is a Lifeline contact center and CCBHC that offers integrated crisis services that range from crisis calls to crisis beds. F&CS prioritizes:

- **Integrated Crisis Services**: To serve the Tulsa Community and individuals in crisis, F&CS provides integrated crisis services for individuals in crisis across acuity levels that include:
    - Crisis contact services
    - Mobile crisis response (24/7/365)
    - Triage, screening, and assessment unit (24/7)
    - Crisis urgent recovery center (chairs, up to 24 hours)
    - Crisis stabilization unit (beds, three to five days)
    - Community response team, a collaboration with the Fire Department, Policy Department, and Mental Health Association) to respond to 911 calls with an eye towards MH support

- **Training:** To best connect individuals contacting the Lifeline to in-person care, F&CS built strong linkages between crisis call counselors and in-person sites of care. For instance, training for all crisis counselors includes visits to all in-person sites of care so that they have actually seen how an individual in crisis would access those services

- **Follow-up:** F&CS prioritizes follow-up by tracking every contact systemically. Community Outreach Psychiatric Emergency Services (COPES) follows up with individuals until they are no longer in crisis and are connected to ongoing outpatient services or a minimum of three attempts have been made to connect them with outpatient services and they are refusing further assistance.[8] The system is set up in Dynamics 365 and replicates a previous paper-based system for tracking individuals with whom to follow-up

Case study: Solari (Arizona)[9]

Solari utilizes advanced technology platforms and system integration that enables operations and reporting capabilities. The Genesys PureCloud / Interactive Intelligence telephony system is a single platform capable of handling inbound and outbound calls, Short Message Service (SMS) text messages, and chat. It permits Automated Call Distribution (ACD), customization between users, supervisory monitoring of all queues, call recording, and automated post-call customer satisfaction surveys.

The electronic medical record system is a Microsoft Dynamics Customer Relationship Management (CRM) product. Solari has taken advantage of the system's extensive customization options to produce an operational flow that allows fast, accurate

---

[7] Family and Children's Services (F&CS).

[8] COPES (Community Outreach Psychiatric Emergency Services) is a free and confidential 24/7 telephone crisis line and mobile crisis service. COPES provides emotional support to children and adults in suicidal crisis or emotional distress. Source: "Crisis Services," Family & Children's Services, accessed February 2022, https://www.fcsok.org/services/crisis-services/.

[9] Input from National Council for Mental Wellbeing, February 2022

documentation that suits the special requirements of crisis contact centers. It fully supports billing encounters, unlike many other systems currently used by other providers.

Examples of Solari's customized technology solutions include:
- **Telephony data integration:** Solari's telephony system sends live call data to the electronic medical record system. This increases data integrity by minimizing the number of fields staff manually complete. The system creates a list of calls that were taken and must be documented, therefore providing a reminder list for documentation
- **Client eligibility data integration:** By using a clearinghouse to automate client eligibility lookups, Solari ensures accuracy of data and allows staff to focus on crisis calls without needing to ask for insurance or funder information
- **Customized, dynamic forms:** The forms are dynamic and adapt based on the call type and what occurs throughout the call. This helps guide staff through the call to ensure complete and appropriate data collection
- **Data integration with external agencies:** The system has the ability to send and receive information with external agencies
- **Dispatch data integration:** An integration function provides a live sync of data with a dispatch management system to convey client data to teams being dispatched on mobile crises

Solari has an information technology department that consistently keeps its contact center equipment and hardware stocked, supported, and updated to support operations. The technology department also includes help desk services that quickly address user issues via a ticketing system. In addition, Solari has an in-house software development team that manages system changes as needed.

While use of automated technology is ideal, it is not needed to enable scheduling, and some providers and contact centers have developed approaches to scheduling without the use of technology.

Resources to build / integrate mobile dispatch technology

Beyond establishing relationships with Lifeline contact centers, organizations with mobile crisis services can support direct linkages between Lifeline contact centers and mobile crisis teams. Real-time dispatch technology enables the contact center to connect directly with the organization's mobile crisis services, as relevant.

According to the SAMHSA National Guidelines, the availability of mobile crisis services should match needs in the area / region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center.[10] Real-time GPS technology can be implemented in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement.

---

[10] SAMHSA, "National Guidelines for Behavioral Health Crisis Care," pg. 28, 2020.

Case study: Solari (Arizona)[11]

Solari developed two methods of electronically communicating client- and crisis-based data points to mobile teams.

Custom mobile team GPS dispatch tracking system

The Dispatch Management System (DMS) enables the following in real-time:

- **Information-sharing with mobile crisis teams** – Once a mobile team is dispatched, the team receives the information related to that dispatch through a mobile application in real-time
- **Tracking of mobile team location** – DMS employs vehicle-mounted hardware that sends GPS location information to track teams in real-time on a map
- **Real-time data entry** – DMS also allows mobile teams to log en-route, on-scene and cleared times in the app, minimizing the need for manual data entry of key reporting data points. These data points are fed back into the EHR and the data warehouse to allow for reporting on the end-to-end experience of the crisis caller

API data integration

Solari technical teams collaborate with mobile team provider agencies to pass client- and crisis service-based data points from Solari's EHR system to their respective EHRs. This also allows mobile crisis providers to receive fields like caller identifiers, eligibility, and the crisis call risk assessment. The providers also send data back to Solari, such as mobile team dispositions, cancellation reasons, and whether police involvement was required. With this technology, Solari holds end-to-end data about the crisis call and related mobile crisis service, enabling extensive data and reporting opportunities.

Case study: Connecticut Department of Children and Families[12]

The Connecticut Department of Children and Families (CT) is exploring the use of integrated mobile dispatch technology platforms that include geo-tracking and real-time appointment scheduling. In the interim, CT has encouraged providers to work on critical successful factors for mobile crisis services. This includes:

- **Knowing their data:** Provider managers are trained to know peak demand during the day (e.g., mid-day, particularly 11am-12pm), during the week (e.g., mid-week), and during the year (e.g., March-April, October-November). This is important for scheduling appropriate staffing levels across sites of care
- **Having flexibility to adjust staffing during peak times:** Providers can adjust their staffing distribution across sites of care, e.g., moving team members from a less busy site of care to a busier site of care
- **Hiring team members to support flexibility:** Providers are required to hire a minimum of 80 percent full time staff to have stability, but are also encouraged to hire additional part-time and per-diem team members who are able to work a

---

[11] National Council for Mental Wellbeing.
[12] Tim Marshall, Director of Community Mental Health at Connecticut Department of Children and Families.

variety of hours, shorter shifts, weekends, and/or nights. Having a deep bench of flexible staff allows the providers to be more responsive to peak times

- **Setting up psychiatric consultation capabilities:** Providers are encouraged to identify ways to have fast, if not immediate, access to psychiatric consultations available to individuals served by mobile crisis teams. At the state level, CT provides funding to the mobile crisis services to pay for psychiatric consultations

2. Linkages to crisis care continuum

There is no wrong door in an ideal crisis system. To best serve individuals in crisis and as part of an integrated crisis system, it is ideal for providers to accept referrals from any source. If the provider is unable to provide appropriate care for the individual, that provider can connect the individual to a provider that can deliver the most appropriate care based on available options.

This section describes:
- Referral processes and practices
- Resources to set up same day access

Referral processes and practices

As part of accepting referrals and providing appropriate care and connection to care to individuals in crisis, providers can evaluate all potential sources of referrals and consider whether or not the provider can accept individuals from or connect individuals to the sites of care.

These sites of care include but are not limited to:

- Mobile crisis services
- Crisis receiving and stabilization services
- Crisis respite facilities
- Urgent care facilities
- Hospitals (EDs, inpatient, and outpatient settings)
- Primary care providers
- Other outpatient sites of care
- Substance use treatment sites of care
- Peer recovery centers
- Jails and law enforcement
- First responders (e.g., emergency medical, fire)
- Community centers and organizations
- 211 centers and other hotlines / warmlines

Beyond connecting to other sites of care, providers can consider updating voicemails and messages that individuals in crisis may engage with and adding a reference to 988 for behavioral health-related emergencies.

In developing specific referral processes for different sources, providers can consider the following practices outlined by the National Council for Mental Wellbeing ('National Council'):

- **Standardized determination of level of care needed:** Individuals should be referred to services based on a standardized determination of the level of care needed.[13] Standard professionally recognized best practice tools permit objective, multidimensional, and quantifiable determination of the appropriate level of service intensity to be provided for individuals in crisis. These include:

---

[13] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, "Roadmap to the ideal crisis system," National Council for Behavioral Health, pg. 60, https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56.

- Level of Care Utilization System (LOCUS) for adults
- Child and Adolescent Level of Care Utilization System (CALOCUS) for children and adolescents
- (Early Childhood Service Intensity Instrument for children aged 0-5
- American Society of Addiction Medicine (ASAM) criteria for SUD crises and treatment needs

- **Standardized risk assessment:** Individualized assessment for suicide risk, violence risk, and medical risk should be completed for each referral[14]

- **Consistency with individual needs:**
  - Referrals should be consistent with the individual's crisis plan or advance directive if available[15]
  - Referrals should be consistent with the use of open dialogue with the person in crisis regarding their own wishes and preferences[16]

Case study: Grand Lake Mental Health Center (Oklahoma)[17]

Grand Lake Mental Health Center, a CCBHC located in Northeast Oklahoma, launched a program to provide iPads to help individuals in crisis immediately connect face-to-face with their crisis line. As a primarily rural state, Oklahoma had traditionally relied on law enforcement to identify and transport people experiencing a MH crisis, defaulting to emergency rooms and inpatient hospitalization. In response, the CCBHC has deployed the "mental-health-machine" [iPads] devices, which are HIPAA compliant and allow patients and first responders to communicate face-to-face with a MH professional.

The program was launched in waves as follows:

- Wave 1: Distribution to law enforcement officers, sheriff's departments, emergency medical services (EMS), and hospitals
- Wave 2: Distribution to local libraries, museums, and other community locations
- Wave 3: Grand Lake is contemplating further expanding the program by putting kiosks with these iPads in places that are open 24/7, like QuikTrip convenience stores (as of July 2021)

Read more about Grand Lake's program here (https://talk.crisisnow.com/in-oklahoma-people-in-need-and-first-responders-get-ipads-for-rapid-face-to-face-mental-health-response/).

Case study: People USA (New York)[18]

People USA and partner organizations have built a robust, integrated behavioral health response for their communities across eight counties. One key to their success is maintaining an up-to-date list of local sites that individuals in crisis can seek out for care

---

[14] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 145-152.
[15] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 136.
[16] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 133.
[17] Stephanie Hepburn, "In Oklahoma, People in Need and First Responders Get iPads for Rapid Face-to-Face Mental Health Response," #CrisisTalk, July 6, 2021, https://talk.crisisnow.com/in-oklahoma-people-in-need-and-first-responders-get-ipads-for-rapid-face-to-face-mental-health-response/.
[18] Steve Miccio, Chief Executive Officer, peopleUSA.

or response. The list encompasses a range of community organizations that may be considered, both traditional (e.g., community providers, addiction providers, hospitals) and nontraditional (e.g., chambers of commerce, police departments, fire responders).

To implement this, a staff member must be accountable for this list and build a process to update it in real time. People USA recommends the list be accessible electronically and in person (e.g., a large board) for people responding to individuals in crisis.

Read more about People USA here (https://people-usa.org/).

Additional information on coordination of care with community systems can be found in the National Council's Ideal Crisis System Report, which includes a summary (page 173), 10 steps for communities (Page 181), and 10 steps for system leaders (page 182) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[19]

Approaches to set up same-day access (SDA)

The provision of SDA for all individuals who seek assistance can help to ensure individuals have rapid access to care and are quickly engaged.[20] The National Council found that **"the longer patients have to wait to get appointments, the more likely they are to go to a different provider. While a same-day appointment has a 10 percent chance of not being kept, almost 25 percent of patients with next-day appointments cancel or simply do not show up. Offering same day access improves operational efficiencies, avoids revenue loss, and allows clinicians to spend more time engaging patients in treatment."[21]**

Same-day access model: A provider that implements same-day-access changes their operating model: individuals are not scheduled individually, resulting in no schedule delays and the elimination of no-shows.

Components of the model include:[22]
- Provider offers blocks of time when an individual can walk in and have an assessment
- When the individual walks in, a clinician completes the comprehensive diagnostic assessment and at least one goal of the treatment plan based on the individual's presenting problem
- Individual leaves with a return appointment for treatment (target: less than eight days) and a psychiatric evaluation appointment (target: three to five days), if warranted

By CCBHC Criteria 2B, individuals are to receive preliminary screening and risk assessment followed by (depending on acuity):[23]
- Immediate action if an emergency (can be telephonic)

[19] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 173, 181, and 182.
[20] Joy D. Fruth, "So You Think You're Doing Same Day Access…," MTM Services and National Council for Emotional Health, February 20, 2020, accessed Feb 9, 2022, https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5e500feaf384a233dd5efdfe/1582305260891/So+You+Think+You%27re+Doing+Same+Day+Access+2-15-20+%28NC%29.pdf.
[21] "Same day access to behavioral health services," National Council for Mental Wellbeing, accessed January 24, 2022, https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/.
[22] Fruth, "So You Think You're Doing Same Day Access," accessed February 2022.
[23] Substance Abuse and Mental Health Services Administration, "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics," page 17, https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

- Initial evaluation in one business day, if urgent (can be telephonic)
- Initial evaluation within 10 business days, if routine
- Comprehensive diagnostic and treatment planning evaluation to be completed within 60 calendar days

Setting up same-day access: To set up SDA, provider organizations can assess their current access-to-care process flows and identify barriers to effective access. As outlined by the National Council, provider organizations can consider:
- "The number of processes, staff, and client time requirements; documentation requirements, including data collection redundancy; and the costing for each access-to-care flow process
- Use of objective flow charts, costing, and data mapping outcomes to increase awareness of change in access-to-treatment processes and practices that can improve access to services
- A standardized access-to-care process flow, including costing awareness"[24]

Results-oriented change techniques include:
- **"Streamlined documentation:** Reduce documentation requirements by focusing on the removal of data elements that are captured repeatedly or not required by funding or accreditation organizations and by changing the answer formats used to capture data elements to reduce overall documentation time
- **Concurrent collaborative documentation:** Eradicate post-session documentation time while increasing person-centered engagement of individuals-in-crisis in their recovery by involving them in the creation of their clinical documentation
- **Walk-in access models:** Implement a zero no-show model to offer more expedient access to care and increased engagement
- **No-show management:** Use policy changes, policy enforcement, engagement specialists, and reminder back-filling programs to help clients increase their show rates and engagement levels
- **Employee engagement and maximization of staff productivity:** Identify ways to get staff to buy in to change so that the organization can achieve its direct-service-staff productivity target" [25]

Case study: Compass Health Network (Missouri)[26]

Compass serves 45 counties in Missouri with a focus on services related to MH and substance use challenges. Before implementing SDA, less than a quarter of initial assessments were completed within 10 days and the average time to first evaluation was nearly three months.

Compass began implementing SDA with the support of MTM Services as part of changes necessary to become a CCBHC (https://www.mtmservices.org/). In their first year, Compass implemented centralized scheduling and began an enhanced data gathering effort to identify challenges and to develop new, responsive training and operational strategies. Compass began to implement SDA in the next year, which required a multi-

[24] "Same day access to behavioral health services," National Council for Mental Wellbeing, 2022.
[25] "Same day access to behavioral health services," National Council for Mental Wellbeing, 2022.
[26] Input from National Council for Mental Wellbeing, February 2022

step training process and, initially, increased staffing as well as enhanced IT infrastructure and workflows.

Compass has now implemented SDA across all 47 locations, doubling the number of first-time clients served and eliminating no-shows. It also increased licensed staff and implemented telehealth capabilities for initial assessments.

	Before SDA	After SDA
Initial assessment done within 10 days	24.5%	100%
Average time to first evaluation	79.8 days	1-2 days
No-show rates for assessment	40-50%	0%
New / first time clients	8,500	15,000+

"We wanted to be able to respond to people when they show up, when they are ready to get help," said Michaela Muehlbach, PsyD, Deputy Chief Clinical Officer at Compass. "When people have to wait for care, they drop out of the system, and we lose the opportunity to help them. We are serving more people, getting them into care quickly, and eliminating no-shows. Same day access is truly a win-win-win."

Read more about Compass Health [here](https://compasshealthnetwork.org/) (https://compasshealthnetwork.org/).

Case study: Recovery Response Center (Durham, North Carolina)[27]

The Durham Recovery Response Center (RRC) is a behavioral health facility providing services that include:

- **Retreat:** 23-hour Observation Unit for 24/7 access to behavioral health assessment, treatment, and referral for persons in crisis
- **Living Room:** Facility-based crisis unit (FBC) for 24/7 access to MH stabilization and non-hospital medical detox
- **Office-based Opioid Treatment (OBOT):** Outpatient treatment or through the crisis facility

RRC accepts walk-ins, police drop-offs, and provider referrals for SDA to SUD treatment service. It also prioritizes full assessments for individuals in crisis, and individuals are assessed within minutes of admission by a registered nurse with a psychiatric background or a master level clinician. Medical and MH assessments are crucial to ensure the recovery of a person seeking same-day SUD services. To ensure SDA, RRC prioritizes flow and engagement. Focusing on prompt engagement from staff allows it to prescribe and receive orders for medications for an admitted guest within four to six hours of admission; these support their SUD concerns. This is particularly important for individuals seeking medication-assisted treatment (MAT).

In addition to being referred by a provider, individuals are able to self-refer and walk-in to the facility 24/7. Additionally, if the person in need of care is suicidal or exhibiting symptoms of substance use and/or MH challenges and does not need emergency medical intervention, first responders may take them directly to the RRC.

Additional Information: Multiple organizations provide resources and services related to SDA:
- National Council for Mental Wellbeing (https://www.thenationalcouncil.org/areas-of-expertise/same-day-access/)
- MTM overview slide deck on same-day-access for CCBHCs (https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5e500feaf384a233dd5efdfe/1582305260891/So+You+Think+You%27re+Doing+Same+Day+Access+2-15-20+%28NC%29.pdf)[28]
- MTM example of a CCBHC in New York that implemented same-day-access (https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5bf58c11c2241b56be160dcb/1542818835505/CCBHC+GRANT+MTM+NCBH_+FINAL2.pdf)[29]

---

[27] Input from RI International, February 2022.

[28] Fruth, "So you think you're doing same-day access," accessed 2022.

[29] Michael Flora and Nancy Manigat, "Where to start as a new CCBHC: Lessons from a first-round CCBHC grantee," https://static1.squarespace.com/static/59c005cd8a02c7dae8cd5e80/t/5bf58c11c2241b56be160dcb/1542818835505/CCBHC+GRANT+MTM+NCBH_+FINAL2.pdf.

3. Crisis care principles

The 988 transition underscores the importance of ensuring crisis systems are able to respond to community needs. SAMHSA's National Guidelines for Behavioral Health Crisis Care lay out a comprehensive view of core services and guidelines for crisis care. [30] This section provides an overview of the key elements covered in SAMHSA's National Guidelines, highlights some specific steps that providers can take to implement key elements into their practice, and offers additional information on how some of these elements have been incorporated by crisis care providers.

Understanding and implementing SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit

Best practice crisis care incorporates a set of core principles throughout the entire crisis service delivery system. These principles offer elements that must be systematically "baked in" to excellent crisis systems as well as the core structural elements that are essential for modern crisis systems.

The SAMHSA National Guidelines principles and practices (the descriptions below contain excerpts from these) include:[31]

1. **Addressing Recovery Needs:** In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. Additional implementation guidance can be found in the SAMHSA National Guidelines on pages 27-28.

2. **Significant Role for Peers:** Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Additional implementation guidance can be found in the SAMHSA National Guidelines on page 28.

3. **Trauma-Informed Care:** Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): Trauma-Informed Care in Behavioral Health Services (TIP 57). Additional implementation guidance can be found in the SAMHSA National Guidelines on page 29.

4. **Zero Suicide / Suicide Safer Care:** The National Action Alliance for Suicide Prevention (Action Alliance) created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC)

---

[30] SAMHSA, "National Guidelines for Behavioral Health Crisis Care," 2020.
[31] SAMHSA, "National Guidelines for Behavioral Health Crisis Care," pgs. 26-34, 2020.

at the Education Development Center, Inc. (EDC). Additional implementation guidance can be found in the SAMHSA National Guidelines on page 31.

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

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

   Additional implementation guidance can be found in the SAMHSA National Guidelines on page 33.

6. **Crisis Response Partnerships with Law Enforcement, Dispatch, and EMS:** Strong partnerships between crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care, justice system diversion, and the elimination of psychiatric boarding in EDs. The absence of comprehensive crisis systems has been the major frontline cause of the criminalization of mental illness and a root cause of shootings and other incidents that have left people with mental illness and officers dead. Collaboration is the key to reversing these unacceptable trends. Additional implementation guidance can be found in the SAMHSA National Guidelines on page 34.

Case study: Compass Health's implementation of the National Guidelines (Jefferson City, Missouri)[32]

Compass Health has taken significant steps to implement the national crisis care principles, with statewide coordinated trainings and resource sharing with peer community health centers. Its close partnership with the state mental health authority (SMHA) enabled Compass Health to create curriculum and training plans that could be used statewide.

The intentional state-level coordination with both other community health centers and the SMHA helped Compass accelerate implementation of the principles and serve individuals in crisis in a more coordinated, best practice-informed way. In addition, the close

---

[32] Joe Parks, Medical Director, National Council for Mental Wellbeing.

relationships between providers, SMHA, and Missouri Department of Public Health built trust, flexibility, and agility into processes.

The partnership between Compass Health, peer community health centers, and SMHA was largely successful because of:

- Comprehensive information-sharing
- Alignment of goals from different organizations
- Consideration of long-term horizons (e.g., one-year later)

Deep dive: Zero Suicide framework[33]

Zero Suicide is a continuous quality improvement framework that shows health and behavioral health care systems how to transform care for individuals at risk for suicide. The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving the safety of individuals in crisis, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.

People experiencing suicidal thoughts and urges often fall through the cracks. Zero Suicide takes a system-wide approach to improve outcomes and close gaps. For health and behavioral health care systems, Zero Suicide represents a commitment to the safety of individuals in crisis, as well as safety and a just culture of support for care providers.

The Zero Suicide model operationalizes the core components necessary for health care systems to transform suicide care into seven elements:

- **Lead**: Leadership support and involvement in Zero Suicide represents a commitment that goes beyond one staff, one supervisor, or one department. Leadership must both help staff see and believe that suicide can be prevented *and* provide tangible support in a safe and blame-free environment—what is known as a just culture. Zero Suicide calls on leaders to use opportunities to improve care driven by data, research and best practices, and feedback from staff, individuals in crisis, and experts alike. This system-wide commitment is vital for the framework to take root and lead to sustainable systems-level changes and better-quality care.

- **Train**: It is essential that all staff members have the necessary skills, which in turn will help staff feel more confident in their ability to provide caring and effective assistance to individuals in crisis with suicide risk. Staff receive training commensurate with their roles in providing safer suicide care. Providers need to ensure that the training contains the following elements:

    1. The fundamentals of the organization's Zero Suicide philosophy

    2. Policies and protocols relevant to the staff member's role and responsibilities

    3. Basic, research-informed training on suicide identification for all staff

    4. Additional training to ensure all clinical staff possess a basic level of skill in assessing, managing, and treatment planning for individuals at risk of suicide, including safety planning and reduction of access to lethal means

---

[33] Barb Gay, Manager of the Zero Suicide Institute at the Education Development Council.

5. Advanced training to deepen skills and increase confidence and effectiveness

- **Identify**: A policy of screening all individuals at intake needs to be established as well as a routine frequency for screening established individuals. Providers should ensure that a comprehensive suicide risk formulation is completed during the same visit whenever a patient screens positive for suicide risk

- **Engage**: Every individual who is identified as being at risk for suicide must be closely supported. By developing a suicide care management plan for individuals so they are engaged and re-engaged at every encounter (no matter the reason for the visit), staff working with these individuals can use these opportunities to instill hope of recovery. The result of active engagement in suicide care is that the individual feels heard, cared for, and empowered to make safe decisions

- **Treat**: Clients with suicide risk must be treated in the least restrictive setting possible. Evidence-based approaches to treating suicidality include interventions and treatment that are designed to target suicide risk directly, which has demonstrated effectiveness in reducing suicidal thoughts and behaviors

- **Transition**: Providers also need to implement follow-up protocols and supportive contacts for individuals in their suicide care management plans. The burden lies on the provider, rather than solely on the individual and family members, to develop methods to ensure that individuals make and keep appointments, and to help them be aware and engaged if they do not

- **Improve**: A well-developed, data-driven quality improvement approach is faithful to both the Zero Suicide model and individual-care outcomes. Continuous quality improvement can be best implemented in a safety-oriented, just culture that is free of blame for individual clinicians when a patient attempts or dies by suicide. Though adverse events may still occur, a learning organization that sees suicide as a never event will derive lessons learned and build new opportunities from that tragedy so that other staff, individuals, and their families may not have to experience similar pain

The Zero Suicide Toolkit details each element, including a description of what each element is, why it is necessary to Zero Suicide implementation, a summary of supporting research, and key readings and tools (https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm).[34] Since 2014, Zero Suicide.edc.org has been an evolving source of free implementation resources and open community support for systems taking on the challenge of Zero Suicide (https://zerosuicide.edc.org/).

The roadmap provided on the Zero Suicide website can help systems begin to implement the model with fidelity (https://zerosuicide.edc.org/about/roadmap).[35] Along with help to determine if Zero Suicide is right for your organization, you will find a guide to getting started.

---

[34] "Zero Suicide Toolkit[SM]," Zero Suicide, Zero Suicide Institute at the Education Development Center, https://zerosuicide.edc.org/toolkit/zero-suicide-toolkitsm.

[35] "Zero Suicide Roadmap," Zero Suicide, Zero Suicide Institute at the Education Development Center, https://zerosuicide.edc.org/about/roadmap.

Examples of impact:

Mental Health Center of Greater Manchester (MHCGM)[36]

MHCGM implemented initiatives to train staff, assess suicide risk in 100 percent of their active cases, and enhance the provision of evidence-based practice. They saw a 44 percent decrease in suicide deaths following their first year of implementation.

Chickasaw Nation Departments of Health and Family Services[37]

Chickasaw Nation Departments of Health and Family Services began implementing in the ED and then expanded to all clinical settings. Standardized screening, suicide risk assessment, collaborative safety planning, and follow-up care practices diverted individuals from admission to inpatient treatment. The department estimated that these diversions have saved over $200,000 per year.

Additional information: Multiple organizations provide resources and services related to Zero Suicide:
- Action Alliance (https://theactionalliance.org/healthcare/zero-suicide)
- SPRC, a project of EDC (https://sprc.org/)
- Additional key results from systems implementing Zero Suicide (https://zerosuicide.edc.org/sites/default/files/2022-01/Zero%20Suicide%20Outcomes%20%281%29.pdf)

Deep dive: Approaches to integrate peers into care

Peers can be integrated across the care continuum, particularly in crisis receiving and stabilization facilities, mobile crisis intervention services, and ongoing coaching and navigation. As stated in the SAMHSA National Guidelines, "one specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities, and compassion of people who have experienced MH crises."[38]

Peer intervention in the crisis setting with suicidal individuals is particularly important in light of the reported 11 percent to 50 percent range of attempters who opt out of outpatient treatment or do not continue outpatient treatment quickly following ED referral.[39]

The SAMHSA National Guidelines outline several key steps to integrate peers into crisis care:

- **Hire:** Hire credentialed peers with lived experience that reflect the characteristics of the community served to the greatest extent possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences, and age.
  - Engaging with peer organizations and advocates in the local community can serve as a helpful starting point for hiring.

---

[36] Barb Gay, Manager of the Zero Suicide Institute at the Education Development Council.
[37] Ibid.
[38] SAMHSA, "National Guidelines for Behavioral Health Crisis Care," pg. 28, 2020.
[39] Ibid.

- o The National Coalition for Mental Health Recovery (NCMHR) has a [list of peer organizations](https://www.ncmhr.org/members.htm) members (https://www.ncmhr.org/members.htm)[40]

- **Train:** Develop support and supervision that aligns with the needs of a program's team members

- **Engage**: Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This can include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members, and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility, crisis respite, and/or alternative sites of care.[41] Many sites integrate peers into the full continuum of care, starting with the initial point of crisis and keeping the same peer support person as the point of contact.

Examples of roles peers have played within provider organizations

Peers have played diverse roles in different crisis programs' service delivery. The following examples highlight ways in which MH and SUD providers have incorporated peers as part of their service delivery model.

Case study: Center for Alternative Sentencing and Employment Services (CASES) and the Nathaniel Clinic (Harlem, NY)[42]

CASES utilizes peers to conduct community work and help with prevention. Areas where peers provide support include crisis responses such as Complete Wellness Recovery Action Plans (WRAP); safety, crisis intervention, and relapse prevention plans; and 24-hour crisis intervention on-call services on a rotating basis.

Peer responsibilities can include:
- Assist client with person-centered goal planning
- Collaborate with client and care management team to identify the services clients should receive based on stage of change, immediate needs, and recommended treatment objectives
- Assess and provide services to clients to address housing, income support, education and vocational training, social supports, employment, and primary care needs
- Assist clients with linkages to and systems navigation within the behavioral health, human services, and criminal justice systems as appropriate
- Act as an advocate and liaison for clients in accessing resources to support service plan goals
- Use motivational interviewing, recovery, and trauma-informed approaches when delivering peer services
- Involve family and significant others in the client's treatment with the team
- Provide individual peer support, wellness counseling, and harm reduction counseling based on motivational interviewing

---

[40] National Coalition for Mental Health Recovery, "Member Organizations and Friends of the National Coalition," 2021, https://www.ncmhr.org/members.htm.
[41] SAMHSA, "National Guidelines for Behavioral Health Crisis Care," pg. 28, 2020.
[42] Daniel B. Fisher, Board President, National Coalition for Mental Health Recovery, referencing information from Billy Green, Project Director, and Lauren Roygardner, Evaluator.

- Provide at least 25 percent of treatment contacts in the community, including accompanying clients to appointments and events (including those actively hospitalized)
- Conduct mobile outreach to clients who unexpectedly disengage from clinic services
- Connect incarcerated persons with telemental health services they can access after release

Case study: Advocates (Massachusetts)[43]

Advocates, a community mental health center (CHMC), has a well-developed peer program that coordinates with the nearby CCBHC and runs a Living Room program, a Community Crisis Stabilization/Respite program, and Mobile Crisis Services.

- **Living Room:** The Living Room was developed to be a completely peer-run crisis alternative for people from anywhere in the community who prefer peer support over other alternatives. It is especially utilized by individuals who have experienced previous trauma in other sites of care. The Living Room has 24/7 staffing by Peer Specialists and Recovery Coaches, and there are no clinical or administrative staff on site. Individuals can stay up to three nights consecutively, and transportation is provided to and from the site if needed. In a survey, 83 percent of respondents indicated that the Living Room had prevented them from having to go to the ED
- **Community Crisis Stabilization / Respite:** This program provides clinical support for individuals in crisis and includes social workers, nursing staff, direct support workers, and one full-time Peer Specialist
- **Mobile crisis services:** Advocates offers mobile crisis services, known as the Emergency Services Program (ESP), for 31 towns in the region. One full-time Peer Specialist is partnered with an ESP clinician in each location to provide peer support to individuals when they ask for additional crisis support. In addition, two full-time Recovery Coaches—peer support oriented to the experience of substance misuse or addiction recovery—work in two local EDs to provide peer support to individuals in the ED

Case study: Burrell's Behavioral Crisis Center (BCC)[44]

BCC houses four treatment programs, all under one roof, including the Rapid Access Unit (RAU), Adult Crisis Stabilization Unit (ACSU), Recovery Services–Social Detox Unit (SD), and Residential Substance Use Disorder (SUD) Program.

Burrell staffs the RAU with 24/7 peer coverage, meaning at least one peer will be assigned to each shift. Burrell defines the peer role as a "Certified Peer Support Specialist." These specialists are people with a background in MH conditions or SUDs or both and a more recent history of successfully maintaining a lifestyle of recovery.

---

[43] Keith Scott, Vice President of Peer Support at Advocates, via Daniel B. Fisher, Board President, National Coalition for Mental Health Recovery.
[44] Email from Bradley Powers, Director of the Burrell Center, via Daniel B. Fisher, Board President, National Coalition for Mental Health Recovery.

Certified Peer Support Specialists:
- Provide non-clinical, strengths-based support and are "experientially credentialed" by their own recovery
- Help to inspire hope that people can and do recover, walk with people on their recovery journeys, and dispel myths about what it means to have a MH condition or SUD
- Provide self-help education and link people to tools and resources
- Support people in identifying their goals, hopes, and dreams, and creating a roadmap for getting there

Peer support workers can help break down barriers of experience and understanding, as well as power dynamics that may get in the way of working with other members of the treatment team. The peer support worker's role is to assist people with finding and following their own recovery paths, without judgment, expectation, rules, or requirements.

In reflecting on the role of peers, BCC Director Bradley Powers said, "In my opinion peers have been a blessing in client engagement and connection, and an immediate impact that I have not seen in the 30+ years I've worked in the MH field. Just in the agency's mission statement alone, there is a specific reference to the value of having PSSs [Peer Support Specialists] in our system "To form meaningful connection and inspire hope," and I believe they are the key to that success. … The people we serve are diverse, and our ability to provide compassionate assistance to everyone who asks is critical to carrying out this mission. Peers' ability to remain objective, non-judgmental, and self-aware is paramount to providing this care. People will enter our doors in a state of crisis, and it is our staff's job to quickly assess their need (sometimes basic human needs) and create an environment and setting that is open, friendly, accessible, and that quickly responds. Crisis is a perceptual state, so the peers' ability to break out of their own, versus biased perception and see through the eyes of each client is the hallmark of creating this [RAU] setting."

Additional resources on incorporating peers into crisis care can be found in the National Council's Ideal Crisis System report (pages 127-128) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[45]

Screening for social determinants of health

Screening for SDOH is a necessary part of the process of level of care determination for MH and SUD crisis. According to CMS, "SDOH are the conditions in the environments where people are born, live, learn, work, play, and age."[46] Providers should screen for and consider the impact of social determinants because an individual's acute crisis is often related to environmental factors in their lives, e.g., what are the aggregating factors such as violence in the home, housing insecurity, and food insecurity. These screening tools are used in addition to the standardized level of care determination tools like: LOCUS for adults, CALOCUS for children and adolescents, and Early Childhood Service Intensity Instrument for children aged 0-5.

Thorough screening for SDOH can contain the following:

---

[45] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 127-128, 2021.
[46] Centers for Medicare & Medicaid Services, "Using Z codes: the social determinants of health (SDOH) data journey to better outcomes," 2021, accessed February 23, 2022, https://www.cms.gov/files/document/zcodes-infographic.pdf.

- **Screening tool:** Standardized criteria that are used to conduct a screening for every client
  - There is no single screening tool for SDOH, but several tools often used in primary care settings can be employed and customized as needed.[47] Screening tools often contain questions related to homelessness, housing insecurity, food insecurity, inability to afford medications, transportation, education, and issues with utilities, caregiving, and employment, among other considerations. O'Gurek and Henke outline three screening tools for a primary care setting:[48]

Tool	Number of questions	Source
The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)	15 core Five supplemental	http://www.nachc.org/research-and-data/prapare/toolkit/
The American Academy of Family Physicians Social Needs Screening Tool	11 (short form) 15 (long form)	**Short:** https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf **Long:** https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-long-print.pdf
The Accountable Health Communities Health-Related Social Needs (AHC-HRSN) Screening Tool	10 core 13 supplemental	https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

- **Continuing case management:** Standardized level-of-care determination criteria can be used throughout each crisis episode, not just at the first contact, and information from a SDOH screening can be included in these determinations. These criteria can be used to determine when clients need to be transitioned to another level of service intensity, whether higher or lower.[49]

- **Coding management:** This activity identifies and tracks social determinants in the reporting of ICD10 Z codes. According to CMS, SDOH-related Z codes "from Z55-Z65 are the ICD-10-CM encounter reason codes used to document SDOH data (e.g., housing, food insecurity, transportation, etc.)." More information can be found in this CMS Infographic (https://www.cms.gov/files/document/zcodes-infographic.pdf).[50] Example Z Codes include:[51]
  - Z55 Problems related to education and literacy
  - Z56 Problems related to employment and unemployment
  - Z57 Occupational exposure to risk factors

---

[47] David T. O'Gurek and Carla Henke, "A practical approach to screening for social determinants of health," *Family Practice Management,* 25, no. 3 (May-June 2018): 7-12, https://pubmed.ncbi.nlm.nih.gov/29989777/.
[48] O'Gurek, "A practical approach to screening for SDOH," 2018.
[49] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 60.
[50] Centers for Medicare & Medicaid Services, "Using Z codes," 2021.
[51] Centers for Medicare & Medicaid Services, "Using Z codes," 2021.

- o Z58 Problems related to physical environment
- o Z59 Problems related to housing and economic circumstances
- o Z60 Problems related to social environment
- o Z62 Problems related to upbringing
- o Z63 Other problems related to primary support group, including family circumstances
- o Z64 Problems related to certain psychosocial circumstances
- o Z65 Problems related to other psychosocial circumstances

Case study: Department of Human Services, Behavioral Healthcare Division (BHD) (Arlington, VA)[52]

A provider of MH and substance use programs, services, and resources, BHD piloted a SDOH screening during the intake of individuals in crisis. The aim of the screening during intake was to capture SDOH information early so it would follow the individual through their meetings with clinicians and be incorporated into treatment plans, rather than emerging over the course of many interactions.

Initially, completion rates for the one-page SDOH screening were high at intake, but during the COVID-19 pandemic, as care was more often virtual, BHD found fewer screenings were being filled in, potentially due to the increased time required to fill out the form for both clinicians and individuals.

BHD used Microsoft Forms to create a screening tool that allowed data to be exported easily into Excel. Additionally, it created forms in multiple languages, including English and Spanish, based on the needs of the local community.

BHD's one page screening can be found in the Appendix. Note the screening tool was written for an adult audience, based on the population served by and services provided by the BHD.

Embedding cultural competence and humility

In addition to following crisis care principles, organizations can consider ways to embed cultural competence and humility into their practices and culture so they can address the needs of all individuals seeking care.[53] Cultural competency can be embedded into all relevant services, needs assessments, screening tools, and trainings.

Providers can:
- Conduct an organization self-assessment with respect to cultural competence and equity (e.g., review practices with the lens of "do the services provided respect and respond to the cultural, linguistic, and other social and environmental needs of the individual.") Practices to review include:
  - o **Needs assessments** that include cultural, linguistic, and treatment needs
  - o **Screening tools and services** that are culturally and linguistically appropriate, and tools / approaches that accommodate disabilities, when appropriate

---

[52] Oliver Russell, Assistant Chief, Behavioral Healthcare at Arlington County, Arlington Department of Human Services.
[53] "CCBHCs and Cultural Competence," SAMHSA, 2022.

-    o **Training plan(s)** that address cultural competence
- Review recruiting practices and prioritize recruiting team members that are representative of the community, understand the community's needs, and/or are able to provide tailored services that may not be addressed, to the degree possible
- Determine how to embed equity considerations into all planning and decision-making
  - Consider starting with a tool such as the Government Alliance on Race and Equity's (GARE's) racial equity toolkit and modifying it to address specific needs of providers[54]
- Conduct analysis of population provider services and how community demographics and needs align with the population that is served
- Disaggregate data to understand access and outcomes

Children, youth, and young-adult related services

To make the promise of 988 a reality for the country,[55] the crisis continuum should be comprehensive and customized for children, youth, and young adults. Some services may need to be tailored to meet their needs. In particular, children's crisis services may not be centered on transporting the individual in crisis to a crisis receiving or stabilization facility. Instead, the most appropriate approach may be de-escalation and stabilization within the home and community. Ideally, every effort should be made to maintain the child or youth in their current environment, when appropriate.

Data collection, sharing, and reporting across the care continuum

National Council's Ideal Crisis System report notes, "Individuals in crisis often move rapidly between services, so information must be effectively shared throughout the crisis continuum. The availability of historical information also contributes to the assessment and resolution of the crisis and is particularly valuable when the individual is unable or unwilling to provide such information to crisis providers. Finally, transmitting information to continuing care providers following the crisis facilitates effective transition planning and reduces the need for redundant and burdensome collection of information" (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[56]

Crisis system data should be gathered to:[57]

1. Efficiently connect individuals in need to care
2. Provide feedback on provider performance
3. Inform crisis system design efforts. Ideally, systems are driven by technology that offers real-time "care traffic control" functioning with transparent sharing of that data throughout the system

---

[54] Julie Nelson and Lisa Brooks, "Racial equity toolkit: an opportunity to operationalize equity," Local and Regional Government Alliance on Race & Equity, September 2015, http://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf.
[55] "988: America's suicide prevention and mental health crisis lifeline," Substance Abuse and Mental Health Services Administration, accessed Feb 22, 2022, https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline.
[56] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 81.
[57] Input from RI International, February 2022

Data collection targets can include:[58]

Service	Data
Mobile Crisis Response	Response time Percentage resolved in the community Percentage escalated to a higher level of care (facility) Disposition (ED, inpatient, crisis facility, outpatient, home, etc.)
Crisis Facilities	Percentage of referrals accepted Number served Referral source (self, law enforcement, EMS, hospital ED, fire, family, outpatient provider) Length of stay Disposition (return to community or transfer to inpatient) Completion of seven-day and 30-day follow-up services
Crisis Call Centers	Number of calls answered Number of text message received and delivered Number of chats received and responded to Call answer time Call abandonment rate Duration of call Percentage of calls originated by law enforcement / first responders Percentage of calls received as 911 transfer Percentage of calls transferred to 911 Percentage of calls transferred to warm line (if applicable) Percentage of calls resolved by phone Reason for call

A sample of reported metrics from Mercy Care (operating as the Regional Behavioral Health Authority and a Medicaid MCO in Arizona) can be found in the Appendix.[59]

To support individuals in crisis, providers can also consider:
- EHR systems and whether current systems best support the organization's goals and population needs
- HIPAA and how to share information as needed and appropriate

Electronic health records: "Efficient and effective EHR in the ideal crisis system and the larger system it serves will facilitate information gathering and treatment planning in communication. In addition, for any providers in the crisis continuum that may not have the resources for an EHR (e.g., a small peer respite provider), clear protocols for information sharing between providers will facilitate collaboration and continuity of care." [60] Additional guidance on criteria for an EHR can be found in the National Council's Ideal Crisis System report (page 81) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[61]

HIPAA: HIPAA allows sharing information for the purposes of referral (which is a key consideration in all crisis system responses) absent patient consent. ONC and CMS interoperability regulations require sharing information with other providers, including for referrals, unless there is documentation that the patient has requested their information not be shared.

---

[58] Input from RI International, February 2022
[59] Input from RI International, February 2022
[60] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 81.
[61] Ibid.

Case study: Behavioral Health Link (Georgia)[62]

Behavioral Health Link's Crisis Now technology solutions that are implemented statewide in Georgia are able to orchestrate connections to care, including:
- 24/7 outpatient scheduling
- Live bed registry
- One-click mobile crisis dispatch
- Robust data analytics

This software solution significantly enhances system efficiency, largely automates care-coordination efforts, and creates transparent insights that support accountability as well as continuous quality improvement efforts.

Case study: DACOTA (Miami, Florida)[63]

The Data Access and Collaboration on Treatment Alternatives program (DACOTA) is a data collection program that collects information in order to improve the way the department responds to people in crisis. [64]
- Treatment history
- Care coordination
- Violence risk
- Recidivism
- MH functioning
- Referrals to treatment

DACOTA is intended to facilitate communication between criminal justice and MH agencies by:
- Developing a shared information database where both criminal justice and MH agencies can each access data systems with summary dashboards and individual treatment histories
- Implementing a co-responder model whereby licensed clinician care coordinators will be in the field with first responder Miami-Dade Police Department (MDPD) Threat Management Section detectives and able to render immediate screenings, continuity of care coordination, and treatment referrals on the scene

---

[62] Input from RI International, February 2022
[63] National Council for Mental Well Being 2021, Roadmap to the Ideal Crisis System, p82
[64] "Miami-Dade County Police Department," The Council of State Government Justice Center, accessed [need date], https://csgjusticecenter.org/projects/law-enforcement-mental-health-learning-sites/miami-dade-county-police-department/, accessed February 2022

Case study: My Mental Health Crisis Plan app

SAMHSA launched an app called "My Mental Health Crisis Plan," which allows individuals who have serious mental illness to create a plan to guide their treatment during a MH crisis. The app provides an easy, step-by-step process for individuals to create and share a psychiatric advance directive (PAD): a legal document that includes a list of instructions and preferences that the individual wishes to be followed in case of a MH crisis, should they not be able to make their own decisions.

My Mental Health Crisis Plan allows individuals with serious mental illness to:
- Clearly state treatment preferences, including treatments to use and those not to use, medications to use and those not to use, preferences for hospitals, and preferences for doctors and other MH professionals
- Decide who can act on their behalf by designating a trusted person (sometimes referred to as "healthcare agent," "proxy," or "health care power of attorney") as a decision-maker for them. Some states require appointment of a decision-maker to carry out the PAD instructions
- Identify whom to notify in the event of a MH crisis
- Share the plan with others, including doctors, other members of the care team, and family and friends
- The app includes state-specific requirements for completing the PAD (such as signatures, witnesses, and/or notary public), and allows it to be shared via PDF or QR code with whomever an individual chooses

My Mental Health Crisis Plan is available in the Apple App Store (https://apps.apple.com/us/app/my-mental-health-crisis-plan/id1497373282) and Google Play (https://play.google.com/store/apps/details?id=org.smiadviser.apa&hl=en_US). Users can view videos on What is a PAD? (https://www.youtube.com/watch?app=desktop&v=0Sc2zdkQ5jI&feature=youtu.be) and How to Use the App (https://www.youtube.com/watch?app=desktop&v=MmHp6XbeDMA&feature=youtu.be). More information is available at www.smiadviser.org/mymhcp."[65]

---

[65] "New SAMHSA app will help people who have serious mental illness to develop a crisis plan," Substance Abuse and Mental Health Services Administration, updated August 9, 2021, accessed Feb 23, 2022, https://www.samhsa.gov/newsroom/press-announcements/202010010505.

4. Access

To make the promise of 988 a reality for the country, the crisis care system must be transformed.[66] To meet the behavioral health crisis needs of individuals across the nation, the system must be able to link those in crisis to community-based providers who can deliver a full range of crisis care services.[67] Providers across the country should work towards being able to serve the full population, regardless of an individual's ability to pay. As part of ensuring access to services for all individuals in crisis, providers can consider how to offer a comprehensive suite of tailored services for groups with unique needs or at higher risk, including offering to coordinate care for services they may not provide directly.

This section describes resources to offer tailored services to groups with unique needs and/or higher risk of experiencing a crisis

Information about tailored services and groups with unique needs and/or at higher risk of experiencing a crisis

Providers should consider how to offer a comprehensive suite of tailored services for groups with unique needs or at higher risk, including offering to coordinate care for services they may not provide directly.

Groups that may have unique needs and/or be at higher risk of experiencing a crisis related to MH and/or SUD include, but are not limited to:
- Children and youth[68]
- Older adults[69]
- People with co-occurring SUD[70]
- People with co-occurring medical conditions / disabilities and/or cognitive conditions / disabilities[71]
- People with cultural / linguistic challenges[72]
- People who live in rural / sparsely populated areas
- People who identify as LGBTQ+
- American Indian or Alaska Native persons
- Other individuals from racial and ethnic minority groups

Effectively serving groups with unique needs necessitates providers think through:

- **Staffing plans:** Staffing plans needs to fully reflect the populations being served
- **Training plans:** Training provided should enable all of the provider's staff to offer culturally-appropriate care
- **Data:** The provider's approach to collecting and analyzing data impacts its ability to view and respond to potential gaps in its coverage of specific populations

---

[66] "988: America's suicide prevention and mental health crisis lifeline," 2022.
[67] "988: America's suicide prevention and mental health crisis lifeline," 2022.
[68] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.
[69] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.
[70] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.
[71] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.
[72] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.

- **Organizational policies:** Providers should consider how policies such as opening hours, appointment availability, and other policies related to the provision of care impact their ability to serve all members of the community

Information about the crisis continuum for many of the groups including considerations and services can be found in the [Ideal Crisis System](#) report (pages 71-77) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[73] It also addresses several specialized services by service type, including:
- Suicide risk screening and intervention (page 145)
- Violent screening intervention threat assessment (page 147)
- Medical screening and triage (page 149)
- Practice guidelines (pages 156-169)

---

[73] Committee on Psychiatry, "Roadmap to the ideal crisis system," pgs. 71-77.

5. Capacity

The 988 transition may result in an increase in the number of individuals seeking assistance, with additional contacts to Lifeline contact centers and behavioral health-related visits to many providers. This section describes ways providers can expand capacity, including medical capacity. It also includes resources about how to set up Mobile Crisis Services and Crisis Receiving and Stabilization services.

Before identifying opportunities to expand capacity, it will be important for providers to understand potential increases in demand associated with the 988 transition. To understand potential demand, they can consider:

- State-level demand projections—for additional information, see the States, Territories, and Tribes playbook
- An estimated population-level monthly need of assistance for 200-230 people in behavioral health crises per 100,000 persons in a community (data is from the Action Alliance) [74]

Additional information: National Council's Ideal Crisis System report covers how to determine geographic access and network adequacy, including time and distance, for receiving a crisis response, as well as wait and travel times for first responders and maximum population (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[75]

Opportunities to expand capacity

There are many flexible solutions that can expand capacity, which include expanding telehealth and creating multi-disciplinary teams.

Telehealth

As outlined by SAMHSA, "Barriers to accessing care include access to appropriate services and providers, stigma associated with SMI or SUD, and competing priorities (e.g., employment and caregiving responsibilities). Telehealth is the use of two-way, interactive technology to provide health care and facilitate client provider interactions. Telehealth modalities for SMI or SUD may be synchronous (live or real time) or asynchronous (delayed communication between clients and providers). Telehealth has the potential to address the treatment gap, making treatment services more accessible and convenient, improving health outcomes, and reducing health disparities."[76]

The benefits of telehealth can be seen across multiple dimensions (improved provider and client experiences, improved population health, and decreased costs). They are described in detail in SAMHSA's Telehealth report on pages 4-6 (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf)."[77]

---

[74] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 48.
[75] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 48.
[76] Substance Abuse and Mental Health Services Administration, "Telehealth for the treatment of serious mental illness and substance use disorders," SAMHSA Publication No. PEP21-06-02-001, page iii, 2021, accessed February 10, 2022, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf.
[77] SAMHSA, "Telehealth for the treatment of serious mental illness," pgs. 4-6, 2021.

Potential interventions / therapies to offer via telehealth: According to SAMHSA, telehealth is effective across the continuum of care for SMI and SUD, covering screening and assessment, treatments, pharmacotherapy, medication management, behavioral therapies, case management, recovery supports, and crisis services.[78] Additional detail about processes and interventions can be found in SAMHSA's Telehealth report on pages 16-25, which describe health outcomes, telehealth-specific outcomes, populations that benefit from the treatment, providers who can offer intervention services, technologies used, intensity / duration / frequency, and lessons learned from transitioning from in-person care to telehealth (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf).[79]

Suicide screening and assessment: Telehealth modalities provide an effective alternative to in-person suicide screening and assessment. The following suicide screening and assessment tools can be implemented through telehealth modalities:

- The Ask Suicide-Screening Question Toolkit (ASQ) from the National Institute of Mental Health (NIMH) is an evidence-based, 20-second, four-question suicide screening tool (https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials)
- The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based intervention to assess, treat, and manage clients with suicidal ideation in a range of clinical settings (https://cams-care.com/)
- Columbia-Suicide Severity Rating Scale (C-SSRS), also known as the Columbia Protocol, can be used to determine whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support the person needs (https://cssrs.columbia.edu/)

If a client is at risk of imminent harm:[80]

1. Assess the immediate danger. If the client is in immediate danger and the provider is unable to detain them or physically intervene, the provider must contact emergency services.
2. Identify the client's location in case emergency services are necessary.
3. Work with other care providers (e.g., suicide prevention coordinators) when contacting emergency services. Remain connected with the client as the client connects with emergency services or while arranging hospitalization.
4. Support clients as they navigate the triage process at an ED. Treatment programs should have safety protocols to mitigate risks and create a workflow to support the client. Providers should determine the suicide risk level with criteria that identify the appropriate clinical response.

Additional information: Best practices and efficacy can be found in SAMHSA's Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders guide (https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP21-06-02-001.pdf).[81]

Examples of virtual health services

If a provider is unable to provide timely services to individuals seeking care, the provider should connect the individual to a provider that can meet their need. Many organizations

---

[78] SAMHSA, "Telehealth for the treatment of serious mental illness," pgs. 16-25, 2021.
[79] SAMHSA, "Telehealth for the treatment of serious mental illness," pgs. 16-25, 2021.
[80] SAMHSA, "Telehealth for the treatment of serious mental illness," pg. 25, 2021.
[81] SAMHSA, "Telehealth for the treatment of serious mental illness," 2021.

have emerged that offer virtual behavioral health services, including Eleanor Health, Brave Health, Included Health, Doctor on Demand, SonderMind, and Mindstrong, among others.

Example: Eleanor Health[82] is a comprehensive, evidence-based outpatient services platform for opioid and other SUDs. Eleanor Health treats addiction as a chronic disease, focusing on clinical and non-clinical factors and providing both human and high-tech support, including MAT.

Example: Brave Health is a virtual, national outpatient behavioral health practice.[83] Brave Health's team includes therapists, social workers, SUD specialists, advanced psychiatric nurse practitioners, and psychiatrists, all of whom deliver virtual care. Its patients' conditions range from low acuity to extremely complex. It uses both human-driven and tech-driven approaches to reach and engage prospective patients quickly and integrate them easily into the healthcare ecosystem. Brave Health also uses data and analysis to drive improvement.

To best serve individuals and improve outcomes in the healthcare system across the acuity spectrum, Brave Health prioritizes speed to care a closed-loop, data-driven approach. Its omni-channel patient engagement strategy has yielded: a 90 percent reach rate (often within 24 hours), a 65 percent opt-in rate, an 80-90 percent kept appointment rate, and seven days to first appointment offered. Brave Health tracks metrics on the individual and population levels and communicates these back to the relevant stakeholders. When it receives a referral from a health plan, PCP, or discharge personnel, it closes the loop with that source and others by providing status updates (reached, opted-in, kept appointment, etc.), thus ensuring no one falls off the radar.

Case study: Alluma (Minnesota)[84]

Alluma, a CCBHC in Northwest Minnesota, uses telehealth to improve timely access to care, regardless of location or weather conditions, and support the maximization of workforce.

Context: Alluma services six geographically large counties (roughly 6,800 square miles) Its CCBHC demonstration catchment area has a total population of 68,000, in addition to the surrounding communities, and it serves 4,200 unique individuals throughout the region annually. Alluma's main office is in Crookston, MN, which is the largest community (7,900 people). The furthest locations it serves are up to one-and-a-half to two hours away. Cold winter weather and the expansive geography make telehealth particularly helpful for clients and the organization.

Incorporation of telehealth into care: Telehealth has been a vital part of providing access to timely services across the region. It is used for assessment, medications, therapy, rehabilitation, peer services, case management, crisis response, and other non-CCBHC services. Alluma's highly trained staff help the client evaluate their telehealth

---

[82] "Compassionate support for your mental health or substance use," Eleanor Health, accessed February 2022, https://www.eleanorhealth.com/.
[83] Anna Lindow, CEO and Co-founder of Brave Health.
[84] Input from National Council for Mental Wellbeing, February 2022

capacity and ensure they have access to technology. It can be at their home or, if they do not have the technology, staff can either send them a device or coordinate with community partners (primary care clinic, library, social services) for them to go to a secure location and connect for their appointments. This allows clients, many of whom experience poverty, the ability to engage in care without needing to travel.

Benefits of telehealth adoption:

- **Increased access:** Brutal winters have historically prevented access to care. With severe subzero temperatures, whiteout conditions, and road closures, staff were unable to safely get to clients' homes and/or clients were unable to travel safely to offices. Alluma recently had to close its office, but was still able to provide many services to clients through telehealth. Care was still offered, staff did not need to take time off, and community partners were still able to access crisis care when it was needed

- **Community partner engagement:** Alluma's 24/7 crisis response team is able to connect with local EDs in the matter of minutes with telehealth. They can quickly conduct crisis assessment, interventions, and crisis planning, instead of waiting for a crisis team member to drive 30-60 minutes to one of the regional hospitals. This has been an asset to the hospitals, clients in crisis, and the crisis team

Creating multi-disciplinary teams

Multidisciplinary teams can help ensure sufficient capacity exists to help individuals in crisis across different levels of acuity. Providers can build teams with a mix of professional and paraprofessional staff and be very efficient in how they use providers' time. Engaging peers, like peer support specialists, in outreach and follow-up work can also expand the capacity of clinical staff. Some providers have had success in expanding capacity by using just-in-time models and exploring different scheduling ones.

Approaches to address medical capacity / manage placement

Providers ideally have plans to ensure that they have the medical capacity to screen for common medical problems across sites of care (e.g., mobile crisis services, crisis receiving facilities) as well as provide appropriate psychopharmacologic intervention for both MH and SUD conditions. For example, for both mobile crisis and crisis receiving services, a common problem is that individuals may be sent to the ED even though they may not meet its threshold—this occurs when no medical staff are available to conduct a medical consultation and make referrals (i.e., screening and triage of low-urgency medical concerns).

Medical capacity needs vary based multiple factors, including population served, existing resources and gaps, etc. A case study of steps that one provider organization took to manage medical capacity is below.

Establishing protocols for the use of psychotropic medications is also critical to a robust crisis system with sufficient capacity to address all individuals in crisis, including people living with SUD. Providers can "implement practice guidelines for the use of psychotropic medications

in crisis settings that are based on the existing evidence-based guidelines that have been promulgated by AAEM and are regularly updated." [85]

Best practices include:
- "Ensuring availability of psychiatric care providers, including nurse practitioners (NPs), physician assistants (PAs), Doctors of Osteopathic Medicine (DOs), and MDs. Either on-site or through telehealth to support every component of the crisis continuum with specific protocols for access and availability, commensurate with the level of acuity of the setting." [86]
- "Establish protocols for psychiatric care provider-to-psychiatric care provider communication and collaboration between crisis settings, and between crisis and community settings. Ensure that community psychiatric care providers are routinely contacted to provide medication information to inform the crisis intervention. Ensure that medication plans are vetted and approved by receiving community psychiatric care providers in order to minimize discontinuity. Identify access to psychiatric care providers for continuity of all types of medications, including clozapine, intramuscular antipsychotics, intramuscular naltrexone, and suboxone."[87]

Additional information: Psychotropic medication practice guidelines can be found in the Ideal Crisis System report on pages 158-159 (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[88]

Case study: Connections Health Solutions (Arizona)[89]

To serve its communities and ensure sufficient medical capacity across the organization, Connections prioritizes:
- **Culture:** Connections' leadership communicates a culture of saying "yes" to individuals in crisis and trying to help all individuals. It believes the organization has a commitment to support as many people as the organization can without putting up barriers and/or passing along individuals in crisis to other sites of care, whenever possible. At Connections, this culture and commitment starts with leadership, who made a statement that the organization is here to have as few barriers as possible and all team members should look for reasons to say yes and provide care to individuals in crisis
- **Team management:** Connections has team members with various levels of experience and credentialing to provide care. Team members are empowered to "work at the top of their license" to ensure that the most credentialed clinicians have capacity to provide care to higher-acuity cases. To support this, Connections staffs Nurses, Nurse Practitioners, and Physicians Assistants 24/7
- **ED coordination and related protocols:** Connections reviewed their protocols to reinforce their commitment to supporting all people in crisis, which included the ones for referring individuals to the ED. It works directly with local EDs to identify when, why, and how individuals in crisis should be transferred and what information should be shared. Its protocols are similar to these recommendations from the American Association of Emergency Psychiatry (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5468070/).[90]

---

[85] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 158-159.
[86] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 158-159.
[87] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 158-159.
[88] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 158-159..
[89] Margie Balfour, Chief of Quality and Clinical Innovation at Connections Health Solutions.
[90] Michael Wilson et al., "American Association for Emergency Psychiatry Task Force on Medical Clearance of Adult Psychiatric Patients. Part II: Controversies over Medical Assessment, and Consensus Recommendations," *Western Journal of Emergency Medicine,* 18, no. 4: (June 2017), 640-646, doi: 10.5811/westjem.2017.3.32259.

- **Standardized assessment and medical clearance:** Connections utilizes a standardized approach to assessment and intervention for medical conditions. One similar approach is the SMART Medical Clearance form (http://smartmedicalclearance.org/forms/).[91] In fact, Michigan has launched a statewide rollout of SMART Clearance (https://mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/).[92]
- **Continuous quality improvement**. Connections has a continuous quality improvement approach that includes:
  - Regularly evaluating data on individuals' referrals to EDs and reasons for their referral to identify patterns with types of cases that the organization could address instead of the ED
  - Maintaining good working relationships with EDs and relevant sites of care to evaluate the types of cases Connections could handle rather than a referral. In one example, it previously sent people with high blood sugar to the ED, but the ED thought Connections could handle those cases. It collaborated with the ED to develop a way to handle people with high blood sugar without referring them further
  - Considering ways to add appropriate capacity to handle more cases, when appropriate, including using telehealth and consultation partnerships with EDs, local primary care providers, and other medical professionals

Resources to coordinate capacity and gaps

Coordinating capacity and gaps requires both: (a) the ability to comprehensively monitor the flow of individuals in crisis through the crisis system, and (b) considering how the organization should be interacting with the community at large and what the gaps are in the community (e.g., conducting a community needs assessment). To coordinate capacity and gaps to serve all individuals in crisis, organizations can consider collaborative, integrated processes and models (e.g., the Collaborative Care model (CoCM)).

Processes to monitor flow of individuals in crisis

As stated in the National Council's Ideal Crisis System Report:
"Processes must be in place to both respond in real-time to fluctuations in demand and barriers to flow and periodically review whether the system has the adequate capacity and operational processes to meet community needs.

It is important to emphasize that community stabilization rates are closely linked to throughput. At each level of care, every effort should be made to stabilize individuals with a plan to continue care in the least-restrictive / least-acute level of care that can safely meet their needs. Not only is this best for individuals, but each person diverted from a higher level of care frees up capacity for those who truly need it, resulting in decreased wait times and more efficient flow.

Recommended metrics to monitor and improve coordination include response times, patient / client satisfaction, and utilization of the appropriate level of care, among others.

---

[91] "SMART Medical Clearance form," 2022, http://smartmedicalclearance.org/forms/.
[92] "MI-SMART Psychiatric Medical Clearance," Michigan Psychiatric Care Improvement Project, accessed February 23, 2022, https://mpcip.org/mpcip/mi-smart-psychiatric-medical-clearance/.

Quality methods involving formal application of quality improvement technology (e.g., LEAN, Plan-do-check-act cycles) are designed to improve process efficiencies and throughput while maximizing the value to and experience of customers and stakeholders. The science of process improvement should be widely adopted." [93]

Conducting community needs assessments

Organizational leadership should have processes in place to analyze the services provided and the needs of the community and with a clear feedback mechanism. The organization should also be attentive and agile in conducting needs assessments so that these assessments are done routinely and in response to needs that may be unpredictable. For example, if an event leads to trauma in the community, the organization should quickly conduct a needs assessment and take action to ensure its service design reflects the needs of the community.

Approaches to set up mobile crisis services and crisis receiving and stabilization facilities

Two core elements of effective, modern, and comprehensive crisis care are[94]
- **Mobile Crisis Services** reach any person and/or individual in crisis in the service area in a timely manner in their home, workplace, or any other community-based location
- **Crisis Receiving and Stabilization Facilities** provide short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment

Mobile Crisis Services include MCTs: "MCTs enable individuals to access care in real time through community-based interventions, wherever an individual is located within the community. The use of trained behavioral health professionals allows for connection to appropriate intervention and resources, and to more effective community stabilization, in the least restrictive setting possible. An overall cost-benefit analysis indicates that mobile crisis services reduce community cost by decreasing unnecessary hospitalizations, reducing hospital readmissions, diverting behavioral-health-related arrests for individuals in acute crisis, and connecting individuals to ongoing supports to deter future crises."[95] Requirements and best practices can be found in the SAMHSA National Guidelines on pages 18-21.[96]

Children's mobile crisis: Mobile crisis services for younger people, often referred to as Mobile Response and Stabilization Services (MRSS), differ from mobile services for adults. MRSS "is a child, youth, and family specific crisis intervention model. MRSS is designed to meet a parent / caregiver's sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis. Caregivers and children are interconnected in their relationship and thus, crisis situations for children significantly impact the parent / caregiver. Although crisis services may be initiated during a behavioral health emergency, a comprehensive array of services and supports is necessary to first de-escalate and stabilize and then to meaningfully engage the child and family in identifying, enrolling in, and accessing appropriate services and supports. MRSS works children and their families to resolve the crisis, identify potential triggers of

---

[93] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 56-57.
[94] SAMHSA, National Guidelines for Behavioral Health Crisis Care, pg. 12, 2020.
[95] Jordan Gulley et al., "Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response Services," Technical Assistance Cooperative and California Health Care Foundation, page 6, January 2022, https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/.
[96] SAMHSA, National Guidelines for Behavioral Health Crisis Care, pg. 21, 2020.

future crises, develop and implement strategies to effectively de-escalate potential future crises, and avert and divert from more restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice." [97]

Building a children's crisis continuum: adult models vs. children / family models[98]

Features	Adult models of crisis intervention	MRSS
24/7 Availability of In-Person Response	x	x
Crisis is Defined by Parent / Caregiver		x
Crisis is Defined by Professional	x	
Focus on Cultural and Linguistic Competence	x	x
Mobile Crisis Intervention / De-escalation	x	x
Onsite face-to-face therapeutic response	x	x
Available within 60 Minutes	x	x
Comprehensive Children's Assessment		x
Specifically, Child- and Adolescent-Trained Staff		x
Interrupts Care Pathway to ED	x	x
Crisis Intervention Worker and Medic Team		x
Partnership with Law Enforcement	x	x
Partnership with all Child Serving Systems		x
Police Joint Response	x	
Contacted by Police with 911 as the Access Point	x	
Single Point of Access		x
Knowledge of Local Resources	x	x
Prehospital MH Crisis Intervention	x	x
Access to Telehealth	x	x
Access to Psychiatric Consultation	x	x
Non-emergency Police Response	x	
Support in the Child's Natural Environment		x
Connection to Community		x
Stabilization Services Provided for up to Eight Weeks		x
Designed to Reduce Reliance on Hospital and Formal Crisis Systems		x
Provides Transportation to ED, Detox, Shelter, etc.	x	
Peer Support as Member of Response Team	x	x

The Technical Assistance Collaborative published a mobile crisis team guide that describes examples of five state approaches to mobile crisis services, including information about funding, coordinating triage and dispatch, availability and capacity, integrating mobile services into the crisis continuum of care, provider selection / contracting / monitoring, and protocols and appropriate roles for law enforcement (https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/).[99]

---

[97] The Institute for Innovation & Implementation at the University of Maryland School of Social Work, "Mobile Response and Stabilization Best Practices," 2021, https://theinstitute.umaryland.edu/media/ssw/institute/national-center-documents/Mobile-Response-and-Stabilization-Model-and-Best-Practice.pdf.
[98] The Institute for Innovation & Implementation, "Mobile Response and Stabilization," 2021.
[99] Gulley et al., "Mobile Crisis Teams: A State Planning Guide," January 2022.

Crisis receiving and stabilization services: Crisis receiving and stabilization services offer the community no-wrong-door access to MH and substance use care and operate much like a hospital ED that accepts all walk-ins, ambulance, fire, and police drop-offs.[100] Requirements and best practices can be found in the [SAMHSA National Guidelines](#) on pages 22-24. Additionally, four different types of crisis receiving and stabilization services can be found in the National Council's [Ideal Crisis System](#) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56).[101] These include urgent behavioral health, intensive community-based continuing intervention, 23-hour evaluation and extended observation, and residential crisis. Several local examples are included in these sections.

Case study: RiverValley & Affiliates (Kentucky)[102]

In setting up their mobile crisis and receiving facilities, RiverValley has chosen to focus on staff quality to ensure the highest levels of service. Specifically, they highlight the importance of:

- **Compensation***:* Mobile crisis services require unique skills that are a combination of crisis-focused clinical skills, good judgement, knowledge of community resources and key leaders, and ability to work under pressure and time constraints. RiverValley suggests providers be open to paying a differential salary of at least 20 percent compared to similar positions, with stipends for on-calls and coverage during holidays. They have also found it helpful to incentivize on-call work with per-diem pay as this type of work can be taxing at times, especially on the weekends, holidays, and in the winter months
- **Safety**: It also recommends a minimum of two staff respond to each crisis, enhanced with GPS location tracking to ensure safety and security
- **Life-work balance***:* It suggests providers allow staff additional MH days. Meet with staff regularly to see how they are doing, especially those who do peer support
- **Training and support:** RiverValley also recommends ongoing training and support to enhance the practice and share ideas with other staff–it is easy to get isolated and burned out given the nature of this work

In addition to a focus on staff, RiverValley has:
- Utilized the 24/7 crisis line as the point of contact and initial screening for mobile crisis. This efficiently determines whether an in-person response is necessary and what response time is needed. Because the crisis line also dispatches mobile crisis runs, it can keep an open channel with mobile crisis staff who are responding out in the community—an additional layer of safety backup
- Paired a licensed clinician and peer support professional for mobile crisis response. Having a case manager or mobile crisis team member with a background in case management is helpful for follow-up work. Any overnight runs requiring referrals or follow-up cases are typically coordinated by the case manager team member
- Prioritized quick response time by ensuring adequate geographical coverage. For example, in its seven-county region, there is an 85-mile span between the farthest two points, an hour and 30-minute drive. RiverValley's team is centrally located so it can respond within an hour. On busy weekends, response is broken up into an east and west team to ensure to rapid responses

---

[100] SAMHSA, National Guidelines for Behavioral Health Crisis Care, pg. 222, 2020.
[101] Committee on Psychiatry, "Roadmap to the ideal crisis system," pg. 100-108, 2021.
[102] Input from National Council for Mental Wellbeing, February 2022

- Focused on coordination to prevent relapses and hospitalizations

Case study: Mobile crisis services (Connecticut)[103]

Connecticut's mobile crisis services (CT) prioritize the following best practices:

- **Rapid face-to-face response:** CT purchases rapid face-to-face service as the typical response and does not do a telephonic triage to determine mobility. The crisis is defined by the caller with the expectations that the face-to-face assessment will begin within 45 min of the call. Prior to the pandemic, the average statewide face-to-face response time for mobile crisis services was 29 minutes (2019) with 93 percent of all calls receiving a mobile face-to-face assessment and 87 percent of all mobile responses made within 45 minutes of the call

- **Follow-up with individuals after a mobile crisis intervention:** After the initial acute crisis is stabilized, the episode of care can continue (with permission of the parents or caregiver) for up to 45 days, providing follow-up support and connecting the client to appropriate longer-term outpatient or other services

- **Use of peers:** Individuals with lived experience can be part of the mobile crisis response and some providers in the state have found having individuals with lived experience can build connections and empathy with individuals in crisis. Parents who in the past have had children who needed behavioral health services and used / needed youth mobile crisis services can build particularly strong connections with parents and caregivers who are currently in a behavioral health crisis

- **Coordination with schools:** CT providers developed formal memorandums of understanding with all the schools in their geographic catchment area and conduct routine outreach, especially with those schools referring students to the hospital EDs for MH assessments

---

[103] Tim Marshall, Director of Community Mental Health at Connecticut Department of Children and Families.

III. Additional Resources

Additional resources for MH and SUD providers are listed below:

Substance Abuse and Mental Health Services Administration (SAMHSA)
> **National Guidelines for Behavioral Health Crisis Care**
> https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
> Crisis care best practice toolkit
>
> **988: America's Suicide Prevention and Mental Health Crisis Lifeline**
> https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline
> Preparing for 988, Frequently asked questions (FAQ)
>
> **Crisis services for Child, Youth, and Family Guidelines**
> Forthcoming

Centers for Disease Control and Prevention (CDC)
> **Health Equity Guiding Principles for Inclusive Communication**
> https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html
> Inclusive communication principles

National Council for Mental Wellbeing
> **Roadmap to the Ideal Crisis System**
> https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56
> Essential Elements, Measurable Standards, and Best Practices for Behavioral Health Crisis Response

National Suicide Prevention Lifeline
> **Our Crisis Centers page**
> https://suicidepreventionlifeline.org/our-crisis-centers/
> Information about crisis centers, their practices, and their locations

Vibrant Emotional Health
> **Vibrant and 988**
> https://www.vibrant.org/988/
> Frequently asked questions (FAQ), Documents for stakeholders, Vibrant statements on 988, and Press releases and statements

Note:

In addition to the sources noted above, this document incorporates information shared during the Mental Health and SUD Providers Working Group meetings of partners of the SAMHSA / NASMHPD 988 co-sponsorship (December 2021 – March 2022).

Appendix

Appendix A: Example SDOH screening tool (Arlington, VA)[104]

Client Contact Information:

Email: _____

First name: _____

Last name: _____

Questionnaire:
1. Are you worried that in the next 12 months, you may not have stable housing?
   - o Yes
   - o No
2. In the last 12 months, has the electric, gas, oil or water company threatened to shut off your service in your home?
   - o Yes
   - o No
3. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
   - o Yes
   - o No
4. Do you have trouble finding or paying for a ride (or any form of transportation)?
   - o Yes
   - o No
5. In the last 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
   - o Yes
   - o No
6. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
   - o Yes
   - o No
7. Do you often feel that you lack companionship?
   - o Yes
   - o No
8. Think about the place you live. Do you have problems with any of the following? (Check all that apply)
   - o Pest such as bugs, ants, or mice
   - o Mold
   - o Lead paint or pipes
   - o Lack of heat
   - o Oven or stove not working
   - o Smoke detectors missing or not working
   - o Water leaks
   - o None of the above

---

[104] Oliver Russell, Assistant Chief, Behavioral Healthcare at Arlington County, Arlington Department of Human Services.

9. In the past year have you or any of your family members been unable to get any of the following when it was really needed (Check all that apply):
   o Food
   o Clothing
   o Utilities
   o Childcare
   o Medicine or any health care (medical, dental, mental health, or vision)
   o Do not have problems meeting my needs
   o Other:
10. Are any of your needs urgent? For example, I do not have food for tonight, I am afraid I will get hurt if I go home today.

_____

_____

_____

_____

_____

Appendix B: Sample of reported metrics for Mercy Care (Arizona)[105]

In central Arizona, Mercy Care (operating as the Regional Behavioral Health Authority and a Medicaid MCO) shares system and provider performance on a regular basis. A sample of their reported metrics can be seen below:

- Total crisis calls
- Percent of crisis calls dispatched to mobile crisis teams
- Average time it takes to dispatch mobile teams
- Total mobile teams dispatched
- Mobile team community stabilization percentage
- Mobile crisis team response time to policy & community
- Number of people treated by an emergency psychiatric center
- Policy drop-offs to all crisis facilities

Total Crisis Calls

Month	Total
Oct	16782
Nov	16290
Dec	16165
Jan	16405
Feb	15637
March	17728
April	19186
May	18422
June	17991
July	17729
August	21379
Sept	18495
Oct	18509

Percent of Crisis Calls Dispatched to Crisis Mobile Teams

Month	Percent
May	11.60%
June	9.80%
July	9.70%
August	9.70%
Sept	11.10%
Oct	10.90%

---

[105] Input from RI International, February 2022

Average Time it Takes to Dispatch Mobile Team in Minutes

Month	Minutes
May	15
June	9
July	7
August	13
Sept	18
Oct	18

Total Mobile Teams Dispatched

Month	Total
Sept	1876
Oct	1818
Nov	1662
Dec	1633
Jan	1638
Feb	1893
March	2015
April	2113
May	2136
June	1767
July	1719
August	2082
Sept	2051
Oct	2025

Mobile Team Community Stabilization Percentage Year Over Year

Legend: 2015, 2016, 2017, 2018, 2019, 2020, 2021

	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
2020	79%	81%	78%	78%	78%	78%	76%	77%	76%	76%	78%	77%
2019	71%	69%	72%/73%	81%	83%	77%	79%	80%	78%	77%	78%	78%
2017	70%	74%	74%	77%	77%	74%	69%	75%	76%	75%	74%	70%
2016	69%	74%	73%	69%	69%	71%	70%	71%	71%	69%	70%	72%
2018	71%	73%	72%	69%	69%	71%	70%	73%	74%	69%	70%	69%
2015	65%	68%	71%	68%	69%	67%	65%	67%	69%	67%	69%	69%
2021	75%	77%	76%	77%	77%	75%	78%	73%	75%/74%			

Crisis Mobile Team Response Time to Police & Community 2020-2021

Legend: Average Response Time Community (Mins), Average Response Time for First Responders (Mins)

	Nov	Dec	Jan	Feb	March	April	May	June	July	August	Sept	Oct
Average Response Time Community (Mins)	42	40	40	44	45	52	53	44	42	52	57	60
Average Response Time for First Responders (Mins)	31	31	31	34	35	35	35	32	35	37	41	38

Number of People Treated by an Emergency Psychiatric Center (RRC, UPC, CPEC)
Year Over Year

Police Drop-Offs to all Crisis Facilities Year Over Year