

ROADMAP TO THE IDEAL CRISIS SYSTEM

Essential Elements, Measurable Standards
and Best Practices for Behavioral
Health Crisis Response

March 2021

ROADMAP TO THE IDEAL CRISIS SYSTEM:

Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response

March 2021

Authored by Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry
Published by National Council for Behavioral Health

CONTRIBUTORS:

Kenneth Minkoff, MD (co-chair)

Jacqueline Maus Feldman, MD (co-chair)

Curtis Adams, MD

Sarah E. Baker, MD, MA

Margie Balfour, MD, PhD

XinLin Chen, MD

Dianna Dragatsi, MD

Michael Flaum, MD

Ann Hackman, MD, MA

Judge Steven Leifman

Stephanie LeMelle, MD, MS

Mark Munetz, MD

Keris Jän Myrick, MBA, MS

Fred Osher, MD

Paula G. Panzer, MD

Joseph Parks, MD

John Santopietro, MD

Yvonne Yang, MD

For additional information, consultation or technical assistance please contact Consulting@TheNationalCouncil.org.

TABLE OF CONTENTS

Forewords	6
Introduction	11
Ideal Crisis Systems: A Framework for Design and Implementation	23
SECTION I: Accountability and Finance	36
• Introduction.....	37
• Structure for Coordination, Collaboration and Accountability.....	40
• Financing.....	42
• Eligibility (All-payer).....	46
• Geographic Access and Network Adequacy.....	48
• Quality Metrics.....	51
• Performance Incentives.....	54
• Flow and Throughput.....	56
• Comprehensive Client Flow Monitoring Data System.....	58
• Formal Assessment of Customer Satisfaction.....	59
• Standardized Utilization Management and Level of Care Determination.....	60
• Relationship to the Rest of the Service System.....	61
SECTION II: Crisis Continuum: Basic Array of Capacity and Services	62
• Introduction.....	63
• Overall Design Elements.....	64
» Value-based System and Program Design.....	64
» Services Address the Continuum of the Crisis Experience.....	66
» Creating Safe Spaces That Are Warm, Welcoming and Therapeutic.....	68
» Safety and Security Practices That Are Both Safe and Welcoming.....	69
» Treating Law Enforcement as a Preferred Customer.....	70
• Population Capacities.....	71
» Age: The Ideal Crisis System Provides a Comprehensive Continuum of Crisis Services for Children/Youth, Adults and Older Adults.....	71
» Crisis Continuum for People With Co-occurring Conditions.....	73
» Crisis Continuum for People With Cultural/Linguistic Challenges.....	76
• Service Components.....	78
» Description of Continuum of Services.....	78
» Continuity of Care and Seamless Vertical and Horizontal Flow.....	79
» Effective Information Sharing Capacity.....	81

- » Client Tracking Through the Crisis Continuum and Beyond.....82
- » Family and Collateral Outreach and Engagement84
- » Outreach and Consultation to Community Providers85
- » Telemedicine, Telehealth and Telepsychiatry86
- Elements of the Continuum.....88
 - » Crisis Center or Crisis Hub.....88
 - » Call Centers and Crisis Lines92
 - » Deployed Crisis-trained Police and First Responders.....94
 - » Medical Triage and Screening.....96
 - » Mobile Crisis.....98
 - » Behavioral Health Urgent Care.....100
 - » Intensive Community-based Continuing Crisis Intervention102
 - » 23-hour Evaluation and Extended Observation104
 - » Residential Crisis Program Continuum108
 - » Role of Hospitals in Crisis Services115
 - » Transportation and Transport.....121
- Staffing Capacity123
 - » Adequate Interdisciplinary Multidisciplinary Team Staffing.....123
 - » Clinical/Medical Leadership and Specialty Consultation125
 - » Peer Support.....127
- SECTION III: Basic Clinical Practice**129
 - Core Competencies for Engagement, Assessment and Intervention.....130
 - » Introduction130
 - » Universal Framework: Welcoming, Hopeful, Safe, Trauma-Informed, Culturally-affirming.....130
 - » Exploration of Open Dialogue as an Emerging Best Practice133
 - » Provider Engagement of Families and Other Natural, Community and Professional Supports.....133
 - » Information Sharing With Family and Other Natural, Community and Professional Supports.....135
 - » Using Crisis Plans and Advanced Directives136
 - » Basic Core Competencies for First Responder and Call Center Staff137
 - » Basic Core Competencies for All Behavioral Health Crisis Staff140
 - Screening and Intervention to Promote Safety143
 - » No Force First: Maximizing Trust and Collaboration, Minimizing Seclusion and Restraint.....143
 - » Suicide Risk Screening and Intervention.....145
 - » Violence Risk Screening and Intervention; Threat Assessment.....147
 - » Medical Screening and Triage.....149
 - » SUD Screening and Triage.....152
 - » Application of Civil Commitment and Assisted Outpatient Treatment (AOT).....154

• Practice Guidelines for Intervention and Treatment.....	156
» Practice Guidelines: Multidisciplinary Teamwork and Case Sharing; Role of Peers	156
» Practice Guidelines: Nonpharmacologic Crisis Interventions.....	157
» Practice Guidelines: Psychotropic Medications.....	158
» Practice Guidelines: Integrated Interventions.....	160
» Practice Guidelines: Co-occurring Medical Conditions	162
• Population-specific Clinical Best Practices	164
» Practice Guidelines: Working With Youth and Families.....	164
» Practice Guidelines: Working With Older Adults and Caregivers	166
» Practice Guidelines: Working With People Living With Cognitive Disabilities and Caregivers	167
• Collaboration, Coordination and Continuity of Care.....	170
» Timeframes/Workflow Within the Crisis Continuum.....	170
» Post-crisis Continuity of Care/Critical Time Intervention.....	171
» Pre- and Post-crisis Planning With Community Providers	172
» Coordination of Care With Community Systems	173
Epilogue	174
Recommendations for Action	177
Conclusion	180
Appendix	184
• Excerpts From Iowa Legislation Establishing Crisis Hubs.....	189
• Community Behavioral Health Crisis System Report Card.....	196
Glossary	201
References	203
Acknowledgments	207
Author Biosketches	208

FOREWORDS

FROM A JUDICIAL PERSPECTIVE

Judge Steven Leifman, 11th Judicial Circuit Criminal Court, Florida

In spite of efforts to improve mental health systems of care, for many decades those living with mental illness have suffered devastating proportions of mistreatment. Deprived of adequate care, appropriate supports, dignity and freedom, their capacity to achieve and maintain recovery has been severely impaired. Overcrowded state hospitals and attempts to honor the civil rights of their occupants led to deinstitutionalization; the overwhelmed, inadequately funded and poorly conceptualized community-based treatment that followed resulted in limited or no access to care. **To this day, insufficient and disorganized resources contribute to decompensation, hospital recidivism and dispositions that put people on the trajectory into the criminal justice system.**

Lack of strategic funding and programming and adherence to treatment guidelines that do not necessarily reflect current best practices have affected certain segments of the population in particularly devastating ways. For many individuals who are unable to access care in the community, the only option is to access care through some of the most costly and inefficient points of entry into the health care delivery system including emergency rooms, acute crisis services and, often, the juvenile and criminal justice systems. **It is interesting to note that while the expenditures in the area of forensic mental health services are often near the top of a state's mental health budget, the level of expenditures on front-end community-based services intended to promote recovery, resiliency and adaptive life in the community are often near the bottom.** Further, people who are receiving the front-end community services that are available still need a full continuum of behavioral health crisis services to respond quickly and appropriately to prevent or minimize adverse outcomes at the times when their mental health and/or substance use conditions may be at risk of decompensation.

Difficult to navigate and inefficient points of entry have resulted in barriers to accessing preventive, routine and competent care, including adequate crisis response. Last year alone, **more than 56% of all adults living with serious mental illness and about 62% of all children living with severe emotional disturbances in need of treatment in the public mental health system had no access to care (SAMHSA, n.d.).** Furthermore, despite recent research that has led to the identification and development of increasingly effective, evidence-based interventions for mental illness and substance use disorders, such treatments have yet to be adequately implemented by many service providers in the public mental health system. Patients seeking care turn to crisis services that are, unfortunately, not available or are insufficient for their needs. The consequences of the failure to design and implement an appropriate system of community-based crisis intervention care for people who experience mental illnesses have been disastrous. Substantial and disproportionate costs shift from considerably less expensive, front-end services in the public mental health system to much more expensive, often more disruptive, back-end consequences of hospitalization, homelessness and/or arrest and incarceration.

The following report was written by the Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. I worked with them before on a project to help psychiatrists and systems of care develop skills and policies to respond to people living with mental illness who have found themselves in the criminal justice system. I am turning to them once again, asking for guidance on how to educate leaders of systems of mental health care, payers, judges, policy planners, legislators and those living with mental illness and their families, about creating a crisis system of care that will facilitate access, enhance assessments, encourage appropriate referrals and **ensure supports are in place to allow for recovery.**

This Committee's response has been to offer this report which defines the essential elements, measurable criteria and best practices as an ideal crisis system. It recommends a redesigned and transformed system of care oriented around ensuring **adequate access to appropriate prevention and treatment services in the community and developing collaborative cross-systems relationships** that will facilitate continuous, integrated service delivery across levels of care and treatment settings. Recommendations are made for the development of a comprehensive and competent mental health crisis system that will prevent individuals from decompensating, instead **quickly and effectively linking them to appropriate services**. Under this ideal system of crisis care, there will be programs incorporating best practices to support adaptive functioning in the community, programs that stabilize these individuals and link them to recovery-oriented, community-based services that are responsive to their unique needs. By designing an appropriate and responsive system of crisis care for individuals living with mental illnesses and/or co-occurring substance use disorders, people will be served more effectively and efficiently. **Public safety will be improved and more costly services will be reduced. Lives will be saved.**

It is my fervent hope that this ideal crisis system will be embraced, endorsed, adopted and funded. My thanks to the committee for their diligence, expertise and commitment.

FROM A CRISIS SERVICE PROVIDER PERSPECTIVE

**Heather Rae, MA, LLP, President and CEO Common Ground
Pontiac, Michigan**

As the CEO of a local comprehensive behavioral health crisis services provider in Michigan, I lead Common Ground, a 50-year-old nonprofit that started as a volunteer crisis line. Our core purpose is "helping people move from crisis to hope." Over the years, we have expanded our crisis continuum in response to community gaps in crisis services. We added crisis stabilization, mobile crisis, crisis legal clinic, victim assistance, sober support, text and chat to our crisis line, crisis residential, crisis parent support partners, youth crisis shelter, support groups and a variety of other crisis services that serve children/families and adults with co-occurring intellectual/developmental disabilities, medical, substance use and mental health challenges.

The Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry provides a much-needed framework to advance local conversations and influence community planning for community crisis services within the context of a system. The report provides the necessary components for each level of the behavioral health crisis system and details about which crisis services are most effective and how they should be organized. Whether the reader is a citizen, crisis provider, emergency services partner, payer or public entity, the guidance is clear and can be implemented at a local level. After all, all crises are local.

As I continue to learn more about the necessary components of a behavioral health crisis continuum, I have come to understand that this conversation is decades overdue when compared to other community-based emergency services. The opioid crisis, increased suicide rate and behavioral health emergency department boarding affect all people and are important reasons to modernize our behavioral health crisis system as a community benefit with accountability, performance standards, adequate funding and in the context of an **emergency services community system – a system built for ALL people, not just those with or without a specific type of insurance.**

As a provider of crisis services, I think this report offers inspiration as well as practical guidance to crisis providers large and small, rural and urban. There is something for everyone to make their local crisis system better. In addition to offering a road map, the ideal behavioral health crisis system offers a vision for what is possible in our communities.

FROM A GLOBAL CRISIS INTERVENTION TEAM PERSPECTIVE

Ron L. Bruno, Executive Director CIT International
Salt Lake City, Utah

Due to an underfunded mental health care system and a common misperception of the danger presented by people with mental illnesses, law enforcement has become the de facto behavioral health crisis response service. However, when law enforcement officers respond to mental health crises, their options to address the situation are limited. Too often, the result is the person in crisis penetrates further into the criminal justice system via arrest or is simply left without intervention or links to behavioral health care.

This is not an indictment of law enforcement. Rather, law enforcement agencies deserve to be applauded for their valiant efforts to fill a gap that an inadequately funded behavioral health care system has created. However, law enforcement cannot repair the failings of the broken crisis system. There will always be a role for law enforcement services in any crisis response system, and every community deserves to have a cadre of specially trained patrol officers to fill that role, but law enforcement should not be the primary gateway into care.

Access to quality behavioral health care services for all members of the community must be a priority. Fortunately, we are starting to see gradual improvements, from only having the option of calling 911 and getting a police officer at your door to being able to call a crisis line for crisis resolution, support and linkage. In some communities, we are seeing the development of non-law enforcement crisis response teams – some involving certified peer providers. Dedicated crisis centers capable of addressing the behavioral health care needs of the person in crisis are being established. While these developments are promising, they exist within a fragmented behavioral health care system where barriers and access disparities are more the rule than the exception.

This report recognizes the need to transform crisis response systems. It clarifies the definition of a crisis response system as being more than just the initial response. It highlights the need to have managed and coordinated processes and services in place to address the behavioral health care needs of all people, in a timely, compassionate and effective manner. This report provides a framework for systemic change.

It is with great hope that this report will bring together governmental agencies, service organizations and communities in a collaborative spirit to transform crisis response systems into true essential services.

FROM A PEER PERSPECTIVE

**Keris Jän Myrick, MBA, MS, Chief of Peer and Allied Health Professions Los Angeles County
Department of Mental Health, Los Angeles, California**

The phone rang on a Saturday in the late afternoon. The voice was distraught, frustrated and scared, “He was taken in by the police and is on a 72-hour hold. He has been there for two days, and I don’t know what to expect.” That Saturday call, like many others I receive, was particularly worrisome for me as a BIPOC (Black indigenous person of color) because the police had been called to respond to mental health crisis of a Black man. Statistics are very clear about outcomes of police interactions with those with mental health conditions and even more devastatingly clear when those interactions involve Black or Brown men and or women. Phone calls and emails like this from around the country are a normal occurrence for me; but they should not be.

When people are in a mental health crisis, what to expect at the basic level of treatment and services before, during and after the crisis should not be a mystery. Instead, people like me, who experience periods of extreme distress and our loved ones rarely know where to turn and when or how to get help. And when help is sought and/or forced upon people, as in police interactions, we are thrown into a dark abyss of the mental health crisis system. How does one avoid the abyss, and when in, how does one get out?

There is a story about a man who fell in a well. Many people tried to help him out, shouting advice from above. Finally, someone crawled down into the well to help. The man exclaimed, “Why would you come down into the well, now we are both stuck?” The person replied, “I was in the well before and I know the way out.” **It takes someone who has been there before** to shine the light in the darkness and lead the way out of the abyss.

I am fortunate that I have made my way out of the abyss of fragmented mental health care with the help of others. I have worked in the mental health field at the local, national and federal level as a peer provider, CEO, advocate and executive. Yet and still, the phone rings and the calls remain the same. So many fall into the abyss. People are lost, their support system confused, without a guiding star or map to help them navigate the systems of care to support their recovery, especially when in crisis. Our crisis system needs help. The people we serve not only need help, but deserve it.

With the keen insights, research and practical experience of a diverse group of providers, peers, family members, payers, researchers and administrators, “The Ideal Behavioral Health Crisis System” was written as a both a vision and practical set of expectations for what crisis systems should be. It is akin to the person in the story who dropped into the well to help the man out - the man in the well symbolizes the system that is in desperate need of help. It is the very type of document we need to not only reduce the confusion, frustrations and fears of those we serve, but also for our systems and the people who work in them. The ideal behavioral health crisis system serves as that beacon of light shining on paths of what can be done to avoid falling into the abyss, in turn leading us to systems that support the journey of **those experiencing a behavioral health crisis to a flourishing recovery trajectory.**

The phone rings....

FROM A FAMILY PERSPECTIVE

Ken Duckworth, Medical Director, National Alliance on Mental Illness

Crisis services represent the best kind of proactive intervention to support recovery and in this way get ahead of an often-difficult illness process. As a psychiatrist, I have come to appreciate that engaged peer-driven services can make a great difference in the arc of a person's recovery process. I became a psychiatrist to help my dad, who was a wonderful man with a very bad illness. Crisis services were something I wouldn't have understood as a young son. I even suspect my family wouldn't have had the wherewithal to figure out that they existed. I now understand how valuable crisis services can be, and how educating the family and their loved ones is essential on how to best use these services.

Even if they existed when I was young, I don't think our family would have been able to use crisis services. As a boy, I felt like I never could recall that my dad even had recurrent episodes of bipolar disorder; so too the rest of my family wanted to forget. Society was also supportive of this kind of amnesia, given how powerful shame and stigma was. I have learned that one thing is true – one must recall the challenge before you can plan for it.

My experience was in the 70s and 80s, in the days before famous people were out with their bipolar disorder and before the National Alliance for Mental Illness (NAMI) became a major force in support and education. The atmosphere was shame-filled, making mental illness hard to recognize, much less proactively plan responses and services. We now live in a time when it is more acceptable to live well with a psychiatric disorder and when families can more easily speak about it. The person living with the challenge and their family have more opportunity to experience it without blame or shame. Now we can plan for it and develop proactive crisis plans before the next episode.

Shame stopped my family from understanding what the options were, but I am sure that the options at the time in my Detroit Ford Transmission plant suburb were either Northville State Hospital or outpatient care. Today, like so many others, Northville State Hospital is closed. Yet today we would likely have proactive ways to identify his triggers, to proactively plan to reduce the frequency and intensity of episodes. If well-funded, designed, and staffed, crisis services could be a major addition to the menu of treatment options. Without the backup of a long-term stay at a state hospital, crisis services could be lifesaving.

As I aged, I recognized discernable patterns in my dad's episodes. There turned out to be an every-other-summer pattern of mania and psychosis. I also came to appreciate there were discernable patterns in dad's speech and behavior when he was beginning to have an episode. This pattern was ideal for proactive planning. The Systematic Treatment Enhancement Program for Bipolar Disorder study later taught me that this kind of pattern is in fact quite common. Crisis services, had they been a resource, would have been a gamechanger for our family.

To be clear, the ability to talk about his illness and get support from NAMI would also have been essential. I think you must be able to see the challenge and to name it in order to plan for it. With a comprehensive crisis service and the ability to name and speak of the challenge, I now see it would have been possible to avoid so many hard moments in our life of police at the door, arrests and court time.

This realization that a major mental illness is something a family can love someone through, plan for and reduce the impact of is something I came to learn as a practitioner and as NAMI's Chief Medical Officer. Let's reduce the number of families and their kids who are living in silence and shame. I learned the hard way that love is a lot, but it isn't enough. A culture of openness and discussion about these hard topics is essential. NAMI is here for you to have that essential element. Proactive and essential services such as crisis services described in this thorough document by the Committee on Psychiatry and the Community for Group for Advancement of Psychiatry are the second half of that crucial equation.

INTRODUCTION

THE CHALLENGE

There is broad recognition that behavioral health crises have reached epidemic proportion, with drug overdoses and suicides having overtaken traffic accidents as the two leading causes of death among young Americans ages 25-44. The COVID-19 pandemic has further underscored the dramatic need for behavioral health services, including crisis services. Yet very few communities in the United States have a behavioral health crisis system that would be considered excellent, let alone ideal.

In most American communities today, the behavioral health crisis system isn't really a system at all, but a combination of services provided by law enforcement and hospital emergency rooms that are typically not designed to meet the needs of individuals in the midst of behavioral health crises. Often the only treatment options for individuals in behavioral health crises are in settings that do not adequately meet their needs despite being extremely costly, such as emergency rooms and inpatient psychiatric units. Further, lack of appropriate and accessible behavioral health crisis response too frequently results in law enforcement being the only available first responders, which may lead to an increase in unnecessary arrest and incarceration for people with acute behavioral health needs.

Thankfully, this situation is changing, as there is growing recognition that behavioral crisis needs special attention to ensure appropriate response for everyone, on par with that provided for medical crises, disaster response, fire response and public safety. Table 1 lists a series of reports over the past decade that describe various components of state-of-the-art behavioral health crisis services. Among the most recent is a toolkit from the Substance Abuse and Mental Health Services Administration (SAMHSA) that proposes national guidelines for crisis services (SAMHSA, 2020). Another important driver has emerged from work on reducing inappropriate criminal justice involvement, recognizing the need for focus on "Intercept O" (an effective community crisis system) in the Sequential Intercept Mapping process (Bonfine, 2019) so that law enforcement involvement in behavioral health crises is minimized. Even more important, federal legislation (National Suicide Prevention Hotline Improvement Act) has led to the initiation of implementation of a national suicide prevention and behavioral health crisis line number - 988 - that is intended to go live nationally by 2022. This major initiative provides an opportunity for the creation of high-quality community crisis response systems that approximate the level of response that we have grown to expect from medical, fire and public safety emergency response since the implementation of 911 several decades ago.

For communities to respond to the need for effective behavioral health crisis response and to implement successful 988 response systems, significant guidance will be needed. Existing reports, such as the SAMHSA guidelines, provide helpful direction for making progress but do not address all the essential elements of a behavioral health crisis system or measurable standards and implementational strategies for communities. Consequently, communities (as well as counties and states) have inadequate guidance regarding the development, implementation and maintenance of behavioral health crisis systems that effectively meet their specific population needs.

The purpose of this report is to fill that gap. This report provides a detailed guide for communities to use to create a vision and direction for their behavioral health crisis systems, to evaluate their current behavioral health crisis capacities and to operationalize a strategy for implementing structures, services and processes that move toward an ideal crisis system.

Table 1. Recent Reports on Behavioral Health Crisis Services and Systems: (Full citations in the bibliography)

- SAMHSA (2009). Practice guidelines – Core elements in responding to MH Crises.
- SAMHSA (2014). Crisis services – effectiveness, cost-effectiveness, and funding strategies.
- National Suicide Prevention Lifeline (2014). Lifeline best practices for helping callers.
- Suicide Prevention Resource Center (2015). Zero suicide toolkit.
- National Action Alliance for Suicide Prevention (2016) Crisis now: Transforming services is within our reach.
- Meadows Mental Health Policy Institute (2016, December). Behavioral health crisis services: A component of the continuum of care.
- National Association of State Mental Health Program Directors (NASMHPD) and Treatment Advocacy Center (2017, October). Beyond beds: The vital role of a full continuum of psychiatric care.
- **NASMHPD (2018, August). A comprehensive crisis system: Ending unnecessary** emergency room admissions and jail bookings associated with mental illness. (Assessment Paper No. 5).
- NASMHPD (2018 August). Making the case for a comprehensive children’s crisis continuum of care. (Assessment Paper No. 8). TBD Solutions (2018). Crisis residential services best practices handbook.
- U.S. Department of Veterans Affairs (2018). National strategy for preventing veteran suicide: 2018-2028.
- National Suicide Prevention Lifeline.org (February 7, 2019). National suicide hotline improvement act: The SAMHSA report to the Federal Communication Commission.
- Policy Research Inc. and National League of Cities (2020, January). Responding to individuals in behavioral health crisis via co-responder models: The roles of cities, counties, law enforcement, and providers.
- **SAMHSA (2020). National guidelines for behavioral health crisis care – a best practice toolkit.**
- **NASMHPD (2020). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies**

RESPONDING TO THE CHALLENGE

The Committee on Psychiatry and the Community for Group for Advancement of Psychiatry (GAP) accepted the challenge by Judge Steven Leifman (a member of our Committee) to define understandable, achievable and measurable expectations for ideal behavioral health crisis system performance, so any community can know what its crisis system should be and take steps over time to achieve that goal. The National Council for Behavioral Health has partnered with GAP to publish and distribute this important material, both for the benefit of its member organizations, many of whom are assuming leadership roles in developing community behavioral health crisis systems, as well as for the benefit of the many stakeholders nationwide who are committed to improving behavioral health services.

This report is based on the available literature on best practices for behavioral health crisis services as well as on the experiences of the authors and other informants who are currently operating effective behavioral health crisis services and designing innovative behavioral health crisis services and systems.

However, an ideal crisis system cannot be designed solely from the perspective of psychiatrists. Multiple perspectives informed this report through provision of direct feedback and input, including individuals who have experienced behavioral health crisis services, often in very traumatic ways: family members of people in need, law enforcement, behavioral health crisis providers, other human service providers; county and state leaders, community advocates and public and private funders. This continuum of input is needed to identify what an ideal behavioral health system consists of and to establish a consensus for action that will result in every community in the US having such a system to meet the needs of its population. The Committee is particularly grateful for the contribution of Keris Myrick, formerly director of the Office of Consumer Affairs for SAMHSA, and discipline chief for peer services in the Los Angeles County Department of Mental Health, who served as a consultant to the Committee. Additional stakeholders who contributed to this report are [acknowledged](#) on page 207.

DEFINITIONS

Establishing Acceptable Definitions: What Constitutes An Ideal Behavioral Health Crisis System?

This report endeavors to describe an ideal crisis system, not just a minimally adequate crisis system. But does it make sense to define an ideal crisis system when many states and counties do not have the additional resources even to create minimal crisis services in every community? Not only does it make sense, it is also imperative.

As a society, we do not view behavioral health crisis services as an essential community service, as we view police, fire, emergency medical services (EMS) and emergency medical care. Historically, the problems of people with mental illnesses, substance use disorders and cognitive disabilities (e.g., acquired brain injury) were not the responsibility of the community. Those were things that happened to “other people.” “Someone else” funds these services. Fortunately, as noted above, **society is beginning to recognize that behavioral health crises are common and can happen to anyone** – to any individual or family – just like crime, fire, flood and emergency medical events. Communities are further recognizing that failure to respond properly to these crises is dramatic in its personal, social and economic cost, resulting in incarceration, devastation, homelessness and death. As a society, therefore, our collective perspective is changing about how behavioral health crisis services should be prioritized.

To describe a vision for an ideal behavioral health crisis system, it is first necessary to define terms.

What is Behavioral Health?

As used in this report, behavioral health is a term of convenience that refers to both mental illnesses and mental health needs (e.g., trauma) and substance use/addictive disorders and substance use needs and issues, as well as to the overlap of those behavioral health issues into primary health, cognitive disabilities, criminal justice, child welfare, schools, housing and employment, and to prevention, early intervention, treatment and recovery.

Behavioral health also includes attention to personal behaviors and skills that impact general health and medical wellness as well as prevent or reduce the incidence and impact of chronic medical conditions and social determinants of health. We are aware that many stakeholders appropriately take issue with the term behavioral health because of its implication that the problem is that people are behaving badly rather than that they are suffering from a combination of medical conditions, trauma and other social and environmental challenges. Nonetheless, with that caveat in mind, for the sake of convenience and for want of better terminology, we will utilize that term throughout this report.

What is a Behavioral Health Crisis?

Behavioral health crisis refers to any event or situation associated with real or potential disruption of stability and safety as a result of behavioral health issues or conditions. Crisis, as used here, does not only refer to situations that require calling 911 or 988. A crisis may begin at the moment things begin to fall apart (e.g., a person runs out of psychotropic medication and cannot obtain more, or is overwhelmed by urges to use substances they are trying to avoid) and may continue until the person is safely re-stabilized and connected or re-connected to ongoing supports and services. Crisis requests may be initiated by an individual, a caregiver or a service provider, as well as by any concerned person observing someone in need. Crisis systems and services should ideally be positioned to respond to any type of crisis request as soon as possible to prevent deterioration and for as long as necessary to help people in need stay safe and keep making progress, just like other community services.

What is a Behavioral Health Crisis System?

A behavioral health crisis system is more than a single crisis program, such as a mobile crisis team, a psychiatric emergency service or a crisis residential unit, and more even than just a few of those distinct elements. The term refers to an **organized set of structures, processes and services that are in place to meet all the urgent and emergent behavioral health crisis needs of a defined population in a community, as soon as possible and for as long as necessary. In short, a crisis system involves an array or continuum of components, processes and services managed collaboratively and interlinked.** The target population for the system of services is ideally defined geographically, as a state, county, multi-county region or city, although other mechanisms (e.g., covered lives) may be used at times. Successful systems require multiple layers of organization and partnership based on ongoing collaborations within the community to address the behavioral health crisis needs of the population of the community.

The concept of a crisis system in this report is intended to be distinguished from the routine system of short-term or ongoing care, although the two must necessarily interact seamlessly for service users and providers alike. Even an ideal crisis system cannot succeed without adequate access to good quality routine care to hand people off to once their crisis is resolved and to meet the behavioral health needs of the majority of the community before they fall into crisis.

What is an Ideal Behavioral Health Crisis System? THE GOAL!

In an ideal behavioral health system, every individual and family with behavioral health issues can receive services that are helpful and effective quickly and easily for as long and as intensively as needed to achieve the best possible results for a successful and meaningful life. "Ideal" as used here does not mean perfect, nor does it assume unlimited resources. It refers to a set of recommendations or criteria any community can use to determine how to invest resources to achieve the best overall outcomes and to incorporate the known best practice processes, programs and practices that would contribute to the achieving the best possible results, as effectively, efficiently and flexibly as possible.

These definitions lead to the aspirational vision for this report.

THE VISION

An excellent behavioral health crisis system is an **essential community service, just like police, fire and EMS**. Every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as it expects for other essential community services.

A behavioral health crisis system is more than a single crisis program. It is an organized set of structures, processes and services that are in place to meet all types of urgent and emergent behavioral health crisis needs in a defined population or community, effectively and efficiently.

While no system will ever likely reach the ideal, the aspirational goal is, “Every person receives the right service in the right place, every time.”

ACHIEVING THE VISION

For communities across the US to transition from minimal behavioral health crisis services toward an ideal system, there must be a blueprint that contains all aspects of an ideal crisis system along with measurable performance criteria that communities can use for ongoing assessment of their progress through a continuous quality improvement process. The blueprint can provide a framework for community leaders (e.g., county executives, behavioral health system administrators, health system leaders, judges), funders (e.g., state agencies, Medicaid, commercial insurers, managed care organizations, accountable care organizations, counties, cities, community foundations) and other stakeholders (e.g., behavioral health providers, other human service providers, emergency responders, law enforcement, people and families receiving services) to come together to develop a shared vision of an excellent crisis system for their community, a set of shared values and action steps for making progress.

This report describes the criteria of an ideal behavioral health crisis system as a blueprint for any community to follow to establish community crisis services for individuals and families with mental health and substance use needs that are on par with other essential community services that respond to other types of crises.

WHO SHOULD READ THIS REPORT?

- Those who plan, administer, fund and regulate systems of care.
- Behavioral health and human service providers, service recipients and advocates for whom quality care is paramount.
- All stakeholders, including legislators, state and county administrators, health systems, judges, law enforcement and other first responders.
- Anyone who is interested in thoughtful and reasonable opportunities to support the transformation of community responses to behavioral health crises from unprepared chaos to best practice.

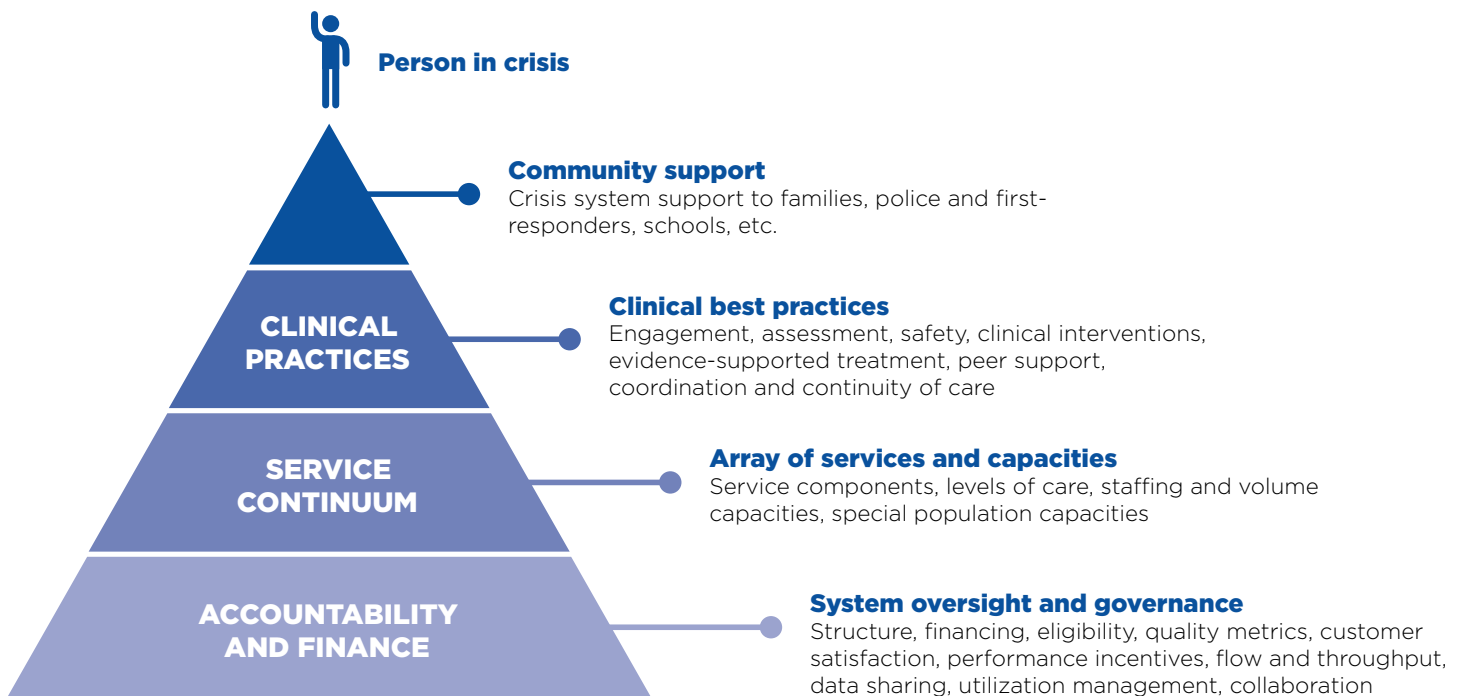
READING THE REPORT

The report begins with an organizing framework that describes how to build an ideal crisis system that is “person-centered” and “customer-oriented”, inclusive of a foundational set of values and operational principles. (Link to Framework, Values, and Principles Chapter).

The report delineates how implementation of successful systems requires three interacting design elements, along with measurable indicators for the components of each. These three interacting design elements provide the structure for the three major sections of this report.

- Section I: Accountability and Finance
- Section II: Crisis Continuum: Basic Array of Capacities and Services
- Section III: Basic Clinical Practice

The following provides a brief introduction to these three sections, along with key takeaways from each.



Section I: Accountability And Finance

An ideal behavioral health crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum.

This continuum of services is responsible for and responsive to a designated community or catchment area (depending on the nature of the area's geography), and each state, county or community will have a mechanism for allocating responsibility and accountability. This section defines the concept of an accountable entity, which is a structure that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.



FINANCING



FLOW AND THROUGHPUT



ELIGIBILITY (ALL-PAYER)



COMPREHENSIVE CLIENT TRACKING DATA SYSTEM



GEOGRAPHIC ACCESS AND NETWORK ADEQUACY



FORMAL ASSESSMENT OF CUSTOMER SATISFACTION



QUALITY METRICS



STANDARDIZED UTILIZATION MANAGEMENT AND LEVEL OF CARE DETERMINATION



PERFORMANCE INCENTIVES



RELATIONSHIP TO THE REST OF THE SERVICE SYSTEM

Section I: Key Takeaways

- **There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.**
- **There is a behavioral health crisis system coordinator and a formal community collaboration of funders, behavioral health providers, first responders, human service systems and service recipients.**
- **There is a stated goal that each person and family will receive an effective, satisfactory response every time.**
- **Geographic access is commensurate with that for EMS.**
- **Multiple payers collaborate so that there is universal eligibility and access.**
- **There are multiple strategies for successfully financing community behavioral health crisis systems.**
- **Service capacity of all components is commensurate to population need.**
- **Individual services rates and overall funding are adequate to cover the cost of the services.**
- **There is a mechanism for tracking customers, customer experience and performance.**
- **There are shared data for performance improvement.**
- **Quality standards are identified, formalized, measured and continuously monitored.**

Section II: Crisis Continuum: Basic Array Of Capacities And Services

An ideal behavioral health crisis system has comprehensive array of service capacities, a continuum of service components and adequate multi-disciplinary staffing to meet the needs of all segments of the population.



OVERALL DESIGN ELEMENTS



ELEMENTS OF THE CONTINUUM

(see inset below)



POPULATION CAPACITIES



STAFFING CAPACITY



SERVICE COMPONENTS

Elements Of The Continuum



Crisis Center or Crisis Hub



Intensive Community-based Continuing Crisis Intervention



Call Centers and Crisis Lines



23-hour Evaluation and Extended Observation



Deployed Crisis-trained Police and First Responders



Residential Crisis Program Continuum



Medical Triage and Screening



Role of Hospitals in Crisis Services



Mobile Crisis



Transportation and Transport



Behavioral Health Urgent Care

Section II: Key Takeaways

- **The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.**
- **Family members and other natural supports, first responders and community service providers are priority customers and partners.**
- **Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.**
- **There is capacity for sharing information, managing flow and keeping track of people through the continuum.**
- **There is a service continuum for all ages and people of all cultural backgrounds.**
- **All services respond to the expectation of comorbidity and complexity.**
- **Welcome all individuals with active substance use in all settings in the continuum.**
- **Medical screening is widely available and is not burdensome.**
- **There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.**
- **Telehealth is provided for needed services not available in the local community.**
- **Program components are adequately staffed by multidisciplinary teams, including peer support providers.**
- **There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.**

Section III: Basic Clinical Practice

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.



**CORE COMPETENCIES FOR
ENGAGEMENT, ASSESSMENT
AND INTERVENTION**



**POPULATION-SPECIFIC
CLINICAL BEST PRACTICES**



**SCREENING AND
INTERVENTION TO PROMOTE
SAFETY**



**COLLABORATION,
COORDINATION AND
CONTINUITY OF CARE**



**PRACTICE GUIDELINES
FOR INTERVENTION AND
TREATMENT**

Section III: Key Takeaways

- **The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.**
- **Engagement and information sharing with collaterals is an essential competency.**
- **Staff must know how to develop and utilize advance directives and crisis plans.**
- **Essential competencies include formal suicide and violence risk screening and intervention.**
- **“No force first” is a required standard of practice.**
- **Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.**
- **Utilizing peer support in all crisis settings is a priority.**
- **Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.**
- **Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.**
- **Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.**

WORKING EXAMPLES

Throughout this report, we have inserted textboxes highlighting working examples of progress at multiple levels. The Appendix contains more detailed examples of system level progress.

Examples include:

- Communities that have organized to develop excellent behavioral health crisis systems: Pima County (Tucson), Arizona.
- Statewide legislation to define a crisis system vision: Iowa's crisis access standards.
- Statewide efforts to establish best practices: Michigan's guidelines for medical screening.
- National efforts to expand resources and expectations for community crisis systems: Certified Community Behavioral Health Clinics (CCBHCs).

USING THIS REPORT TO IMPROVE COMMUNITY CRISIS SYSTEMS: 10 STEPS FOR COMMUNITIES; 10 STEPS FOR POLICY MAKERS

The intent of this report is to provide guidance for action both at the community level and at the system leadership and advocacy level.

It includes specific recommendations for action steps that can be taken to advance the development of ideal behavioral health crisis systems at the state and local level: [10 Steps for Communities](#) and [10 Steps for System Leaders and Advocates](#). In addition, the Behavioral Health Crisis System Report Card in the [Appendix](#) incorporates the essential elements and measurable indicators in this report into a self-assessment scorecard which can be used to evaluate the current baseline in any community and measure progress over time.

How to proceed. This document deals with complex systems of care and is designed for stakeholders who desire radical change yet understand the need to proceed in small steps. Those who utilize the criteria incorporated in this report can delve into each section in as much detail as may be relevant to their own system. The baseline crisis system status, the level of change desired and the degree of community collaboration that has been developed will inform the level of detail with which each reader or community will use each recommendation and the approach to measuring its successful attainment.

All stakeholders can and should be engaged in participating in crisis system design and development: legislators, payers, state and local policymakers, service providers, researchers, service recipients, family members, judges, advocates and community members. We hope that by defining the ideal crisis system, we can stimulate activity at many levels to help every community identify next steps of progress toward that ideal system and to have the impetus and inspiration to keep going until its behavioral health crisis system is as close to the ideal as possible.

No matter what your community's level of progress in developing a behavioral health crisis system, this document will help you and your community make progress. As you read this report, you and your community partners can assess your current baseline and use this document as a roadmap for what you eventually want your behavioral health crisis system to become and to identify the next achievable steps on your journey. Each time your community makes a little progress, give yourselves a round of applause, then go back to the document and identify your next steps...AND KEEP GOING. Our goal is that communities and systems all over the U.S. use this document to guide their progress to achieve the vision described at the beginning of this chapter.

This is a process of progress TOWARD perfection. Do not be discouraged if your community has a long way to go. We recommend further that communities and systems do not hesitate to ask for help (e.g., consultation, technical assistance) at any step, in order to facilitate progress by contacting Consulting@TheNationalCouncil.org. The journey toward developing ideal crisis systems will be a new venture for most communities and outside facilitation may be needed to help the community or state come to consensus on the best path to reach their goals.

No matter where you are in the continuum of crisis system development, our hope is that you can use this document to assess your level of progress and find your next steps forward in the spirit of continuous improvement.

IDEAL CRISIS SYSTEMS: A FRAMEWORK FOR DESIGN AND IMPLEMENTATION

THE FRAMEWORK FOR DESIGNING AN IDEAL CRISIS SYSTEM

The framework for designing an ideal crisis system for any community begins with the aspirational vision: Every person gets the right response, in the right place, every time.

Therefore, the design process must begin by putting the customers in the center of the framework and articulating a set of principles and values that guide every aspect of their experience.

The next challenge is to identify the “right response” to delineate the best practice (evidence-based and experience-based) crisis intervention services that individuals, families, collateral caregivers and first responders (the customers) are provided and to align those best practices with these customer-oriented principles and values.

Next, it is important to identify the “right place” to delineate a comprehensive continuum of crisis capacities and components that match the diverse crisis needs and presentations of the population.

Finally, it is important to have a system that responds to everyone, rather than a disconnected set of components or different responses for different populations. This requires a mechanism for system design and oversight, including adequate financing, performance monitoring and quality improvement to ensure that the “right response” is provided in the “right place, every time.” This process of oversight requires delineation of measurable criteria for each element of the system, as well as an implementation process that is governed by best practices of system performance management and continuous quality improvement.

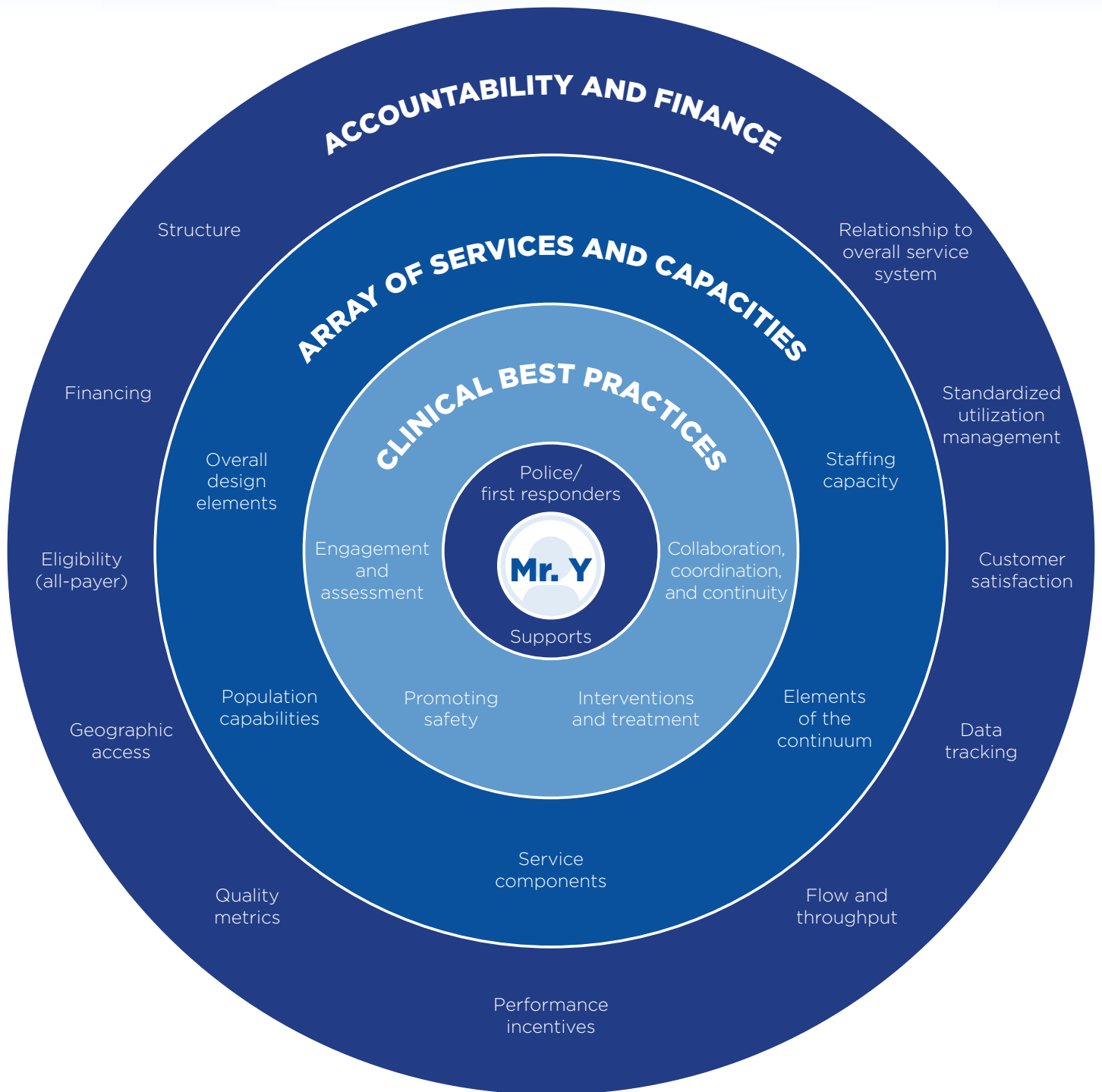
This chapter describes each component of this framework.

In almost every community, successful EMS 911 response is organized under a collaborative framework for accountability and finance, including an array of necessary service components and partners (e.g. various types of EMS transport and emergency facilities), with a quality improvement framework for best practice emergency medical care designed to ensure every person receives the “right response, in the right place, every time.”

VISUALIZING THE FRAMEWORK

The framework for the ideal behavioral health crisis system therefore places the person in the center, the collateral caregivers and the first responders surrounding the person and three interactive design elements within its overall framework, as illustrated in the following diagrams.

1. **Accountability and Finance**
2. **Crisis Service Continuum with a Comprehensive Array of Capacities and Services**
3. **Clinical Best Practices for Crisis Intervention**



This illustration depicts three major design elements that have multiple sub-elements within them, all of which are described within sections of the report corresponding to each major element, along with their rationale, evidence-base and measurable indicators of successful implementation.

These major design elements envelop the primary consumer and their supports and first responders, which are elaborated upon in the following figure:

PERSON IN CRISIS



A PERSON-CENTERED CUSTOMER-ORIENTED APPROACH

The people the system serves are at the center of the framework. This includes the primary customers – those experiencing the crisis, their families and/or natural supports and other secondary customers, such as those who may have been involved in helping them contact the system, such as police and other first responders, as well as those community supports involved in helping them through the crisis.

While documentation of crisis services in the medical literature and available research on evidence-based crisis intervention practices have a place in this report, understanding the experience of real people is imperative. An ideal crisis system must be defined first and foremost by how individuals and families in need are served when they are in crisis. All standards, guidelines, criteria, components and interventions must be developed with the goal of creating excellent experiences for the individuals and families served, as well as for the many people who may participate in serving them. Within that “person first” perspective, all available research, clinical evidence and best practice experience for how to design and deliver effective and efficient crisis systems and services are included.



For economy of wording, throughout this report, families, friends, other natural supports, and community service providers and supports connected to a person in crisis are often referred to as collateral contacts or collaterals. Primary customers are individuals in crisis and their collaterals. All criteria and interventions are developed to provide high quality experiences as the goal for primary and secondary customers. Stories of people with both good and bad crisis service experiences are used throughout the report to help understand and illustrate the gap between what people often currently receive as a crisis response and what they should receive.

The central story of Mr. Y is described here in detail in this section and serves as a connecting thread throughout the report. Mr. Y is introduced here in the context of having a serious behavioral health crisis in a system that is far from ideal.



The Foundation: The Story of Mr. Y

The following story is both tragic and absurd. It is based on the experience of a real person in a large American city, but the details have been changed. The story is from the perspective of law enforcement and the justice system. Please take a moment to imagine how frightening this whole experience was for Mr. Y.

Mr. Y is a 24-year-old man who was arrested at a convenience store on a Friday afternoon for eating multiple bananas without paying for them. When the clerk demanded payment, he refused and became increasingly argumentative, so the clerk called the police. Police officers found a disheveled young man standing in a corner clutching a banana that he pointed at the officers as if it were a weapon. He remained uncooperative and illogical, yelling that the store clerk and the police were “in on the plot” and “out to get” him. He became combative when police attempted to handcuff him and had a blunt of marijuana in his possession. When the officers reviewed his record, they noted two recent previous calls, one for a similar incident and another for vagrancy. On both occasions he was given warnings.

This time, he was arrested and taken to the local jail where he remained agitated, uncooperative and

disorganized during the booking process and during a night in jail, screaming so loudly he had to be moved into a solitary cell where he spent the weekend crying and yelling that he was being

tortured. When taken before the judge on Monday morning, he was more agitated than the previous day and was hoarsely shouting nearly incomprehensible

things about the judge and public defender conspiring against him with demons. The judge was concerned that he was not competent to stand trial on charges including theft, resisting arrest, assaulting an officer (with a banana) and marijuana possession and ordered a competency evaluation.

Mr. Y remained in jail for several months waiting for the completion of the evaluations. Six months later, two evaluators determined that Mr. Y was not competent to stand trial. The following month the judge adjudicated him incompetent and ordered the state human services agency to send Mr. Y to a state psychiatric facility for restoration of competency. Since there were no available beds at the restoration facility, Mr. Y remained in jail an additional six months until a bed became available.

After three months at the restoration facility, Mr. Y began to take medication and started his competency restoration classes. Three months later, the doctors at the facility determined his competency had been restored and sent him back to the local jail for trial. Mr. Y's court date was set 60 days after his return to jail. The local county jail used a different drug formulary than the restoration facility and changed Mr. Y's medication. As a result, Mr. Y stopped taking his medication. By the time he returned to court, he had decompensated. In court, Mr. Y once again was agitated and shouted that the judge and the lawyers were conspiring with the CIA to kill him. The judge reordered competency evaluations. He was subsequently found incompetent to stand trial again and ordered back to the restoration facility.

After another six months at the restoration facility, Mr. Y, with his competency restored, again returned to the jail to stand trial. After spending almost two years between jail and the restoration facility, Mr. Y was offered credit for time served to close out his case. He accepted the plea offer and left the courthouse without any mental health services or housing. He returned to the street homeless.

In this scenario, the community's behavioral health crisis system was designed so law enforcement was the first responder in a behavioral health crisis. This resulted in Mr. Y being arrested while in a severe crisis, instead of getting direct access to behavioral health crisis services. Although Mr. Y had access to no behavioral health crisis services before his arrest, the system spent hundreds of thousands of dollars on his incarceration and competency restoration without addressing his illness or improving his health. Sadly, this scenario repeats itself regularly in the United States.

What should have happened? If Mr. Y were fortunate enough to live in a community with an ideal crisis system, what would he and the community want to happen instead? Throughout this report, we insert examples of how different elements of the ideal behavioral health crisis system might have benefitted Mr. Y.

The “[Epilogue](#)” illustrates how Mr. Y's experience would have been different had an ideal behavioral health system served him.

Confinement should never be used as an alternative for treatment.

GUIDING PRINCIPLES AND SYSTEM VALUES

Recognizing the foundational importance of putting people in the center and providing everyone in the population the right service in the right place every time, there are seven fundamental principles that guide the design of the ideal behavioral health crisis system. These principles provide a framework for community leaders and other stakeholders to articulate a shared vision, design the implementation process and identify opportunities for progress.



BASED ON SHARED SET OF VALUES



CLINICALLY EFFECTIVE



DESIGNED FOR COMPLEXITY



PROVIDE VALUE-BASED INVOLUNTARY INTERVENTIONS



COST EFFECTIVE



USE SHARED DATA FOR CONTINUOUS IMPROVEMENT



ACCOUNTABLE TO PEOPLE AND POPULATIONS

1. Ideal behavioral health crisis systems are based on specified, agreed-upon values.

Services that reflect core values must be fundamental to every aspect of the system. Implementation of all aspects of system functioning (structure, process, standards, practice, and outcomes) according to those values must be regularly measured to ensure continued progress toward success. Shared vision and values are articulated by political leaders, health and behavioral health system and provider leaders, public and private funders, judicial system leaders, human services providers, individuals and families receiving services and other key stakeholders. Consensus on vision and values by community leaders and stakeholders is often an important first step. Examples of important values that are the starting place to define an ideal crisis system begin with the type of experience that Mr. Y would want or his family would want for him: welcoming, safe, caring, hopeful, empowering, engaging and as non-restrictive as possible. A more comprehensive set of values that areas foundational are included in [Table 1](#).

Table 2: Values and Guiding Principles for Development of an Ideal Behavioral Health System

CORE SERVICE VALUES — All services are:

- Person/family-driven.
- Welcoming and accessible (every door is the right door).
- Recovery-oriented.
- Resiliency-enhancing.
- Empowering, hope-giving and strength-based.
- Trauma-informed.
- Embedded in cultural humility.
- Integrated/complexity capable.
- Family-engaged.
- Community inclusive (including promoting citizenship and societal responsibility.)
- Effective and evidence informed.

CORE ORGANIZATIONAL VALUES — All organization processes are:

- Population health-based, prioritizing vulnerable and special needs populations.
- Value-based (treat each other the way we wish to treat our customers).
- Accountable.
- Customer-oriented (people receiving service, people providing service and service partners).
- Strategically planned with measurable and achievable objectives.
- Empowering, partnering and collaborative.
- Inclusive of consumers, families and other stakeholders.
- Continuously improving.
- Organized and standardized, but flexible to support creativity and variability.
- Outcome-driven.
- Effective, evidence-based/informed.
- Resource maximizing and efficient (fiscal, human, materials, time).

Establishing fundamental values of welcoming, empowerment, self-determination and hope is often termed recovery-orientation and is particularly necessary in crisis systems. For many individuals with lived experience, like Mr. Y, encounters with crisis services can be extremely traumatic, characterized by loss of power, control and dignity; imposition of involuntary interventions; and physical/chemical restraint and incarceration. It is essential that the ideal crisis system eliminate those experiences to the greatest possible extent, while recognizing that for some individuals, involuntary intervention to prevent significant harm to self or others can be both lifesaving and/or essential to the initial steps of recovery. In this report, guidance is provided for how to design behavioral health crisis systems that incorporate involuntary interventions when needed, while maximizing engagement, empowerment and hope to the greatest extent possible, including utilization of strategies like advance directives to promote choice.

2. Ideal behavioral health crisis systems are accountable for people and populations.

Being accountable for “people and population” means that the system as a whole and specific individuals and organization(s) are responsible for engagement, service delivery and outcomes for all the people in that community who may experience behavioral health crises. This includes people of all ages and all types of cultural and linguistic backgrounds – not just those who are asking for help, but also those who have a difficult time accessing services and those who may not access services at all without considerable outreach and engagement.

An ideal behavioral health crisis system would respond to Mr. Y even though (and in fact, especially because) he is so ill that he has an extremely difficult time asking for help in a conventional way. Mr. Y represents a wide range of people with serious behavioral health crisis needs who do not engage in conventional services and for whom the ideal behavioral health crisis system must remain responsible: individuals who do not show up for appointments, are unable to engage in billable events, present in non-behavioral health care settings (e.g., shelters, jails, emergency rooms, schools), drop out of service or are unable to fit in with current programs.

Those so-called “difficult” people must be a priority and not ignored or abandoned. Accountability includes not just the expectation of responsibility for the whole population, but also the expectation that the system’s performance with regard to the population will be measured. Measurement indicators connected to both values and responsibility for both individuals in need and the population as a whole are critical to having an accountable system. A list of elements that are essential for system leadership and administration for Structure, Oversight and Accountability are listed in [Table 2.](#)

3. Ideal behavioral health crisis systems have the expectation that systems, populations and individuals in crisis are complex.

Complexity refers to the overlap between mental health and substance use issues, as well as between behavioral health and health issues, cognitive disabilities and all types of human service needs. An ideal behavioral health crisis system has to be able to design services based on the expectation of complexity (i.e., co-occurring mental health and substance use issues, combined with other health and human service needs) in all settings and be aware that successful performance involves partnership with multiple collaborative systems, as well as attention to behavioral health issues for people whose major connection to service may be in a non-behavioral health service setting and for whom under-attention to behavioral health issues may lead to high costs in other domains.

The system must recognize that individuals with complexity must not only be served, they must also be prioritized because the more complex issues a person is experiencing, the more likely they are to be in crisis and the harder it will be for them to stabilize and connect to conventional services. Mr. Y, for example, is not only suffering from a mental illness, he is also using marijuana, experiencing homelessness and may be in trouble with the law. His life may be affected by other social determinants (e.g., unemployment, lack of education, few emotional supports, adverse childhood experiences, impaired physical health). The ideal behavioral health crisis system must be designed to respond to Mr. Y and all his complex needs as a matter of routine priority and necessity. The system also needs to understand and reflect in its services the culture(s) of its population, including those who carry cultural norms as a result of their lived experiences, such as the cultures of veterans and military families, the cultures of homelessness, and so on. A system of care needs to assess the needs of its population, so as to assure engagement, appropriate services and positive measurable outcomes.

4. Ideal Systems Are Designed To Be Clinically Effective

A starting place to understand clinical effectiveness in behavioral health crisis systems is to consider that we should expect the same level of quality response (parity of quality) for individuals in behavioral health crisis as we naturally expect, and generally provide, for individuals in medical crisis. When designing the ideal behavioral health crisis system, it is important to shift our perspective from thinking it is simply good enough to help Mr. Y avoid arrest. The perspective of parity means that Mr. Y’s experience of crisis response as a person living with a serious behavioral health crisis should be no different than if he was experiencing a serious medical event. If Mr. Y was having a seizure that caused him to engage in strange behavior in a store, we would expect a continuum of emergency medical response designed to keep him safe and help him heal without regard to his ability to pay and provided for him whether he requests the service or is seen by others as in need of the service. At every level, we must expect no less of a behavioral health crisis system and behavioral health crisis response.

In a clinically effective system, clinical practices are based on the best available research and practice-based evidence. Ideal systems continually adapt and improve with new information. Clinically effective best practice applies to the whole system along with sub-systems and each program – for the whole community and for specific populations. The principle of clinical effectiveness requires measurement of community outcomes. For example:

- Implementation of Zero Suicide to prevent suicide.
- Implementation of interventions to prevent unnecessary arrest and incarceration.
- Elimination of emergency room (ER) boarding.
- Individual and family outcomes (e.g., access to services, prevention of harm, engagement in continuous crisis intervention at the most appropriate level of care, stabilization in continuing community care).

This report is based on the available literature on best practices for behavioral health crisis services as well as from the experiences of the authors and other informants who are currently operating effective behavioral health crisis services and designing innovative behavioral health crisis services and systems. See the [“References”](#) for a complete list of resources and references.

5. Ideal Systems Are Designed To Be Cost-Effective

All communities have limited resources and competing demands that impact essential services. Ideal behavioral health crisis systems maximize efficient utilization of resources and align clinical and cost-effectiveness. While implementing an ideal system is not cost-neutral, just as EMS is not cost-neutral, avoiding unnecessary use of restrictive or expensive interventions like ER visits, hospitalizations or arrests is clinically desirable and fiscally responsible. Consequently, just as our clinical expectations of behavioral health crisis response should be in parity with medical crisis response, our expectations of cost-effective funding of behavioral health crisis response should be in parity with our expectations of other non-medical community safety-net services.

Parity here means that the behavioral health crisis system, like other community crisis response services, is supported by designated and collaborative multi-payer funding that is adequate to cover the costs of the services and administration of the crisis system. It cannot succeed as an unfunded mandate upon behavioral health providers or as a community charity effort. Its funding must be a community obligation that engages multiple payers as necessary and appropriate, including public and private insurers, county and municipal funders, with funding support from the federal and state governments, the same as occurs for police departments, fire districts and ambulance districts.

6. Ideal Behavioral Health Crisis Systems Provide Values-Based Involuntary Interventions When There Is No Other Way To Prevent Harm

Providing care in the most engaging and least restrictive manner possible while acknowledging that there are some individuals who will require involuntary interventions in order to be safe and engaged is an essential system. For individuals who require involuntary interventions, welcoming, hope, compassion and trauma-informed practice are even more important, recognizing the inherent trauma associated with the power differential that occurs when involuntary intervention takes place.

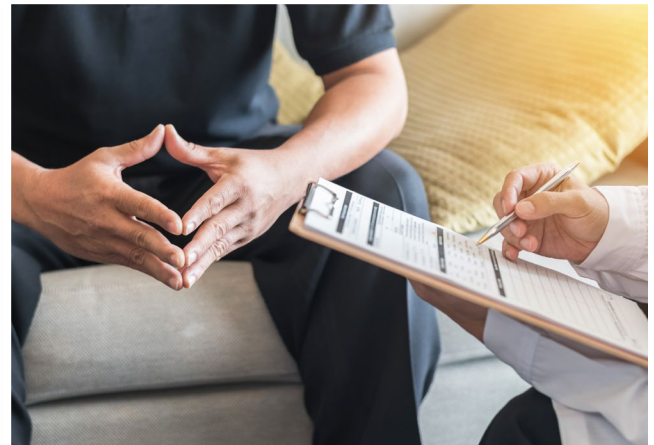
7. Ideal Behavioral Health Crisis Systems Use Shared Data For Continuous Improvement

Behavioral health crisis systems, a safety-net service, involves interacting programs which work to achieve optimal results, using best practices for performance management in dynamic systems. They utilize shared data for customer-oriented continuous quality improvement (CQI). An important function of the system accountable entity, beyond implementation, is the collection of performance data.

3 INTERACTIVE DESIGN ELEMENTS - OVER 60 SPECIFIC STANDARDS: MEASURABLE PERFORMANCE CRITERIA FOR EACH

In the body of this report, the three interactive design elements for an ideal community behavioral health crisis system – Structure and Process for Accountability and Finance, Continuum of Comprehensive Capacities and Services and Best Practices for Crisis Intervention Services – are each described in detail. Specific standards are articulated for each of the three design elements, over 60 standards in all.

However, because Ideal behavioral health crisis systems’ design and implementation must be managed, measured and continuously improved by the communities they serve (as well as by state agencies, managed care organizations, provider organizations and advocates), it is not enough to simply list a set of standards. Actionable and measurable criteria for implementation and accountability are needed.



This report provides these measurable criteria for design and implementation of an ideal behavioral health crisis system, so communities across the US can begin to make progress to implement the vision upon which the report is based.

For each of these, the report:

- Delineates one or more specific measurable objectives or standards.
- Identifies measurable and achievable system performance targets that measure progress toward each objective.
- Describes indicators that allow assessment toward the target.
- Suggests policies, procedures, programs, practices or models, as indicated, that are examples of progress.

The performance measures contribute to the ideal “Behavioral Health Crisis System Report Card” (see [Appendix](#)) with actionable items implemented under the leadership of accountable entities. To implement an ideal behavioral health crisis system, communities can use this Report Card to identify an accountable entity, community partners and concrete metrics for success and collaboratively measure baseline performance of their current behavioral health crisis system, begin to make step-by-step progress toward an ideal behavioral health crisis system and identify and celebrate progress along the way.

IMPLEMENTATION OF CRISIS SYSTEMS: CUSTOMER ORIENTED CONTINUOUS QUALITY IMPROVEMENT AND SYSTEM PERFORMANCE MANAGEMENT

The approach in this report for designing and implementing an ideal behavioral health crisis system aligns with the tenets of the Triple Aim for health and behavioral health systems: improving customer experience, improving population health outcomes and reducing unnecessary costs. In this regard, the available knowledge base regarding crisis services intersects with two important implementation methodologies designed for customer-oriented, principle-driven systems:

- Customer-oriented CQI.
- Best practice management of (behavioral health) system performance.

Customer-oriented Continuous Quality Improvement (CQI)

CQI is a recognized technology within management science by which any system or organization can steadily improve its structure and processes to achieve better experiences and outcomes for its customers. In behavioral health crisis services, the most important customers of the system are the primary customers – individuals in need and their families and loved ones. But the system has secondary customers as well, including service providers, law enforcement, other first responders and the general public. In the framework of customer-oriented CQI, behavioral health crisis systems and all their participating service providers, just like other organizations and systems, must identify and continuously improve processes that are failing their customers, with the goal (in CQI terminology) of achieving 100% excellence for “every customer, every time.”

A variety of quality improvement processes exist that utilize the stories and experiences of customers to inform system design and development. One of those processes most readers will be familiar with is root cause analysis (RCA), a practical, logical way to identify problems and solutions. While RCA is commonly used to analyze specific adverse events within a system (e.g., sentinel event review), it can be used more broadly. This approach considers the adverse experiences – in fact, anything less than 100% excellent experiences – of Mr. Y and others in our current crisis systems to be sentinel events for the purpose of designing the ideal behavioral health crisis system. Real people’s stories, like that of Mr. Y, reflect a wide array of customer experiences, often with a precipitating event that marks the beginning of an official entry into the system. As a result of the analysis of those stories, it is possible to articulate a continuous process of improvement to inform every activity in the crisis system and define how to drive measures for success and progress throughout the system. The story of Mr. Y is the foundation for this process in this report.

Best Practices for Crisis System Performance Management

The implementation approach in this report derives from the individual and collective expertise of committee members regarding how complex behavioral health system performance is managed, measured and continuously improved by state and county agencies, managed care organizations, provider organizations and application of system-based practice.

[Brief biographical sketches reflect the robust systems and clinical expertise of the authors.](#)

As previously noted, available information about best practices for crisis service delivery and the continuum of crisis system capacities and services has been generated by a review of the literature on crisis services (including, but not limited, to the reports listed in Table 1 in the Introduction) as well as the committee’s own experiences operating crisis services, designing crisis services and working in both higher and lower quality crisis service systems.

Based on both the literature and our collective experience, an initial working list of system components and practices is enumerated in [Table 2](#). This list was further refined as specific measurable criteria for each element of the ideal crisis system were generated. In addition, it is recognized that in an ideal behavioral health crisis system, each of these components has to be looked at not only for the crisis system as a whole, but also within each subsystem (e.g., regions within a large county) and each subsystem process and for each specific target population (e.g., age, ethnicity, rural/urban, types of complexity) to reflect the needs of the entire community.

However, best practice for system performance management teaches that simply articulating criteria for what a crisis system should do is inadequate, unless accompanied by how the implementation of those criteria for an ideal behavioral health system would be measured and how the accountability for the attainment of those measures would be anchored in each community and across all system components. Therefore, in addition to delineating the value base of ideal crisis service measures, it is important to understand various types of performance measures and at what level of the system their application would be most effective to incentivize behavior.

Performance measures in health care are traditionally categorized as follows (Donabedian, 1988):

1. **Structure:** The environment in which care is delivered (e.g., organizational structure, resources, staffing).
2. **Process:** The techniques and processes used to deliver care (e.g., use of screening tools, specific interventions).
3. **Outcome:** The outcomes of the patient's interaction with the health care system (e.g., days in the community, housing, employment status).



While the goal is always to achieve positive outcomes, structure and process measures are critically important for shaping the development of all aspects of the system needed to produce those outcomes. In complex systems, such as behavioral health crisis systems, a continuous quality improvement framework implies that the components of that system, including state/county authorities, funders, health systems, providers and collaborative systems such as law enforcement work as quality improvement partners to implement structures and processes to achieve shared targets for measurable outcomes. Measurable criteria themselves must adhere to the standard of scope or actionability. For a measure to be effective, the responsible entity must have influence over the resources needed to affect a solution when performance is suboptimal. Then, within a system, each partner can focus on issues within the control of each partner individually, as well as issues that require collaboration of all the partners collectively, to promote attainment of the larger goal.

There are limited numbers of recognized set of standards for behavioral health crisis services. One published framework (Balfour, et al., 2016) suggests that crisis system performance measures should align to the following value-based domains: timely, safe, accessible, least restrictive, effective, consumer/family-centered and community partnership. These domains are consistent with the Institute of Medicine's six aims for quality health care while also focusing attention on goals unique to the behavioral health setting. These measures are incorporated into this report. However, this document goes much further.

There is a clear need to not only measure the many possible metrics that address customer outcomes and experience, but also to regularly assess all the intervening parameters that define how the system and the multiple subsystems and processes within an ideal behavioral health crisis system function - individually and collectively - to produce those results. Measuring an ideal system requires the capacity for the system to routinely attend to measures at all these levels at the same time, to produce better results for individuals like Mr. Y. These must include actionable measures of structure, process, standards, practices and outcomes at a variety of different levels within a single system.

Crisis system metrics can also be helpful markers of overall delivery system performance. While a portion of crises are unpredictable and unavoidable even in the perfect overall behavioral health delivery system, many behavioral health crises are a direct result of inadequate performance by the rest of the behavioral health delivery system and other human service systems such as justice, housing, immigration and child or adult protective services. Common behavioral health system causes of behavioral health crises include inadequate access to routine services, premature discharge from treatment programs and inadequate attention to patient engagement. The ideal crisis system therefore has a role in providing some of the performance measurement for the rest of the behavioral health delivery system. Conversely, successful performance by the ideal behavioral health crisis system is likewise dependent on good performance by the rest of the behavioral health delivery system. Lack of prompt access to routine and maintenance care will necessarily result in poor performance of even the most ideal behavioral health crisis system when the rest of the behavioral health care provider system engages in practices like refusing referrals based on coverage status, restricting services to only a few selected diagnoses, refusing referrals based on selected comorbidities and restricting services to only those that are most profitable.

These considerations help identify data-driven metrics to support implementation, documentation and measurement of incremental success, which further guide refinement in strategies to attain the desired outcomes.

In many systems, contract deliverables may require reporting of these measures and both expect and incentivize incremental progress. In many instances, measures could be targets for pay-for-performance contracting to guide quality improvement initiatives. However, even if pay for performance options are limited, the system leaders and partners can work collaboratively to identify mechanisms for mutual accountability to make progress toward the goal of an ideal behavioral health crisis system as an essential community service.

In this report, each performance measure is designed to be actionable in real world systems under the leadership of what we term the “accountable entities” for community behavioral health crisis systems (See [Section 1](#)). To implement a behavioral health crisis system, accountable entities can use these metrics for an ideal behavioral health crisis system to work with local stakeholders to:

- Define a standard set of values.
- Develop corresponding quality measures that help that system measure its current baseline.
- Make step-by-step progress toward the ideal.

The Three Major Sections of This Report

The following sections provide the detailed recommendations for essential elements, measurable criteria and best practices. Within each of the three sections, there are descriptions of performance measures with measurable criteria and indicators of progress for the design and implementation of all aspects of the ideal behavioral health crisis system for any community.

- **[Section I: Accountability and Finance.](#)** Accountability and responsibility for designing, financing, and operating the crisis system, with the goal of ensuring that people like Mr. Y are appropriately served and do not fall through the cracks.
- **[Section II: Crisis Continuum: Basic Array of Capacity and Services.](#)** Identifying a comprehensive continuum of best practice crisis system components, including the full complement of functions, programs and staffing resources needed for successful operation.
- **[Section III: Basic Clinical Practice.](#)** Identifying best practice crisis intervention strategies, clinical practices/practice guidelines and staff core competencies to provide those interventions throughout the continuum.

Within each section, the document lists the specific elements or standards defining an ideal behavioral health crisis system. For each standard, there is a description of the rationale and background for the standard, followed by measurable criteria, with concrete indicators of progress that would determine whether such a standard was met.

SECTION I: ACCOUNTABILITY AND FINANCE

Introduction	36
Structure for Coordination, Collaboration and Accountability.....	39
Financing.....	41
Eligibility (All-payer).....	45
Geographic Access and Network Adequacy	47
Quality Metrics	50
Performance Incentives	53
Flow and Throughput	55
Comprehensive Client Flow Monitoring Data System	57
Formal Assessment of Customer Satisfaction	58
Standardized Utilization Management and Level of Care Determination.....	59
Relationship to the Rest of the Service System.....	60

INTRODUCTION

An ideal behavioral health crisis system must have a mechanism to both finance a comprehensive continuum of crisis services and ensure the accountability and quality of the continuum's performance. Because of the complexities and challenges associated with behavioral health crisis response, individual crisis programs and collection of crisis programs cannot hold themselves accountable to respond to broadly defined community needs or align effectively with multiple behavioral health crisis partners without a mechanism for oversight and accountability to ensure quality. This section describes the criteria for administrative and financial structures for a successfully operating crisis system.

The following definitions of key concepts are used in this section:

- **Community or catchment area:** In this report, an ideal behavioral health crisis system is responsive to and responsible for a designated community or catchment area. The delineation of this community or catchment area will vary depending on the nature of the geography served.

In a large urban environment (say a county with a population of a million or more), the crisis system catchment areas may be defined by geographic regions within the county. The same may apply for a county in which the population may not be as large, but the county is geographically spread out. In a moderately-sized county, the crisis system catchment area may be the single county. In more rural areas, the crisis system catchment area may include multiple counties, depending on geography and population. In some states, counties do not represent meaningful ways to organize catchment areas and they may be defined by responsibility for cities and towns instead. Finally, tribal organizations may define catchment areas for behavioral health crisis response according to the dispersion of the tribal population across the geography defining the boundaries of tribal land.

In an ideal system, each state will have a consistent mechanism for allocating responsibility and accountability for behavioral health crisis systems to counties or other intermediate structures (e.g., cities, towns, regions, districts) throughout the state.

- **Accountable entity:** In this report, accountable entity describes the structure that holds accountability for behavioral health crisis system performance for a community or catchment area and may also have the role of providing funding and/or coordinating multiple funding sources to support the crisis continuum. The term purposefully indicates that there are many different structures that can carry out this function.

We are not recommending one particular type of structure. For example, an accountable entity can be a county behavioral health department, but it also can be a behavioral health managed care organization responsible for Medicaid and indigent funds, a nonprofit managing entity or a formal collaborative structure that is set up for crisis system oversight by one or more communities or counties. In a large county or city, the single accountable entity might be responsible for overseeing and coordinating crisis systems that are responsible for different catchment areas within that county or city. The same might be true in a small state or a state with a small population, where the state is the accountable entity coordinating and overseeing performance of catchment area crisis systems statewide.

In most states, regardless of the locus of accountability, the operation of the crisis system requires collaboration across multiple levels of government (state, county, local) and across multiple types of funding (e.g., health, law enforcement) and involving both public and private payment systems. The state may share elements of accountability with counties and/or local communities, or vice versa. However structured, the role of the accountable entity is to ensure appropriate management to ensure and continuously improve quality and outcomes for the population served.

- **Values-based accountability:** In the context of our effort to emphasize the importance of core values (see [Table 1](#)) as the foundation for all service delivery, it is essential to build those core values into every aspect of the accountable entity. The first job of the accountable entity is to be responsible for maintaining core organizational values and incorporating them into all organizational processes, including contracting, incentives, data collection, quality improvement and outcomes. Priorities must include person and family driven values, such as welcoming, safe, accessible, recovery-oriented, resiliency enhancing and trauma-informed care, emphasizing cultural humility and maximizing engagement, hope and empowerment and minimizing involuntary interventions to those situations where they are clearly needed to promote safety and well-being.



The accountable entity is also responsible for designing and coordinating funding for a continuum that meets the needs of the whole population served, emphasizing those that are more vulnerable and complex, as well as those with special needs or at risk of experiencing disparities in care. The accountable entity must proceed to design all services and processes in a collaborative quality improvement partnership that monitors indicators of all important values in service delivery, but is flexible enough to engage providers as partners and support creativity and variability in how the services are provided.

The system is always responsible for person- and family-driven values based on effective evidence-informed care and embedded in cultural humility (see [Table 1](#) for additional information on values, including accessible, recovery-oriented, resiliency-enhancing and trauma-informed care). Internal review and systematically collected feedback from consumers, families, providers and other stakeholders that is reviewed to identify areas for improvement ensures maintained accountability for these core values. It is essential to regularly address identified areas for improvement in the delivery of value-based services in systemic continuous quality improvement activities. In all the following indicators of system accountability, value-based services are fundamental features of every element of care.

There are many possible mechanisms for structuring an accountable entity.

In Arizona, Medicaid-managed care intermediaries function as accountable entities for crisis systems that serve everyone, not just the Medicaid population.

Arizona has had a managed Medicaid system from its inception, which is called the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS contracts via a competitive bid process with managed care organizations throughout the state, including a RBHA in each geographical service area. In southern Arizona, the RBHA is Arizona Complete Health (formerly Cenpatco Integrated Care, part of Centene). The RBHA braids multiple funding streams, including Medicaid, SAMHSA block grants, state and county funds to serve as a centralized point of accountability for the behavioral health system. Pima County has a full continuum of crisis diversion and behavioral health services, including for SUD, and services for both juveniles and adults through a larger provider network. In addition to funding the crisis response center (CRC) services, the RBHA contracts with multiple providers to operate the crisis call center, a dozen mobile crisis teams that are dispatched from the call center, residential and step-down facilities and various other crisis services not on the CRC campus (Manauagh, 2020).

In Pennington County (Rapid City), South Dakota, a county-led collaboration of agencies and providers oversees the operation of the crisis continuum, with the Sheriff's Office holding ultimate accountability.

The Care Campus is a partnership of the Pennington County Sheriff's Office, Pennington County Health and Human Services, the City of Rapid City and the Crisis Care Center operated by Behavior Management Systems, a private provider, under the oversight of the Pennington County Sheriff's Office. The Care Campus includes a full continuum of co-located services addressing the crisis stage of mental health and substance use disorders and support services to assist Care Campus clients with attaining recovery and maintaining stability in the community (Manauge, 2020).

In Kent County (Grand Rapids), Michigan, the accountable entity is being formed as a new organization by a collaboration between the county, four major health systems, three behavioral health provider organizations and the Community Mental Health entity that manages specialty behavioral health Medicaid and indigent services.

In Kent County (Grand Rapids) MI, the county has organized a population health consortium to lead important community health projects, one of which is to develop a state of the art behavioral health crisis system. The consortium consists of the County Executive, a community business/foundation leader, CEOs of four health systems, CEOs of two psychiatric hospitals, the CEO of the local CMH/Medicaid managing entity and the CEO of a large community crisis provider. The consortium obtained consultation to operate under the Kent County Department of Health, which convened a Consensus Working Group representing over 25 key constituencies and organizations. This group has developed a consensus plan, with prioritization, and is working on transitioning this structure to a formal "Accountable Entity" governance model, using local EMS as a template.

The remainder of this section describes various elements of accountability and financing in an ideal system. For each element, there is a brief discussion of rationale, followed by measurable criteria for system implementation and oversight.

STRUCTURE FOR COORDINATION, COLLABORATION AND ACCOUNTABILITY

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. To operationalize such an ideal system, it is not adequate to simply have an array of discrete programs and providers. It is essential that all the payers and providers within the system work collaboratively to ensure that the various components work effectively together and are accountable for excellent crisis response and continuous improvement of crisis response to community members. Effective coordination and quality improvement require commitment as well to sharing both aggregate performance data and personal health information (PHI) systematically between all points of service.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for delivering direct services and/or coordination of all service elements that establishes a formal crisis collaboration structure and process with an identified crisis coordinator function and capacity for managing both case data and aggregate data for continuous improvement.

- **Crisis coordinator:** The crisis coordinator position is a clearly identified role and may be a staff person in the accountable entity (e.g., county, managing entity) or a staff person associated with a lead crisis provider. If the latter, it is independent from that person's provider responsibilities so there is clear accountability for the whole system's performance and not just the individual provider's.
- **Data collection and analysis:** The accountable entity provides or contracts resources for data collection and analytic capacity to engage in continuous quality improvement functions. The data repository is held by the accountable entity, the major crisis hub provider or both.
- **Crisis coordinator functions:** The crisis coordinator oversees, delineates and continually improves the policies, procedures, protocols and services that govern how the individual elements of the crisis system work together to ensure high quality and seamless response for individuals and families. This responsibility has appropriate authority to review quality metrics and recommend quality improvement interventions to the accountable entity and is written in to all relevant provider and payer contracts.
- **Crisis collaboration structure:** The accountable entity and crisis coordinator hold a regular crisis coordination meeting at least monthly for each geographic area, attended by representatives of first responders, crisis continuum providers, human service agencies, ambulatory service providers, housing providers, funders and advocates. In most communities, there will be separate meetings for adult and youth crisis coordination. Attendance is mandated for contracted providers. Each meeting has formal minutes and identifies specific action steps for follow-up monitored by the crisis coordinator with support from the accountable entity.
- **Case review processes:** The crisis coordinator and, where appropriate, the crisis coordination meeting structure have procedures for individual case review and root cause analysis to respond to adverse outcomes and recognize unique successes. Root cause analysis is designed within a formal quality improvement (QI) framework with indicators that respond to any instance of inadequate response to individuals or families at any point in the continuum of care.



MR. Y'S CASE, for example, would be appropriate for such review given that his behaviors in the convenience store were criminalized rather than treated as a behavioral health crisis. Lack of preparation (training) in the first responders led to a misinterpretation of the presenting problem(s).

- **Data-driven quality improvement collaboration:** The crisis coordinator utilizes the crisis coordination meeting as a QI meeting for the entire crisis system. Aggregate data on key indicators are collected and reported and key themes are reviewed for continuous improvement. Evidence of these activities is in the meeting minutes, including data and appropriate plan-do-study-act cycles of improvement, are reported to and overseen by the accountable entity. Results of these processes include revision of policies, procedures and protocols that define the roles and responses of the key partners in the crisis collaboration.
- **Sharing protected health information:** To ensure the system can provide care effectively and safely, prompt and systematic of sharing patient information across all points of care within the system when a crisis is occurring is essential. The accountable entity for the comprehensive crisis system must:
 - » Include in all provider contracts specific detailed requirements of how the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and any local confidentiality laws will be interpreted and applied in all provider contracts and agreements.
 - » Include in all provider contracts the expectation to use a specific standardized patient consent to share PHI in a “crisis” by any contracted or referring provider without further consent in a crisis.
 - » Implement maintain and improve connectivity with local IT systems such as health information exchanges (HIEs) and hospital admission, discharge and transfer data exchanges to assure that crisis service providers are part of the standard methods of exchanging PHI and fully integrated in the broader health care system in terms of data connectivity.
 - » Actively provide ongoing education regarding all crisis service exceptions to sharing PHI in HIPAA, 42CFR Part 2 and local confidentiality statutes to all provider organizations in their service area.
 - » Assist and facilitate all providers adoption of any necessary business associate agreements and participation in any local HIE within the crisis service system area.

High-level community collaborations, such as the Healthy Living Alliance in Greene County (Springfield), Missouri, can play a key role in crisis system initiation, funding and implementation.

In Greene County (Springfield), Missouri, the Healthy Living Alliance (HLA) is a high-level collaboration which meets monthly, staffed by the Department of Health and facilitated by leaders of local foundations. It includes two health system CEOs, a Community Mental Health Center (CMHC) CEO, a Federally Qualified Health Center (FQHC) CEO, the president of Missouri State University and law enforcement organization (LEO) leadership, among others. HLA received foundation funding for a community mental health assessment, which identified a need for improved crisis services. They developed a collaborative plan for a community crisis center (with capacity for MAT initiation) with residential crisis service beds to complement existing call center and mobile crisis services. They were able to pass a local tax initiative to obtain start-up funding and arrange private insurance contracts to help support operations. The first-of-its-kind in Missouri facility opened in summer 2020 in the midst of the COVID pandemic.



FINANCING

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community in the same way that police, fire, EMS and emergent/urgent medical care are essential community services. For this reason, there must be adequate financing for that continuum of services to achieve appropriate community response, just as is the case for other safety-net services. Aligning multiple funding streams to support a single crisis system, rather than each funder developing its own system is likely to be more efficient, effective and accessible to customers.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for providing direct services and/or coordination of all service elements that has the following approach to financing:

- **The accountable entity is responsible for producing a global budget for the ideal crisis continuum.** This budget is initially based on historical utilization data of all components and all payers of community behavioral health crisis response and has projections for future utilization based on movement toward an ideal system. For example, projections of inpatient utilization are modified by the addition of increased diversion and step-down capacity. Projections of ER visit utilization are modified by addition of non-ER-based crisis programs.
- **Shared resource contribution:** The behavioral health crisis system is a shared system capacity like an electronic health record (EHR) system or ambulance district. All funders of health coverage whose beneficiaries could potentially utilize the behavioral health crisis continuum are accountable over time to contribute resources to core capacity. This includes federal resources (Medicare, Veterans Administration, Department of Defense), state resources (including Medicaid), local (e.g., county, city), public funding (in lieu of inappropriate use of law enforcement or jails), managed care organizations and commercial insurers of all kinds and accountable public and private health systems (e.g., accountable care organizations or other large payers receiving value-based payment, hospitals accountable for preventable readmissions, ER visits). Funding for a “global” crisis financing budget is defined in each community as a collaboration between public payers (states, counties, cities/towns), public and private insurers and accountable health systems. Proportional contribution is based on historical utilization and potential value added.
- **Delegated financing authority:** The accountable entity must have either direct or delegated governmental authority at the state and/or local level to require participation of funders, assure adequate rate-setting, determine funder and provider participation requirements, determine standard of care and quality performance metrics and award and enforce service contracts.
- **Financing supports capacity, not just utilization:** For example, no community would establish a fire department that is paid only when it responds to a fire. Financing is a necessary community expenditure, like EMS, not something that will ultimately always pay for itself through savings. Financing methodology must balance assuring availability of the service with incentive to provide service. Each component of the crisis system has a base payment to maintain capacity to provide the service, and a second reimbursement based on utilization, fee-for-service. There are various reimbursement models for how this can be done.
- **Adequate reimbursement rates:** Both payments for reimbursement for crisis services must be commensurate with the complexity and comprehensiveness of service provided. This includes contacting collaterals, phone calls, home-based outreach, travel time for mobile response and complex disposition planning. Rate-setting must be based on the actual cost of providing the service as determined by provider cost reports.

- **Incentive payments:** A financial incentive for performance and penalties for non-performance on critical indicators (see [“Performance Incentives”](#)) should be included as a third component of the overall payment methodology. Any incentive payment should not be based solely on meeting cost saving or utilization reduction targets but should also include quality of care measures. Incentive payment methodology should be initiated with bonus payments for good performance. Negative incentives with reduced payment for poor performance should not be initiated until organizations have at least two years of experience with positive incentive value-based payments. Negative incentive penalties or payment reductions based on performance should not exceed 5% of the actual cost of service provision.



- **Payment for full continuum of crisis services:** Reimbursement for crisis services by all payers must be designed to support the full continuum of crisis response: payment for early or pre-crisis intervention, outreach and engagement, payment for active treatment including medication during a crisis event, payment for the continuum of crisis diversion programs (see [“Value-based System and Program Design”](#) and [“Crisis Continuum for People with Co-occurring Conditions”](#)), and payment for crisis follow-up at necessary level of intensity for at least 14 days and up to 90 days for individuals with high levels of need who are not easily connected to routine community-based services.
- **Budget full capacity at a 95% maximum threshold:** Because crisis utilization naturally waxes and wanes, the budget is designed with the expectation that utilization for each component is over maximum capacity no more than 5% of the time, or no more than 18 days per year. Provision is then made for funding temporary overflow on those 18 days (e.g., for extra crisis workers, contracting for overflow crisis beds). Budgeting is also designed to ensure minimization of under-utilized capacity and regularly adjusted based on actual data.
- **Payment for all populations, including those with comorbidities:** Reimbursement for crisis services by all payers is designed to support interventions for youth, adults and older adults, as well as individuals with mental health, SUD and cognitive disabilities in any combination. Funding from various categorical pots (e.g., developmental disability [DD] waiver, SUD block grant) may be blended to fund the crisis continuum, but the continuum itself has clear funding instructions that support a full array of services to individuals and families with all types of comorbidity and complexity (See appropriate sections in [“Crisis Continuum: Basic Array of Capacity and Services”](#)). For example, if an adult with co-occurring DD and a mental health disorder presents in crisis, there is a clear set of instructions that indicates that the behavioral health crisis team responds using its core resources, then coordinates with the DD-funded crisis respite and continuing supports system for ongoing services as indicated. The same applies to individuals like Mr. Y with co-occurring mental health and SUD conditions, as well as youth in foster care/social service custody or youth/adults in custody of the justice system. Funding instructions for each significant type of comorbidity and complexity must be delineated in all funding and provider contracts.
- **Financing for safety net:** Financing mechanisms are designed so the behavioral health crisis system can operate as a safety net for the entire delivery system. There must be no instance in which an individual or family receives no response because there is no clear allocation of funding and responsibility. In all such instances, the behavioral health crisis system must be defined as the default safety-net provider.

Certified Community Behavioral Health Clinics: Expanding Access to Care in Times of Crisis

The Certified Community Behavioral Health Clinic (CCBHC) model was established to improve access to crisis care and expand Americans' access to addiction and mental health treatment in community-based settings. CCBHCs support a robust community treatment infrastructure that includes 24/7 crisis care, mobile crisis teams and partnerships with local law enforcement and hospitals.

In contrast to the patchwork of crisis care typically available in other communities, all CCBHCs must provide a standard array of crisis services linked with ongoing outpatient treatment. CCBHC's crisis management services are available and accessible at all times, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. CCBHCs must partner with organizations that frequently come in contact with individuals in crisis – such as local emergency departments and local law enforcement agencies – to facilitate crisis intervention, care coordination, discharge and follow-up. Following a crisis, CCBHCs work with the individual on a crisis plan to prevent and de-escalate potential future crisis situations, while ensuring they are linked to comprehensive ongoing community-based treatment. CCBHCs must have an interdisciplinary care team that works together to coordinate the full range of support services needed by individuals in crisis and following a crisis. Staff must be culturally competent and have access to language services depending on the community the CCBHCs.

Results to date show substantial improvement in access to crisis care. More than half of CCBHCs added crisis services where none existed before. All engaged in new partnerships with hospitals and law enforcement to support crisis intervention and coordinate post-crisis care. (1) As a result of improved crisis intervention and ongoing community-based care, CCBHCs have produced significant reductions in hospitalizations, emergency department visits and incarcerations (2).

CCBHCs and the Crisis Now model is gaining attention and popularity as a means to improve communities' response to crisis care. The approach focuses on five core elements of crisis care including: 1) regional or statewide crisis call centers coordinating in real time; 2) centrally deployed, 24/7 mobile crisis teams; 3) short-term, "sub-acute" residential crisis stabilization programs; 4) essential crisis care principles and practices; and 5) development and implementation of protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive setting.

CCBHCs provide the opportunity to further advance the Crisis Now model, both by establishing a critical connection to ongoing community services in areas where Crisis Now has been implemented and by offering a financing model that can support many of the costs of implementing Crisis Now in areas where the model does not currently operate. Aligned with the elements of the Crisis Now model, CCBHCs provide 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. They also establish partnerships with organizations where individuals in crisis may frequently present – such as local EDs and local law enforcement agencies – to facilitate care coordination, discharge and follow-up, as well as relationships with other sources of crisis care. Following a crisis, CCBHCs work with the individual on a crisis plan to prevent and de-escalate potential future crisis situations while ensuring access to the full range of community-based services needed to keep the individual out of crisis.

The CCBHC model improves access to crisis care by funding activities that have traditionally been difficult to implement. There are two CCBHC funding tracks: a Medicaid prospective payment rate calculated to cover CCBHCs' anticipated costs or a 2-year grant that funds CCBHC activities. Both funding streams support:

- Expanded access to crisis care through an enhanced workforce. CCBHCs' funding can support the cost of hiring new staff such as nurse care managers, training staff in required competencies such as suicide prevention and naloxone administration, and placing staff liaisons in settings like EDs or jails where individuals in crisis commonly present.
- Timely follow up and "warm hand-off" from the ED to ongoing, community-based services. CCBHCs must establish partnerships with hospitals and other providers and ensure services are available to transition patients from an ED or hospital to a community-care setting. Through quality reporting requirements, CCBHCs are held accountable for the timeliness of a patient's transition between care settings and ensuring that no patient falls through the cracks.

- Electronic exchange of health information for care coordination purposes. CCBHCs' funding can support purchasing or upgrading electronic systems for real-time electronic information exchange - along with data collection, quality reporting and population health approaches to care.
- Enhanced patient outreach, education and engagement. CCBHCs' funding supports the cost of activities that have traditionally been near-impossible to reimburse, yet play a critical role in crisis intervention, care management and coordination of services.
- Care where people live, work and play. CCBHCs' funding covers services provided outside the four walls of their clinic. For example, via mobile crisis teams, home visits, telemedicine, outreach workers and emergency- or jail-diversion programs.

CCBHC Expansion Legislation Introduced

In light of the program's success, as of January 2021, Congress has extended the original 8-state Medicaid demonstration to two additional states and allocated yearly funds for CCBHC expansion grants since 2018. Thirty-three states now have at least one CCBHC. The bipartisan Excellence in Mental Health and Addiction Treatment Act (S. 824/H.R. 1767) would renew the CCBHC Medicaid demonstration program and expand it to new states. By renewing and expanding the demonstration, Congress could expand behavioral health capacity and alleviate the pressure on our nation's jails and emergency rooms. This legislation will also ensure sustainability for CCBHC grantees beyond their 2-year grant terms by supporting more states in implementing the model as part of Medicaid.

1. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2019). Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2018. Accessed July 15, 2020 at <https://aspe.hhs.gov/report/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018>
2. National Council for Behavioral Health. (2020). Expanding Mental Health and Addiction Treatment: An Impact Report. Accessed July 15, 2020 at: <https://www.thenationalcouncil.org/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf?dof=375ateTbd56>



ELIGIBILITY (ALL-PAYER)

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community, in the same way that police, fire, EMS and emergent/urgent medical care are essential community services.

However, unlike police, fire or EMS, in many parts of the country behavioral health crisis response is determined first by payer (or lack of payer) and in some communities, each payer (Medicaid, insurer, managed care organization [MCO]) may have a different continuum of services with different eligibility criteria. This is challenging for individuals and families trying to access help and an inefficient and duplicative use of resources.

Therefore, in an ideal community behavioral health crisis system, there is ONE crisis continuum that is responsive to ALL individuals and families. It is never necessary to establish insurance coverage before responding to behavioral health crisis; everyone is eligible for the full continuum of crisis response and all payers support the full continuum. Cross payer collaboration – not competition – is necessary for ideal community crisis response.

All-Payer Example - Kent County, Michigan

The Kent County crisis collaborative under the auspice of the population health consortium has developed a business plan for a crisis center, call center, behavioral health urgent care, and mobile crisis that includes all Medicaid Health Plans and commercial plans (including Medicare Advantage) as potential partners. The three largest health plans have been invited to the table and have agreed to participate in the funding collaboration. In Michigan, the Medicaid health plans are responsible for mild to moderate behavioral health but not crisis, even though 60% of Medicaid recipients who have behavioral health crisis are in the mild to moderate group. However, the Medicaid health plans can benefit directly from supporting ED diversion and are interested in partnering with community leaders because of the high level collaboration that has been created.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring with the following eligibility criteria:

- **Access to all:** The full continuum of crisis services is available to all members of the community, including individuals travelling through, regardless of whether they are insured or the type of insurance coverage, just as with the continuum of fire services.
- **Resource contribution by all:** See [“Financing.”](#)
- **Community education on access to all:** All payers and community providers communicate to members and service recipients, first responders and other human service providers, a clear and consistent message about how to access the community’s all-payer, all-eligible crisis system, 24-hours per day, seven days per week.
- **Contracts with providers include access for all:** Contracts with all crisis providers include the expectation that everyone is equally welcome for care, whether privately insured, public insured or uninsured. No one is turned away based on insurance coverage or lack of coverage.
- **Contract with public payers support the full-service array:** Contracts with all public payers doing business in the community include the expectation that the full continuum of crisis services will be supported and reimbursed for their members. This may include provision for out of network payment for certain services that may periodically be at capacity within network.
- **Contracts with private payers support the full-service array:** Contracts by businesses in the community with all private payers doing business in the community include the expectation that the full continuum of crisis services will be supported and reimbursed for their members. This may include provision for out-of-network payment for certain services (e.g., inpatient child psychiatry) that may periodically be at capacity for within network.
- **All payers involved in coordination and QI activities:** All payers are expected by contract to participate in community crisis coordination activities and quality management activities as defined by the “accountable entity.”
- **Access to innovations and data:** Innovative services developed/contracted by any payer are expected to be made available to individuals served by all payers. Individual payers may retain their unique care coordination and data tracking functions for their members, but all aggregate data are accessible to the accountable entity.
- **Delegated authority:** See [“Financing.”](#)



GEOGRAPHIC ACCESS AND NETWORK ADEQUACY

A comprehensive behavioral health crisis system with a complete continuum of service is an essential element of safety-net health and human services for any community in the same way that police, fire, EMS and emergent/urgent medical care are essential community services. In many parts of the country, even when crisis services are available, access to those services is not commensurate with the population size and/or the size of the geographic area served. In an ideal system, a comprehensive crisis system with a complete continuum of services must be available to serve each catchment area, as defined by population in urban and suburban areas and by combinations of population and geography in more rural areas. Adequacy of geographic access is defined by a combination of performance metrics and population size/distance.

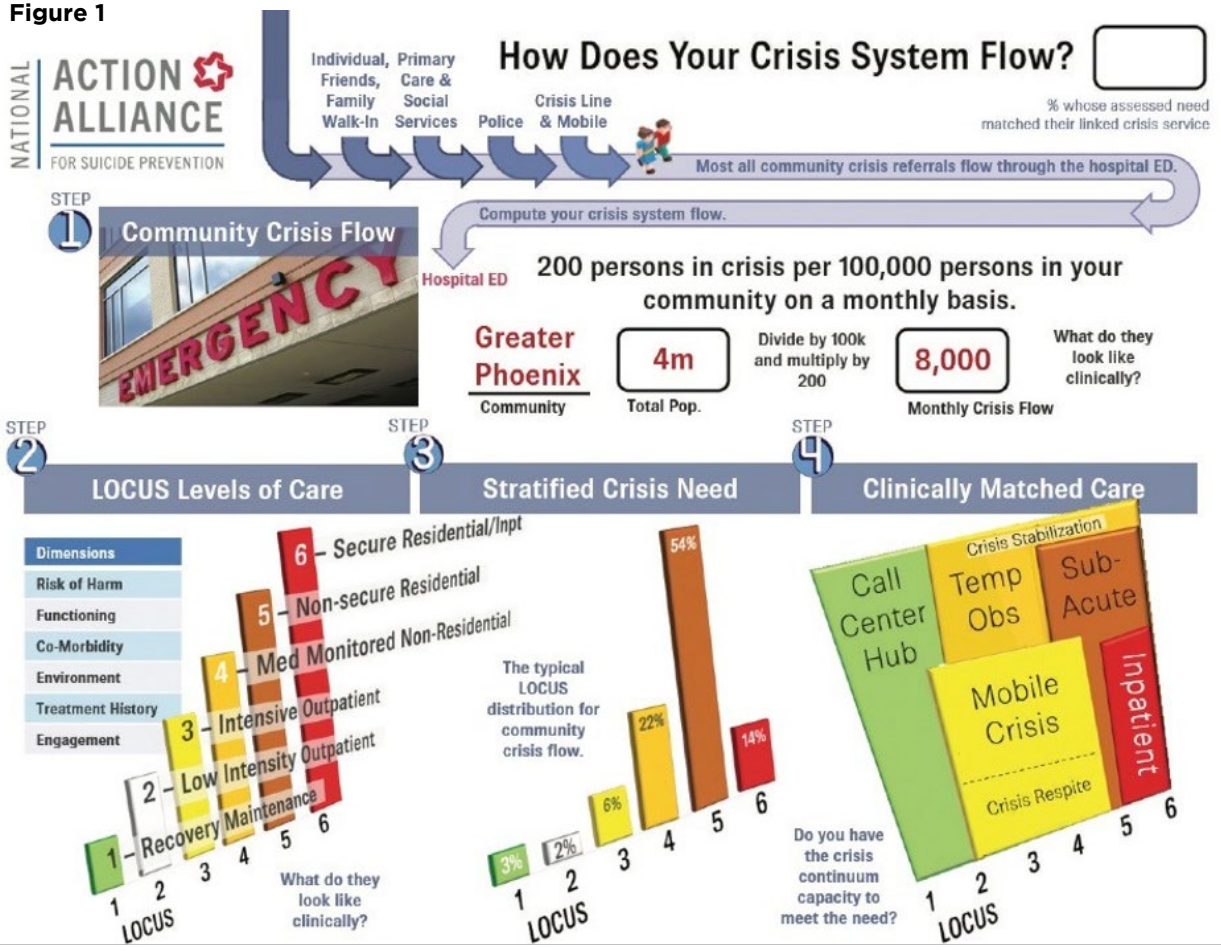


Expected volume of need: There is no clearly delineated standard for estimating the volume of need for crisis services in any community or region. The National Action Alliance for Suicide Prevention package, “Crisis Now,” recently released a document based on available data for the Phoenix, Arizona, area in Maricopa County, as illustrated in Figure 1, that suggests a guideline for estimating crisis need of 200 people in behavioral health crisis per 100,000 persons in your community on a monthly basis. This guideline (or other available community data) should be utilized to plan for network adequacy and geographic access in implementation of the following standards.

Measurable Criteria for an Ideal System

- **Crisis system network adequacy:** The accountable entity defines customer-oriented performance metrics for the crisis system and for each crisis service component within the system to regularly ensure the adequacy of system resources to meet the needs of the geography and the population within that geography. The following measures have been developed by reviewing of current standards from high-performing crisis systems and may include, but may not be limited to:
 - » **Time and distance to receive crisis response:** Usual standards are a 30-minute drive time in urban areas, one hour in rural areas.
 - » **Wait times and travel times for first responders:** Usual standards are that travel times are no greater than travel to the jail and wait times after arrival are less than 15 minutes.

Figure 1



- » **Percent of individuals withdrawing request for help before receiving service:** Usual standards are less than 5% of individuals leave prior to being seen.
- » **Adequate space and staff for evaluation:** Standard should be that staffing and space for evaluation should ensure privacy and dignity for each individual/family seen and should not require being kept in a large room with multiple chairs in a public observation area.
- » **Waiting time for disposition:** Standard is that the average time for disposition is three hours or less.
- » **Absence of ER boarding:** The Joint Commission for Accreditation of Hospitals defines boarding as more than four hours in the ER waiting for the next appropriate service. The target should be zero.
- » **Absence of “avoidable” arrests:** The target should be zero. The definition of “avoidable” may be developed collaboratively through the QI process.
- » **Absence of avoidable hospitalizations:** The target should be zero. Again, probably defined after the fact through the QI process.
- » **Absence of individuals and families not receiving help because of lack of response capacity:** The target should be zero.

- **Geographic access:** The accountable entity ensures a full continuum of services – including a crisis hub – is available for each catchment area within the larger system (e.g., within the region, county, city) up to the following maximum size of service population and/or geographic area served:
 - » **Consistent availability:** Every location in the nation should be part of a specific, geographically defined, comprehensive crisis service system overseen and maintained by an accountable entity. Every comprehensive service system provides adequate access to the full array of crisis services.
 - » **Appropriate role in overall behavioral health delivery system:** The Ideal behavioral health crisis system complements – but does not substitute for – the need for adequate access to good quality, comprehensive routine behavioral health care.
 - » **Maximum population of 250,000:** In an urban or suburban area, maximum population served by a crisis hub and a crisis service continuum is 250,000. An urban county of 1 million people would have a minimum of four crisis hubs/crisis continua, each one responsible for one quadrant of the county. Based on the guideline provided by Crisis Now, these four hubs or continua would collectively serve 2,000 individuals presenting in crisis per month, each averaging 500 per month, or 16.67 per day, who need an initial crisis assessment and response. The duration of the crisis episode might last for days or weeks, so the number of individuals served throughout the crisis system on any given day would be higher. The drive time to each hub should be no more than 30 minutes from any location in the urban catchment area; however, there may be some tertiary services (high cost, low volume) that might be provided by a specialty crisis center serving the entire urban area and supporting the individual crisis hubs, possibly through telehealth.
 - » **Maximum geography of one-hour drive radius:** In a rural or frontier area, maximum geography served is a one-hour drive radius from the largest regional hub, even if population in that geography is less than 250,000.
 - » **Combinations of population and geography:** In locations where urban and rural areas are proximal, maximum catchment area is defined by no more than 250,000 people and no more than one-hour drive from the regional hub.
 - » **Adaptations for frontier areas:** For very rural or frontier catchment areas where population may be significantly less than 250,000, service capacity may be correspondingly adjusted, for example, the available number of crisis beds may be less.
 - » **Access to telehealth services for underserved areas:** For rural or frontier catchment areas, as well as other areas where on-site service availability may be limited, it is understood that certain components of service like psychiatric assessment or qualified mental health professional assessment may need to be provided through telehealth to achieve full availability on a 24/7 basis. In a frontier area, a one-hour drive may bring the person to a rural ER that is served by telepsychiatry from a regional crisis hub. Each catchment area may need to develop unique solutions to provide the full array of crisis services to support its population and geography in a cost-effective manner.



QUALITY METRICS

The accountable entity must define specific quality metrics to measure performance for the ideal crisis system and each of its components to ensure transparency for all funders and stakeholders in the achievement of value-based quality performance on multiple dimensions. It is important to understand various types of performance measures and at what level of the system their application is most effective to incentivize behavior. Performance measures in health care can be categorized as follows:

1. **Structure:** the environment in which care is delivered (e.g., organizational structure, resources, staffing).
2. **Process:** the techniques and processes used to deliver care (e.g., use of screening tools or specific interventions).
3. **Outcome:** the outcome of the patient's interaction with the health care system (e.g., days in the community, housing and employment status).



An interesting consideration might be related to the Veterans Administration (VA) system. A system needs an analysis of its population, just as it tracks its road, fire hydrants, etc., to ensure that who they serve and who represents the population is taken in to account when planning, financing and analyzing the work. It would lead a community to ask, "Is there a military base in our community?" "Is there a VA?" to ensure linkage to them can occur, such as responders, informants and payers.

The selection and application of thoughtful quality metrics are critical to ensuring that the component parts of the crisis system work together in concert towards achieving common goals. First, one must articulate the foundational values of an ideal crisis system, then measures can be selected that reflect those values and tailored to incentivize desired outcomes at all levels of care. For example, if one of the core values is stabilization in the least restrictive setting possible, measures reflecting this value can be applied to service providers at every point in the continuum. It is important to note that measuring diversion rate is more than calculating how many people evaluated in an emergency room for hospitalization are sent elsewhere, because systemic diversion capacity is increased by the successful performance of each component of the crisis continuum working in concert with the other components. As such, crisis call centers measure the percent of calls that are resolved telephonically without having to dispatch police or mobile crisis, mobile crisis teams measure the percent of encounters that are resolved in the field without having to transport to an ER or other facility and crisis stabilization facilities measure the percent of encounters that are discharged to community settings without having to be admitted to inpatient psychiatric units or ERs, and so forth.

Measurable Criteria for an Ideal Crisis System

Quality measures are documented by the accountable entity and included in performance contracts for individual providers, other partners and the system as a whole. Quality measures meet the following criteria:

- **Values-based:** Measures are selected that reflect each of the foundational values of the crisis system and are tailored to incentivize desired outcomes at all levels of care. Relevant values for which metrics should be developed are listed in [Table 1](#) of the introductory section.

One published framework (Balfour, et al, 2016) suggests that crisis measures should be aligned at minimum to these values-based domains: timely, safe, accessible, least restrictive, effective, consumer/family-centered and community partnership. These domains are consistent with the Institute of Medicine's six aims for quality health care: safety, effectiveness, equity, timeliness, patient-centeredness and efficiency, while also focusing attention on goals unique to the behavioral health crisis setting.

- **Actionable:** Measures are actionable by the entity that is being held accountable and address structure, process and outcomes in line with the foundational values.
- **Aligned across all levels:** Quality metrics defined by the accountable entity are commonly aligned between various intermediary funders (e.g., counties, MCOs) and the providers with which they contract.

Consider a structure in which the state contracts with various accountable managed care organizations or behavioral health authorities (MCO/BHAs) or other accountable entities to manage crisis services. The state may have a goal to reduce ER utilization for mental health reasons. The state can include these outcome metrics in their subcontracts with additional metrics to ensure adequate attention and oversight of the issue, such as requiring that the MCOs provide a plan for reducing ER utilization among its members (a structure metric). Different MCOs may come up with different solutions. One MCO/BHA's plan may focus on increasing same-day access at outpatient clinics and, thus, their subcontracts with providers would in turn include process metrics such as referral-to-assessment time, percent seen within 24 hours of referral, etc. Another MCO/BHA may focus its plan on high utilizers of ER services and their subcontracts may include process metrics related to convening interagency case conferences to develop alternative service plans for these members. By comparing the performance across different MCOs/BHA, the state can learn which interventions are most effective and incorporate them into future MCO/BHA contracts. In this way, the cascade of performance incentives from state to MCO to provider can support values-based outcomes, foster innovation and support the continuous quality improvement efforts.

- **Collaborative:** Measures are developed in collaboration with community stakeholders. In addition, measures that require collaborative performance (e.g., individuals are seen in an outpatient clinic within seven days of completing service within the crisis system) are appropriately designed to reinforce performance by all the involved collaborating entities.
- **Clear and consistent:** Operational definitions for quality measures are clearly defined and measured consistently by all providers
- **Reported promptly and accurately:** Timely and accurate reporting of core quality metrics is a deliverable of all contracted providers in the crisis continuum.
- **Reported in a dashboard:** Measures are aggregated into a system-wide quality dashboard that is routinely and transparently disseminated to relevant stakeholders.
- **Included in a quality plan:** The accountable entity ensures the development of a quality assurance/performance improvement plan (QAPI) that is transparent, shared with all stakeholders, includes relevant quality metrics and aligns with provider and payer contract measures.
- **Aligned with performance incentives:** Quality metrics and value-based purchasing (pay-for-performance) contracting are aligned in order to drive system goals.

Quality metrics should demonstrate attention to all aspects of crisis system performance using a customer-oriented perspective that addresses both individual and family experience, relevant experience and crisis provider performance/experience. Structure, process and outcome measures should be included. The array of potential quality metrics in a crisis system is far too numerous to be fully delineated here. There are numerous examples in addition to the network adequacy measures described in the previous section that might include:

- Percent of crisis customers who have welcoming hopeful customer experience.
- Percent of customers who receive “no force first” engagement.
- Percent of crisis calls that are resolved without having to dispatch police.
- Percent of mobile crisis team encounters resolved in the field without ER or police transport.
- Percent of individuals discharged safely to non-hospital settings.
- Percent of individuals who receive crisis follow-up care within 48 hours.
- Percent of families engaged collaboratively in the crisis intervention process.
- Percent of crisis encounters resolved successfully within two hours.



IN THE STORY OF MR. Y: In a high-quality crisis system. Mr. Y’s behavioral health crisis in the convenience store might have been addressed by a mobile crisis team, without police and without force. Mr. Y’s behaviors would have been understood as part of a mental health crisis.



PERFORMANCE INCENTIVES

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. Accountability for delivering such services, at the community system oversight level or the provider level, commonly will incorporate performance incentives that may be tied to funding. It is important that those incentives are aligned with supporting the appropriate outcomes for individuals, like Mr. Y and families in need, as well as for the community as a whole.

Systems must be very cautious in application of incentives in contract to beware of unintended consequences that may drive crisis response in the wrong direction, as well as to avoid consequences that place disproportionate emphasis on some elements of response at the expense of others. Systems that are unfamiliar with the application of performance incentives to drive proper crisis system performance must obtain consultation from those who have more experience in doing this properly.

It is beyond the scope of this report to illustrate every possible example of a successfully worded incentive – that is why consultation is so important for systems that do not have the expertise and experience to design incentives properly. Poorly designed contract incentives have great power to inadvertently drive crisis systems to use limited resources unwisely.

A common example of performance incentive contracting involves creating a window for both incentives and penalties in relation to performance around an important metric. This type of contracting can be included in state contracts with MCOs, as well as in MCO (or other accountable entity) contracts with providers.

For example, an important quality metric might be: 85% of mobile crisis requests are responded to in less than 1 hour. The contract might be designed to include a 5% performance bonus for exceeding 90% and a 10% penalty for under 75%.

Another example involves paying a higher rate for desired activities. The Massachusetts Behavioral Health Partnership established an enhanced rate for “bridge visits” to facilitate rapid transitions from hospitals to community care, resulting in a decline in readmission rate.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring. The accountable entity, the crisis providers, other crisis partners and crisis service funders (insurers, MCOs) who are themselves contracted, are all partners in the crisis system who may have performance incentives (with financial rewards and penalties) incorporated into their contracts. Elements of successful performance incentives and performance contracting include the following:

- **Rewards and penalties balanced:** Performance incentives must always balance opportunities for rewards based on successful achievement, with penalties and withholds based on underperformance. Further, they should be designed on the assumption that the positive incentives will be achieved. The goal is to keep resources in the system to leverage progress, not to take resources away. Within this approach, small percentages of base funding can be withheld initially as contract incentives for performance, with the expectation that any reasonable performer can be successful.

- **Incentives aligned with successful response, not just utilization reduction:** Performance incentives must be aligned with successful crisis performance for individuals, families and the community, NOT with reduction in utilization. Any at-risk contracts must be careful to only award incentives for reduction of utilization when quality of care is simultaneously maintained at a stipulated acceptable level or increase.
- **Incentives are built on adequate base reimbursement rates:** See [“Financing.”](#)
- **Incentives are phased in:** Incentive payment methodology should be initiated with bonus payments for good performance. Negative incentives with reduced payment for poor performance should not be initiated until organizations have at least two years of experience with positive incentive value-based payments. Negative incentive penalties or payment reductions based on performance should not exceed 5% of the actual cost of service provision.
- **Report card of quality indicators:** Performance incentives can be tied to the specific measurable quality indicators included in other sections of the ideal crisis system recommendations and designed as a dashboard or report card. Each system can identify appropriate prioritization and weightings for different elements, based on the individual responsibilities and accountabilities of the various partners in the system.
- **Incentivize engagement:** Incentives based on reduction of utilization must always include a commensurate provision for achieving an adequate quality of care on selected performance measures or improvement in quality-of-care outcomes. For example, creating an incentive based on reduction in emergency crisis utilization could be associated with an increase in suicide, arrest or extrusion from community placement. Wording of the incentive must be framed with the positive result in mind: “An increased percentage of individuals in crisis receive a successful response from the crisis and community provider system without going to the ER,” or “Individuals who are frequent users of emergency crisis services have increased engagement in community services, including non-emergent contact with crisis providers, in order to reduce emergency visits.”
- **Prioritize responsiveness:** Incentives begin with an expectation of welcoming and proactive response to community members and service providers. It is important to highly prioritize responsiveness to counter a natural tendency of crisis providers to want to be non-responsive to situations they perceive to be “not real crises,” which leads to an inadvertent increase in the level of crisis presentation and crisis tone throughout the system. Metrics of success include identification and reporting of both welcoming access and instances of under-response. A different standard might endorse the value that all are welcome no matter which front door they enter and all should have a comprehensive plan when they leave.
- **Balance of clinical and administrative performance:** Incentives must balance attention to administrative drivers, like documentation requirements, with clinical drivers so clinical performance is prioritized. A crisis system with 100% meeting of documentation targets or 100% meeting timely completion of intervention targets is not doing a good job, because people in crisis may not permit perfect documentation and effective crisis response does not always fit into a strict timeframe for completion.
- **Collaborative development of incentives:** The crisis collaboration structure can be a venue over time in which incentives and metrics can be identified by reviewing previous QI conversations and identifying consensus community priorities for performance incentives in the coming year.
- **Annual review:** Performance incentives MUST be revisited annually to see which can be dropped as no longer meaningful and which are added to leverage the next steps of system and provider improvement.



FLOW AND THROUGHPUT

An ideal crisis system is comprised of component parts that form a continuum that quickly, efficiently and safely provides care matched to individual need. This issue is relevant to the determination of crisis system network adequacy, discussed earlier, but is also relevant to overall performance of the crisis system as a whole. Demand for crisis services can be projected, but never predicted with 100% accuracy. Therefore, the component parts of the crisis system must be orchestrated so they operate in concert to respond to variations in demand. Continuous monitoring of throughput is necessary so that a minor delay in one area doesn't become amplified, resulting in bottlenecks that create backups across the entire system.

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. 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 throughout the system with support from the accountable entity.

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.



Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and at least one accountable provider responsible for provision of direct services and/or coordination of all service element. The accountable entity should have the following approach to throughput management:

- **Ensure capacity:** As noted previously, crisis services should be funded and staffed in order to create capacity. This is sometimes referred to as the firehouse model – you are paying for the fire department/crisis provider to be available at 2 a.m. whether or not there is a fire/crisis at that time on that particular day, because there may be a fire/crisis at 2 a.m. tomorrow, and you need to be prepared.
- **Flow metrics:** The accountable entity is responsible for defining quality metrics that reflect expectations for timely care and efficient flow at each level of care in the continuum. In addition to the other metrics described in previous sections, these flow metrics are included in contracts and monitored in performance and include:
 - » **Time until the person seeking service gets what he/she needs:** Call center speed of answer, mobile team time from dispatch to arrival, facility door to doctor time, etc.
 - » **Flow from one level of care to another:** Crisis clinic door to discharge time, time from ER request to transfer to a crisis facility to arrival at the facility, crisis facility time from disposition decision to departure, facility length of stay, etc.
 - » **Indicators of excessive waits:** Call center dropped calls, hours of psychiatric boarding in emergency departments, facility left without being seen, facility hours on diversion, etc.
- **Community stabilization:** At each care level (e.g., call center, mobile team, crisis urgent care) the percentage of referrals that resulted in disposition to a lower level of care. Repeat visits/readmissions can be measured as a check and balance to mitigate the risk of incentivizing premature discharge.
- **Transparent reporting:** Performance data on flow and throughput is shared with stakeholders in the form of regular reports.
- **Response plans for immediate fluctuations in demand:** QI processes and plans are in place to monitor and respond to real-time fluctuations in demand and throughput (e.g., surge plans, flagging individuals with excessive waits/placement delays).
- **Response to trends over time:** QI processes are in place to monitor and respond to trends over time in demand and throughout (e.g., periodic evaluation of existing capacity and performance by the accountable entity, discussion at stakeholder meetings).
- **Improvement plans for systemic barriers to flow:** The accountable entity identifies and creates solutions for systemic barriers to throughput. Some areas where centralized planning can be beneficial include:
 - » Ability for the call center to make outpatient appointments with any provider, regardless of time of call.
 - » Bed registry with real-time monitoring of all inpatient bed capacity for a catchment area.
 - » Centralized bed placement function – one entity responsible for coordinating requests for transfer to inpatient psychiatric facilities.
 - » Ensuring timely transportation to the needed level of care.
 - » Working with providers to review and modify admission or discharge requirements that slow down or disrupt movement through the system.



COMPREHENSIVE CLIENT FLOW MONITORING DATA SYSTEM

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. Within that system, it is important to have the ability to monitor and follow client specific data through the system, both to identify instances where individuals fall through the cracks for individual cases and for aggregate understanding of overall utilization patterns. These data are often gathered through a centralized call center that supports the “air-traffic control” or “client flow monitoring” mechanisms of the system.

Measurable Criteria for an Ideal System

The accountable entity provides directly or through contract a data driven “air-traffic-control” system for client flow monitoring, which includes at least the following elements:

- **Centralized data system for client flow:** All 988 calls and crisis encounters are recorded in the data system with associated tracking of type, length, level of care and location of intervention, as well as whether appropriate continuity of services was maintained and whether recidivism occurred. The data system has the capacity to support care coordination efforts for individuals or cohorts, identify instances where clients are lost to follow-up and gather aggregate data for reporting to stakeholders for quality improvement and accountability.
- **Systematic level of care assessment:** The system uses formal definitions of the levels of care available and tracks the levels at which crises originate and assesses people in crisis for the level of care they need utilizing a multidimensional assessment that includes comorbidities and social determinants of illness (see [“Standardized Utilization Management and Level of Care Determination”](#)).
- **Resource identification:** The system has a mechanism (e.g., a “bed board”) to identify available resources within the crisis continuum to more effectively direct clients and manage flow and throughput in real time.
- **Data system reporting:** The crisis system’s data system regularly reports on key features of crisis system performance, ideally through an easily understood dashboard, so performance is transparent to all stakeholders **and collaborative improvement efforts can be easily implemented.**
- **Prompt reporting for care coordination:** All crisis encounters, ER visits and hospital admissions are promptly reported to the patients most frequently seen behavioral health and primary care provider within 24 hours of service. The reporting occurs as a data push that does not require the most frequently seen behavioral health or primary care provider to login and review a report on a daily basis.



FORMAL ASSESSMENT OF CUSTOMER SATISFACTION

In addition to the quality metrics already identified, it is important to have an effective mechanism for assessing customer satisfaction with crisis response already identified within the crisis system's QI processes. Customers include not only individuals and families in crisis, but also important referents such as law enforcement, ERs, behavioral health providers and human services providers. Routine, formal and objective assessment of customer satisfaction permits the accountable entity for the crisis system along with payers, providers and other system stakeholders to have objective criteria to monitor and continuously improve responsiveness of all components of the crisis system.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring that incorporates:

- **Routine formal assessment of customer satisfaction:** The accountable entity requires all crisis providers to routinely measure satisfaction of individuals, families and referents with all elements of crisis response, including welcoming access, timeliness, comprehensiveness, clinical quality and successful disposition. In addition, the accountable entity conducts its own measures of customer satisfaction.
- **Utilization of established customer service strategies such as “secret shopper:”** Understanding that individuals in crisis often have difficulty responding to customer surveys, the accountable entity regularly monitors access and responsiveness of the crisis continuum utilizing secret shoppers and similar techniques on a regular basis.
- **Data collection:** Customer satisfaction data are collected no less often than quarterly and utilized to provide positive and negative feedback to providers. Consultation and technical assistance are provided to crisis providers to help them continuously improve customer satisfaction. Contract incentives are tied to customer satisfaction performance and performance improvement.



IN THE STORY OF MR. Y: Mr. Y and his family would certainly would have given low consumer satisfaction ratings to the handling of his behavioral health crisis as might the police.



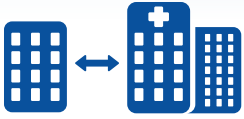
STANDARDIZED UTILIZATION MANAGEMENT AND LEVEL OF CARE DETERMINATION

A comprehensive behavioral health crisis system must have an effective mechanism for utilization management that uses a standardized tool to create a common language for determining level of care for both adults and youth in crisis. This permits the accountable entity for the crisis system along with payers, providers and other system stakeholders to have objective criteria to determine clinical service matching for individual clients and effective planning for resource allocation across levels of care within the crisis continuum.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, including utilization management, contracting and quality monitoring that incorporates:

- **Standardized level of care assessment:** All utilization managers, payer intermediaries and providers in the system utilize a standard professionally recognized best practice tool that permits objective, multidimensional and quantifiable determination of the appropriate level of service intensity to be provided for individuals in crisis (e.g., the Level of Care Utilization System [LOCUS] for adults, CALOCUS for children and adolescents, Early Childhood Service Intensity Instrument for children aged 0-5).
- **Continuing utilization management:** Standardized level of care determination criteria are used throughout each crisis episode, not just at the first contact, to determine when clients need to be transitioned to another level of service intensity, whether higher or lower.
- **Data collection:** The accountable entity collects, aggregates and reports data on utilization across different levels using the standardized tool and applies that data for case review, system improvement and resource allocation. Data are also generated on instances where the client is recommended for a certain level by the standardized tool, but that level is not available, so that lack of capacity can be identified and addressed.
- Performance improvement
 - » The portion of people receiving a level of care (LOC) lower or higher than that for which they scored is tracked and reported by payer.
 - » The accountable entity implements and maintains a program to measure and improve interrater reliability on scoring the LOC instrument across providers and between providers and payers.



RELATIONSHIP TO THE REST OF THE SERVICE SYSTEM

This comprehensive crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. As such, the crisis system and each of the crisis providers and programs, must be positioned as a proactive and helpful partner to all mental health, SUD, intellectual disabilities/developmental disabilities (ID/DD), brain injury (BI), health, public safety, education and human service providers within the community it serves.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for providing direct services and/or coordination of all service elements that has the following expectations incorporated into the contract with associated quality indicators and metrics of success:

- **Welcoming response to community requests:** The crisis system, and each element of the crisis system, demonstrates a welcoming response to requests for help from all components of the community service system. Welcoming response is a measurable indicator for oversight.
- **Customer service protocols for staff:** There are policies, procedures and protocols in place that define for staff who respond to requests for help the importance of a welcoming response from all community partners. This is defined as a customer service response – “Even if your request does not fit the narrow definition of a behavioral health crisis, we will work with you to see that we help you find a solution to the situation that led you to call.”
- **Instruct community partners how to ask for help:** The crisis system provides to all providers instructions for how to obtain a welcoming response, with instructions to ask for help sooner rather than later. There is a mechanism for immediately accessing administrators on call if the initial response is not satisfactory.
- **Administrator-on-call to facilitate response:** There is a 24/7 protocol for how to access administrators on call to negotiate challenging discussions between the crisis system and service providers so that the service provider experiences the crisis system as responsive and welcoming.
- **Response to customer complaints:** The accountable entity and accountable provider(s) regard each instance of customer dissatisfaction or customer complaint as a significant incidence for response within a QI framework. The type and number of these incidents are measured and contribute to incentive payments.
- **Proactive support and consultation to community partners:** When the community service system or individual providers are having difficulty with managing certain clients or situations, the crisis system has a mechanism for providing proactive response and consultation.
- **Continuous Improvement:** Within the crisis collaboration structure, the crisis coordinator and the accountable entity continuously document attention to how the crisis system can better support the community-based service system.

SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITY AND SERVICES

Introduction	62
Overall Design Elements	63
• Value-based System and Program Design.....	63
• Services Address the Continuum of the Crisis Experience.....	65
• Creating Safe Spaces That Are Warm, Welcoming and Therapeutic.....	67
• Safety and Security Practices That Are Both Safe and Welcoming.....	68
• Treating Law Enforcement as a Preferred Customer.....	69
Population Capacities	70
• Age: The Ideal Crisis System Provides a Comprehensive Continuum of Crisis Services for Children/Youth, Adults and Older Adults.....	70
• Crisis Continuum for People With Co-occurring Conditions.....	72
• Crisis Continuum for People With Cultural/Linguistic Challenges.....	75
Service Components	77
• Description of Continuum of Services.....	77
• Continuity of Care and Seamless Vertical and Horizontal Flow.....	78
• Effective Information Sharing Capacity.....	80
• Client Tracking Through the Crisis Continuum and Beyond.....	81
• Family and Collateral Outreach and Engagement.....	83
• Outreach and Consultation to Community Providers.....	84
• Telemedicine, Telehealth and Telepsychiatry.....	85
Elements of the Continuum	87
• Crisis Center or Crisis Hub.....	87
• Call Centers and Crisis Lines.....	91
• Deployed Crisis-trained Police and First Responders.....	93
• Medical Triage and Screening.....	95
• Mobile Crisis.....	97
• Behavioral Health Urgent Care.....	99
• Intensive Community-based Continuing Crisis Intervention.....	101
• 23-hour Evaluation and Extended Observation.....	103
• Residential Crisis Program Continuum.....	107
• Role of Hospitals in Crisis Services.....	114
• Transportation and Transport.....	120
Staffing Capacity	122
• Adequate Interdisciplinary Multidisciplinary Team Staffing.....	122
• Clinical/Medical Leadership and Specialty Consultation.....	124
• Peer Support.....	126

INTRODUCTION

This section describes the components, elements and capabilities of an ideal crisis continuum serving any community or catchment area. The organization of criteria in this section falls into five major subheadings.

- **Overall design elements:** These design elements relate to the creation of a crisis continuum that operationalizes core values, organizes crisis responsiveness to the full continuum of crisis experience and provides crisis space that is warm, welcoming, safe and secure, in which walk-in customers as well as law enforcement and everyone in between, feel that their needs can be appropriately met.
- **Population capacities:** This section addresses the need for the crisis continuum to be responsive to a full range of populations in need: individuals of all ages, ranging from children to elders; individuals with various comorbidities, such as mental health/substance abuse disorder (SUD), behavioral health/cognitive disabilities and behavioral health/medical conditions and disabilities; and individuals with cultural and linguistic challenges, including immigrants, hearing impaired populations, veterans and LGBTQI/gender-non-conforming individuals.
- **Overview of the service continuum:** This section addresses the core characteristics of a service continuum versus discrete and disconnected components, with the ability for both clients and information to flow smoothly through that continuum, as well as the ability to engage family members and other collateral informants (e.g., caregiver, friends, faith-based providers) and community providers and services, together with the individual client as part of their journey through the continuum, both with face-to-face services and application of telehealth capabilities throughout the continuum as needed.
- **Components of the crisis continuum:** This section describes the many specific components of an ideal continuum of crisis services. The centerpiece of this continuum is often an on-site crisis center sometimes termed a crisis hub or “crisis response center, that may include or coordinate with a full array of other components ranging from a call center, to the roles of first responders, to various types of mobile crisis, to various types of crisis beds, to acute inpatient beds, to various mechanisms for ongoing crisis intervention. There is a description of a centralized mechanism or point of accountability through which all the components of the continuum are coordinated, as well as capability to ensure that individuals and families in crisis do not get lost and are engaged effectively in needed services.
- **Staffing capacity:** The final section discusses the general staffing capacity needs within the crisis continuum, including the amount and types of staff needed, the types of clinical leadership needed, and the need for specialty expertise. This section does not, however, attempt to define the specific staffing pattern requirements for each component of the crisis system; that level of detail is beyond the scope of this document.



OVERALL DESIGN ELEMENTS

VALUES-BASED SYSTEM AND PROGRAM DESIGN

Safety is Foundational

Welcoming, customer-oriented, hopeful, strength-based, trauma-informed and person/family-centered services are essential.

Values-based, as used here, means that all services in the system are designed in accordance with core values. This term should be distinguished from value-based as applied, for example, to value-based payment, which means that payment is based on producing cost-effective outcomes. Although both terms are similar, and both are relevant to ideal behavioral health crisis systems, they refer to different concepts.

Some have conceptualized the medical model and recovery model as competing and incompatible frameworks at opposite ends of a spectrum. This is a false dichotomy. A much more useful framework is Maslow's Hierarchy of Needs Triangle. At the base is safety, which is everyone's responsibility. It encompasses elements often attributed to the medical model, such as risk assessment and nursing/medical protocols, as well as operational and physical plant considerations. Once processes are in place to ensure that people will be safe during their encounter with crisis services, additional recovery-oriented (welcoming, hopeful, strength-based, person-centered) elements are integrated, such as home-like environments, peer support, individualized service planning and shared decision-making. The boundaries between these levels of the triangle are not rigidly demarcated. For example, incorporating recovery concepts can improve safety (e.g., using peers in clinical processes to decrease restraints and injuries). Conversely, safety/medical concepts can enhance the ability to deliver recovery-oriented services (e.g., training peers to recognize and respond to safety concerns).

The full continuum of crisis services, including all programs and processes, needs to start with a set of values based on the safety and experience of the customers of that service. One of the primary challenges of crisis systems is the need to create a positive experience for individuals and families who wish to ask for help voluntarily and, at the same time, create a positive experience for individuals who are brought involuntarily and the law enforcement and other first responders who are usually responsible for transporting them to a safe place. Many crisis centers err in one direction or another. At one extreme, in order to establish security for those who are involuntary, the crisis setting resembles a holding cell. At the other extreme, in order to create a welcoming environment, individuals who are agitated, at risk of violence or unwilling to come cannot be served. A comprehensive crisis continuum needs to be accessible to all in need and, ideally, the "front door" of the crisis system is set up so those who are brought involuntarily have a safe and welcoming experience. It is always important to view the crisis continuum through the lens of the customers to ensure that foundational values are met.

Emphasizing safety first is a foundational principle. Crisis services serve people during the most acute periods of their mental health and/or substance use illnesses when the risks of suicide, homicide and other serious adverse outcomes are at their peak. In addition, the high burden of chronic medical illness among people with serious mental illnesses and/or substance use disorders results in a higher likelihood of premature death from chronic medical conditions especially during a crisis when people may not be able to engage in optimal self-care.

A foundation of safety implies safety for individuals receiving crisis services, staff providing crisis services, community referents (including law enforcement) and the community as a whole. Safety, however, is not in conflict with the other values – welcoming, hopeful, trauma-informed, person/family-centered – it is fully intertwined.

The more welcoming and hopeful services are, the safer they are. Creating trauma-informed services implies that individuals are safe from being re-traumatized. People who experience welcoming and hope (i.e., recovery-oriented services) are less likely to become agitated. Staff who provide welcoming, hopeful, trauma-informed services are less likely to get injured. While it is challenging to design services in which all these values are incorporated, it is feasible.

This also applies to providing services to racial, cultural, and ethnic minorities, who frequently experience all types of health and behavioral health services as traumatizing, in both overt and covert ways. Designing services that are proactively welcoming, intentionally focused on avoiding re-traumatization and being purposefully anti-racist and anti-discriminatory is the cornerstone of successful experiences for both service recipients and service providers.

Finally, it is important to acknowledge the inherent unpredictability in crisis services. There cannot be a pre-written rule for every scenario that may arise in a crisis setting. The 2016 United Airlines debacle, in which a passenger sustained serious injuries while being forcibly removed for refusing to give up his seat, dramatically illustrates the dangers of overly rigid and concrete reliance on rules, particularly when, as in this case, enforcement of rules may be disproportionately applied to minority populations. As the United CEO later said, “It was a system failure. We have not provided our frontline supervisors and managers and individuals with the proper procedures that would allow them to use their common sense. They all have an incredible amount of common sense, and this issue could have been solved by that.” In addition, one wonders if these actions would have occurred if the passenger in question had been white?

When rules fail, frontline crisis workers should be equipped with a firm understanding of core system values, and given the trust, support and skill (usually through role playing and rehearsal, as well as constant supervision) needed to engage in creative problem solving when confronted with challenging scenarios. Crisis system values must be embedded in guidance for staff in all situations, but in a pinch, a good rule of thumb is “First, safety is the prime directive; second, when in doubt, be welcoming; and third, follow the Golden Rule.”

Measurable Criteria for an Ideal System

There is a comprehensive crisis continuum comprised of programs capable of safely managing a continuum of acuity.

- Programs range from serving:
 - » **High-risk populations** that need intensive psychiatric and medical interventions in a highly-monitored and locked environment.
 - » **Low-risk populations** that mostly need peer and recovery support in a low- intensity home-like environment.
- All program environments create a welcoming, hopeful and trauma- informed experience, including those for high-risk population (See [“No Force First: Maximizing Trust and Collaboration, Minimizing Seclusion and Restraint”](#) for a discussion of clinical processes).
 - » Enhancing staff engagement processes, including, but not limited to peer support, in high-risk environments.
 - » Procedures are in place for reducing conflict and maximizing de-escalation while emphasizing hope for a successful resolution of a painful situation.
- Space designed to permit minimal conflict and over-stimulation. Triage processes in place to ensure that patients are placed in the setting best matched to their acuity and safety needs.
 - » Placing someone in a high acuity crisis in a setting designed for low acuity crises results in risk for adverse safety outcomes.
 - » Placing a person in a low acuity crisis in a setting designed for high acuity crises results in risk for suboptimal treatment experience and inefficient use of resources, as these settings often are more expensive.
 - » The “no wrong door” concept ensures that people are accepted and NOT turned away wherever they present. If a person in high acuity distress presents or is brought by law enforcement to a low acuity program, processes are in place to quickly transfer to the appropriate program, and vice versa.

The accountable entity has a quality improvement/performance plan that includes oversight of all aspects of client experience, including safety, welcoming, hope and avoidance of re-traumatization. This plan should include:

- **A defined set of safety incidents reported to the accountable entity.** These should include both events related to behavioral health safety (e.g., self-directed violence with injury, assaults, falls) and events related to medical management (e.g., adverse medication reactions, transfers to medical emergency rooms (ERs) for glycemic management, etc.).
- **A defined set of criteria identify whether or not people have been welcomed and engaged,** whether hopeful messages have been provided and whether appropriate conflict reduction strategies have been applied in a trauma-informed person-centered manner.
- **At the accountable entity level, reportable incidents are tracked, trended and discussed** in order to identify program-specific and system-wide opportunities for improvement.
- **At the program level, reported events are tracked, trended and discussed to identify improvement opportunities.**
 - » The physical health field has well-established patient safety program framework that should be adapted to behavioral health crisis settings.
 - » Sentinel safety events should result in a root cause analysis in order to learn from the event and develop a plan to mitigate the risk of similar events in the future.
- At both the accountable entity and program level throughout the crisis continuum, safety culture and welcoming, customer-oriented experiences should be assessed regularly with a validated tool such as the Agency for Health care Research and Quality Culture of Safety Survey.

SERVICES ADDRESS THE CONTINUUM OF THE CRISIS EXPERIENCE

Another fundamental characteristic of crisis continuum design is recognition that the crisis experience encompasses more than a single discrete event. Individuals and caregivers may seek help early as warning signs manifest prior to the acute crisis event. In fact, crisis resolution is enhanced when individuals seek help sooner rather than later. However, many crisis systems focus attention only on the acute event (e.g., the 911 call). This can result in ill-considered barriers, such as requiring that a person be imminently suicidal or dangerous in order to qualify for services. Thus, the system inadvertently incentivizes allowing people to decompensate before they can receive help, which escalates the overall level of crisis in the system. Conversely, some crisis systems aren't able to provide services for the most highly acute crises and, as a result, the default disposition for these individuals is often emergency departments or jails.

Furthermore, the crisis experience does not abruptly end after the individual has been assessed and had referrals made for disposition. Rather, a crisis is an episode of care requiring a time-limited set of services to ensure smooth transition back into more routine community-based care. After a crisis encounter or admission, individuals may need assistance navigating the system, problem-solving for system barriers (such as problems filling prescriptions) and ongoing support as they recover from their crisis, as well as support to ensure successful engagement with ongoing community services, particularly when such services have not been established prior to the crisis.

An ideal crisis system should be able to respond to the full continuum of the crisis experience with services that are easy to access, tightly coordinated and have a timeframe that supports the goal of staying engaged with resolving the crisis until the person can be successful in the most community-based setting possible.

Measurable Criteria for an Ideal System

Pre-crisis: In addition to 988 call centers, services and outreach activities that can prevent individuals experiencing early crisis signs from progressing to an acute crisis event include the following:

- **Community outreach and education:** The accountable entity supports education and training to the community regarding how to recognize and respond to individuals with mental health needs (e.g., Mental Health First Aid [MHFA]) and information about how to access 988 and the local system, including encouragement to ask for help quickly from the crisis system if there is an emerging need for an individual or family member.
- **Walk-in and after-hours access at community mental health clinics:** The accountable entity requires community mental health clinics and other community-based services (e.g., assertive community treatment [ACT] teams, home-based support teams) to have plans in place to ensure walk-in crisis capability and after-hours access to critical services (e.g., medication refills) for their current clients, not just a recording directing them to call 988 or 911. This is a certification requirement for Certified Community Behavioral Health Clinics (CCBHCs).
- **Easy enrollment and access to services:** The accountable entity ensures 24/7 assistance to individuals and caregivers seeking information about enrolling in services, including the ability to make an urgent appointment with an appropriate network provider within seven days. This is a certification requirement for CCBHCs.

Acute crisis: The accountable entity ensures that the continuum of crisis services (as described in Section 2, the current Section) provides service to all in need in a given catchment area. Services are not arbitrarily limited to narrow criteria such as involuntary status, law enforcement custody, etc.

- **Early access encouraged:** There are no rules that require the individual be possibly committable or at risk of hospitalization to access crisis services.

Individuals seeking care voluntarily are welcome to access acute crisis services as needed in order to prevent further progression of their symptoms. The crisis continuum can step up quickly when routine pre-crisis services are unavailable or unresponsive to individual need. This is a certification requirement for CCBHCs.
- **Access to crisis services for a full range of conditions is available.** There are no rules that require the presence or absence of particular diagnoses. There is no exclusion due to comorbid conditions such as substance use disorder or intellectual disability. This is a certification requirement for CCBHCs.
- **High risk access easily available:** Services readily exist for the most highly acute individuals (e.g., agitation, intoxication, dangerousness), including those who are at potential risk. It is not necessary for someone to demonstrate violent action or self-harm before they can receive an appropriately urgent response.

Post-crisis: The accountable entity ensures that the crisis care episode includes smooth transitions among components in the crisis continuum and coordinated handoff to post-crisis care. This includes:

- **Continuing care coordination:** Care coordination is routinely available as the individual transitions through different levels of the crisis continuum (e.g., mobile crisis to acute crisis stabilization to crisis residential step-down). This is a certification requirement for CCBHCs.
- **Post-crisis services:** Post-crisis services are routinely available which provide care, coordination and support until the individual successfully transitions to routine community-based continuing services. This is a certification requirement for CCBHCs.

CREATING SAFE SPACES THAT ARE WARM, WELCOMING AND THERAPEUTIC

One of the important mechanisms for embedding appropriate values in the design of crisis services is the space in which services are provided. The ideal crisis care system has facilities that are welcoming, therapeutic and respect individuals' dignity and privacy. The physical architecture of a crisis facility can influence engagement, treatment and outcomes for people with mental illnesses in crisis. Crowding, loud noise, poor indoor air quality and inadequate light can contribute to anxiety and agitation. Therapeutic environments maximize open space and access to natural lighting.

Furthermore, the ideal crisis care system must have facilities that promote the safety of staff, clients, visitors and members of the public. Clients, many of whom have histories of trauma, may be unable to focus on recovery and be more likely to act out behaviorally if they feel threatened or at risk of injury and staff cannot provide optimal care in an environment in which they feel unsafe. Therefore, the ideal crisis care system provides a secure physical environment and has strategies to address safety concerns as they arise.

The emphasis on safety should not compromise the therapeutic milieu in an ideal crisis care system; patients should not feel they are being treated as potential threats, unless demonstrating threatening behavior. Design and safety should work together to create a therapeutic milieu that enhances mental health and addiction care.



IN THE STORY OF MR. Y: When Mr. Y was taken to the detention center, his presentation deteriorated further. A welcoming, safe, therapeutic space, as opposed to a solitary confinement cell at the jail, would have spared him further trauma and perhaps hastened his recovery.

Measurable Criteria for an Ideal Crisis Space

Crisis space design should ideally be reviewed prior to construction by an advisory committee of stakeholders including consumers, families, crisis staff and law enforcement in order to ensure that the best possible design is achieved to balance the full range of needs. Safe spaces maximize the safety of clients, staff and visitors, while keeping the client experience as pleasant as possible. The following criteria should be utilized by the accountable entity to review crisis service space and facilities to determine whether the space is safe, welcoming and therapeutic: While acknowledging that the design of specific facilities must be tailored to state and local building codes, regulatory requirements, existing physical plant constraints and the level of acuity of the population to be served, the following criteria are general principles to guide the planning and design of crisis facilities in an ideal system.

- Layout allows easy visual observation of clients by staff, without compromising client dignity and respect.
- Ligature and other safety risks are minimized via the use of specialized hardware and fixtures with special attention to bathrooms, as these are the highest risk areas within behavioral health facilities.
- Furniture is comfortable, heavy (i.e., hard to throw) and easy to clean.
- Elopement risks are minimized via the use of secure entry/exit.
- Quiet rooms that are separate from the common milieu are available where clients can de-escalate.
- Interview areas that permit privacy while permitting safe exit if agitation occurs.
- Seclusion or restraint rooms should contain proper equipment and safety features to minimize injury, such as rounded corners, safety padding, etc.
- Cameras both enhance the ability to provide real-time monitoring and also allow video review of safety incidents for compliance and quality improvement purposes.

Therapeutic spaces are designed based on current principles of evidence-based design, with input from relevant stakeholders, including clients/families.

- Ample use of natural light and views of outside green space.
- Acoustic abatement to reduce noise levels.
- Therapeutic milieu with open spaces and seating areas that facilitate interaction.
- Familiar and non-institutional-looking materials with calming colors, varied textures and soothing artwork.
- Design features to assist clients' orientation, such as direct and obvious travel paths, key locations for clocks and calendars and avoidance of glare.
- Adequate separation and sound insulation to prevent confidential conversations from traveling beyond consulting offices.

SAFETY AND SECURITY PRACTICES THAT ARE BOTH SAFE AND WELCOMING

Crisis services must be able to safely respond to individuals of varying levels of behavioral acuity while also maintaining a welcoming and engaging experience. It is difficult, but critical, to maintain this balance. Services that sacrifice safety can lead to poor outcomes, while sacrificing engagement can discourage people from seeking services altogether.

Two common areas of concern are the use of security personnel and the degree to which patients are searched. Staff who feel unsafe tend to advocate for the most extreme security measures such as liberal use of uniformed security guards and metal detectors. However, such measures do not necessarily increase safety and may create a more adversarial atmosphere that leads to more agitation rather than less. The need for such measures should be kept to a minimum and can be reduced with appropriate staffing and training combined with a quality improvement approach that seeks to learn how to prevent unsafe situations from occurring.

Measurable Criteria for Safety and Security Practices That are Both Safe and Welcoming in an Ideal System

- **Crisis facilities have a safety and security plan that maximizes both safety and engagement and is reviewed at least annually.**
 - » A wide variety of stakeholders have the opportunity to provide input, including front-line staff and clients/peers.
 - » Injuries and assaults are reported, tracked and trended.
 - » Quality improvement processes are in place to discover and address common precipitants of agitated or violent behavior (e.g. long waits without treatment, frustrating intake processes).
 - » Critical incidents (i.e., calling security/police) trigger a critical incident review or root cause analysis.
- **Agitated and violent behavior is managed by trained behavioral health staff rather than security personnel.** It is possible to provide crisis services to people in the most behaviorally acute crises without the use of security personnel. Staff receive regular training in de-escalation best practices, such as preventing and managing crisis situations.
- **Search protocols are matched to the intensity of the crisis service being provided.** For example, people voluntarily walking into a crisis clinic may be asked to place their belongings in a locker, while people needing admission to a locked observation unit require a more extensive search including metal detectors and removal of potentially dangerous items.
- **Processes are in place to ensure that staff can quickly call for assistance such as panic buttons, radios and behavioral codes.** Further, all staff are trained in – and rehearse – how to respond promptly to situations in which escalation is occurring.

TREATING LAW ENFORCEMENT AS A PREFERRED CUSTOMER

Within the overall framework of a customer-oriented, value-based service design, it is important to create a welcoming experience for all customers, including law enforcement personnel. Law enforcement are often the first responders to behavioral health crisis and provide transportation for people they arrest for cause or whom they believe meet state criteria for emergency voluntary or involuntary evaluation. Policies regarding physical and chemical restraints in custodial situations need to consider both citizen and officer safety and the impact these controls have on people with mental illnesses.

Given recent events in 2020, utilization of law enforcement in providing crisis services for those living with mental illness has reached a point of reckoning. Public mental health services must be enhanced, with the resulting diversion of crisis intervention moving from traditional law enforcement to mental health and addiction recovery workers.

Crisis facilities that are capable of assuming custodial responsibility should be available at all times and have qualified personnel to conduct a mental health evaluation. To enable officers to return quickly to their duties, information should be obtained efficiently and protocols should ensure that medical triage/screening for clearance, if needed before drop-off, is completed in a timely manner. People considered to have behavioral health needs who are brought by law enforcement to community crisis centers that are the “front door” of the crisis system in that community should never be turned away.

It is important to have safe and welcoming protocols that transfer custody (care) of a person who is brought involuntarily from law enforcement personnel to welcoming crisis center staff, while at the same time making sure the person is in a secure location so that they will not immediately walk out the door necessitating law enforcement to pick them up again. Protocols are also needed for those individuals who have been arrested and need to remain in police custody following crisis assessment (as for expressing suicidal ideation) whether or not they are referred for hospitalization. Treating law enforcement as a preferred customer – with quick, easy, and successful drop off – incentivizes them to bring people in need of crisis services to treatment instead of jail.

Measurable Criteria for an Ideal Crisis Continuum That Treats Law Enforcement as a Preferred Customer

- **All law enforcement officers are trained on the potential for trauma from the use of restraints.**
- **Law enforcement follows its own policies regarding restraints in custodial situations.**
- **Each jurisdiction has access to a crisis facility capable of assuming custodial responsibility** for individuals with behavioral health needs 24/7.
- **Protocols at receiving facilities are in place to achieve a transfer of custody as quickly and efficiently as possible, with a goal of 15 minutes or less.** Data is collected on the wait times for law enforcement personnel in crisis settings. Data is collected to ensure that individuals brought in by police are not released without thorough evaluation and provision for safe follow-up.
- **If an individual arrives in restraints, protocols are in place for crisis personnel to remove the restraints and begin treating him/her as a client** – in a welcoming, hopeful, trauma-informed manner – as quickly as possible.
- **If an individual has already been arrested, protocols are in place for maintaining communication with the arresting law enforcement agency** to ensure that proper supervision is maintained throughout the individual's continuing care.
- **The crisis system's community collaborative identifies a stakeholder group to review data and adjust policies and procedures to improve public health and public safety outcomes,** minimizing use of arrest and incarceration.



IN THE STORY OF MR. Y: The lack of an ideal crisis system left the police with limited choices, as arresting him may have been more expedient than taking him to a crowded emergency room. Implementation of an ideal crisis system would have improved the interaction between Mr. Y and law enforcement officers, enabling them to quickly provide information and drop him off for mental health evaluation and treatment without arresting him.



POPULATION CAPACITIES

AGE: THE IDEAL CRISIS SYSTEM PROVIDES A COMPREHENSIVE CONTINUUM OF CRISIS SERVICES FOR CHILDREN/YOUTH, ADULTS, AND OLDER ADULTS.

Crisis services welcome all in need. Although most crisis services are primarily for adults, there is a need for specialized programs and services to meet the unique needs of children and older adults across all shifts. This involves designing separate spaces for provision of crisis services to children who are sufficient in size to meet the needs of that population in the crisis system's catchment area, as well as preparing staff for the unique needs of these populations and identifying when pediatric or geriatric specialist services and providers are necessary.

Measurable Criteria for an Ideal System

The accountable entity should ensure provision of a full continuum of safe and accessible crisis services for children/youth and older adults, as follows:

- **Services for children and youth:**
 - » **All types of services within the crisis continuum are available to children/youth.**
 - » **All services provided in facilities have separate space capacity to serve children and youth.** In larger systems with high numbers of consumers, there might be sufficient volume to create a separate child/youth continuum of services (e.g., child/adolescent crisis access center, child/adolescent crisis stabilization, crisis residential services). In large volume settings, services for children may need to be separated from those for adolescents. In smaller systems, it may be adequate to have separate spaces available within existing services with separate staff or staff who are dually trained for adults and children, depending on volume of need where children/youth can be served. In even smaller systems, children/youth in severe crisis may occur only occasionally, so there may need to be capability to provide services individually with wraparound staffing either at home or in another safe location.
 - » **Home-based crisis services for children/youth and families are available for both acute intervention and continuing crisis intervention.** These services apply wraparound principles or other best practice approaches (e.g., Open Dialogue) to engage families for a period of crisis resolution prior to connection to continuing community-based services.
 - » **Established relationships and protocols to guide services to child serving agencies and systems that are important customers.** Crisis services for children often respond to the needs of schools, juvenile detention, child protective services and child residential settings (foster care and group homes). These services must also attend to legal custody and guardianship issues, including sometimes conflicting parental wishes. Responsive protocols must be developed to attend to needs of child agency customers and include mechanisms to solve problems collaboratively. Legal consultation should be available for issues regarding custody and child protection.
 - » **Service network adequacy for children/youth and other quality parameters, are measured and monitored separately from adult monitors, by both the accountable entity and by each involved provider.** Improvement plans for evidence of inadequate or suboptimal services are regularly developed to ensure that services for children/youth meet the same quality standards as those for adults.

- » **All services provided in facilities have separate space capacity for serving children and youth.** In larger systems, there might be sufficient volume to create a separate child/youth continuum of services (e.g., child/adolescent crisis access center, child/adolescent crisis stabilization, crisis residential services). In large volume settings, services for children may need to be separated from those for adolescents. In smaller systems, it may be adequate to have availability of separate spaces within existing services where children/youth can be served with separate staff or staff who are dually trained for adults and children available, depending on volume of need. In smaller systems, children/youth in severe crisis may occur only occasionally, so there may need to be capability to provide services individually with wraparound staffing either at home or in another safe location.
- » **Home based crisis services for children/youth and families are available for both acute intervention and continuing crisis intervention.** These services apply wraparound principles or other best practice approaches (e.g., Open Dialogue) to engage families for a period of crisis resolution prior to connection to continuing community-based services.
- » **Service network adequacy for children/youth and other quality parameters are measured and monitored separately from adult monitors, by both the accountable entity and by each involved provider.** Improvement plans for evidence of inadequate or suboptimal services are regularly developed to ensure that services for children/youth meet the same quality standards as those for adults.
- **Services for older adults:**
 - » **All types of services in the crisis continuum are available to older adults.**
 - » **All services provided in facilities have adaptable space and supports for serving older adults who may have physical or cognitive limitations and/or are medically frail.** In most systems, this requires specific provisions for medical and physical safety on as needed basis in existing facilities to accommodate the needs of older adults who have these limitations. There should be provision as well for visiting nurse services to supplement existing staff capabilities in crisis residential settings when indicated.
 - » **Home-based crisis services for older adults in need and their families/caregivers are available for both acute intervention and continuing crisis intervention.** These services apply wraparound principles or other best practice approaches (e.g., Open Dialogue) to engage families for a period of crisis resolution prior to connection to continuing community-based services. Visiting nurse services may supplement the capability of these services for individuals who have complex medical needs.
 - » **Service network adequacy for older adults and other quality parameters are measured and monitored separately from adult monitors, by both the accountable entity and by each involved provider.** Improvement plans for evidence of inadequate or suboptimal services are regularly developed, to ensure that services for older adults meet the same quality standards as those for adults.
- **Services for both children/youth and older adults:**
 - » **Clinical practice development and access to specialty consultation:** All programs in the crisis continuum that may be serving populations that include children, youth and/or older adults should have protocols for clinical practice guidelines and competencies for all staff and expect them to understand and respond to the unique needs for the children and older adults they will be serving. Specific content areas for these practice guidelines will be discussed in [“Screening and Intervention to Promote Safety”](#) and access to specialty consultation is discussed in [“Clinical /Medical Leadership and Specialty Consultation.”](#)



» **Coordination with community resources:** Within the community crisis collaboration, it is expected that there will be a specific committee that focuses on resource coordination for children and youth, in which those agencies that work primarily or exclusively with children/youth/families establish the networking, guidance and oversight to ensure the successful functioning of the crisis continuum for that population. It is helpful to have a specific committee or subcommittee that has a similar focus on the subset of resources and agencies that work primarily or exclusively with older adults. The crisis coordinator, or designee, will work specifically with each of these subpopulation collaborations to ensure that necessary information and protocols are communicated throughout the crisis continuum.



» **All relevant crisis programs in the continuum have access to policies, procedures, protocols for engaging and coordinating with age specific human service agencies, providers and resources.** More detailed discussion of coordination with community services is provided elsewhere in this document.

CRISIS CONTINUUM FOR PEOPLE WITH CO-OCCURRING CONDITIONS

Continuum of Co-occurring Capable Services for People in Crisis with Co-occurring Mental Health and Substance Use Conditions

A comprehensive behavioral health crisis system, with a complete continuum of services responsive to individuals in crisis with any combination of mental health and SUD presentations, is an essential element of safety-net health and human services for any community. Because of the high prevalence of crisis presentations in which substance use and/or SUD are an issue, the crisis continuum must maximize its capacity within all services to respond to individuals with substance related crises, with or without co-occurring mental health conditions. This is a certification requirement for CCBHCs.

Measurable Criteria for an Ideal System

Continuum of Crisis Response for Substance Use Disorder/Co-occurring Disorders

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible to provide direct services and/or coordination of all service elements that incorporate the following expectations and performance metrics into the design of the crisis system.

- **Comprehensive continuum of substance use disorder/co-occurring disorders (SUD/COD) crisis services:** Individuals and families in crisis with active substance use, with or without co-occurring mental health conditions or symptoms, are welcomed for crisis response and have access to a continuum of services to appropriately meet their needs based on level of severity of intoxication/withdrawal, severity of medical risk, severity of mental health comorbidity and stage of change for addressing substance use. Some systems may provide crisis services specific for individuals with active substance use disorders, such as sobering centers or withdrawal management (detox) programs, while others may provide withdrawal management services as part of medically monitored mental health/SUD crisis residential programs and provide sobering drop-in services as part of more

People with co-occurring illnesses and complex needs are an expectation, and require routine access to integrated services that provide appropriate crisis intervention.

generic mental health/SUD crisis respite programs. In either case, the focus must be on meeting individual needs and engaging individuals in continuing care, just as for any other individual in crisis, not simply the process of becoming sober or entering detox.

- **Co-occurring capability:** All crisis providers and programs in the continuum are co-occurring programs that have a formal commitment to co-occurring capability, engage in regular self-assessment using established tools ([COMPASS-EZ](#), [DDCAT/DDCMHT](#)) and demonstrate regular quality improvement (QI) planning and activity to improve continuously over time. Specifically, all crisis programs designed to respond to mental health crisis, including mobile crisis and peer respite services to psychiatric inpatient units, must be co-occurring capable. Further, all crisis programs designed to respond specifically to individuals in SUD crisis must be co-occurring capable as well. Crisis service matching for individuals with both mental health and SUD needs is based on which setting best meets the needs of the individual.
- **No access barriers based on substance use levels:** Under no circumstances should any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with substance use based on requiring alcohol level to be below a certain number or that a urine screen must be completed and cleared prior to initiation of services.
- **Managing intoxication and withdrawal:** All crisis providers shall have policies and protocols to manage individuals experiencing a behavioral health crisis who may be intoxicated in a welcoming and safe manner and to provide support for withdrawal management commensurate with the level of medical care available. The vast majority of intoxicated people do not require a medical intervention to safely become sober. The determination of level of medical detox is based on assessment of history and risk factors. All but the most severe detoxes can be managed in non-hospital settings.
- **Medication-assisted treatment (MAT) initiation and induction:** The crisis system must have routine capacity to induct individuals into MAT for opioid use disorder (OUD), with or without co-occurring mental illness, including buprenorphine induction, initiation of naltrexone (as for jail discharges who are at risk) and rapid connection to same day or next day methadone initiation. This is a certification requirement for CCBHCs.

Increasingly, state of the art crisis centers, such as the crisis response center (CRC) in Tucson, Arizona, are developing the capacity for initiation of MAT immediately on site for individuals in behavioral health crisis with opioid abuse disorder (OUD) who are at high risk of overdose.

- **Collaboration with SUD providers:** For individuals who do need and want referral to abstinence-based addiction services for any SUD or COD, the crisis system maintains strong partnerships with the continuum of SUD service providers, including provision of proactive consultation and welcoming offers of instant crisis response for clients who become hard to manage safely. This is a certification requirement for CCBHCs.
- **These guidelines are monitored for quality improvement and performance incentives.**

Continuum of Co-occurring Capable Services for Individuals in Behavioral Health Crisis With Co-occurring Medical Conditions/Disabilities and/or Cognitive Conditions/Disabilities.

Because of the frequency individuals with behavioral health crisis presentations also have co-occurring medical and/or cognitive conditions, a comprehensive behavioral health crisis system must have a complete continuum of services responsive to individuals in crisis who may have a wide range of medical and cognitive conditions or disabilities.

Measurable Criteria for an Ideal System

- **Continuum of crisis response for co-occurring mental health and addictions recovery and medical needs:** The accountable entity establishes the following criteria for individual crisis providers and for the system as a whole.
 - » **Access for individuals with medical conditions:** The crisis continuum welcomes the opportunity to provide behavioral health crisis services to all individuals whose medical conditions do not require immediate emergency medical intervention in an ER or who do not require medical hospitalization and/or round the clock skilled nursing care. This includes admitting and working with individuals who may require injectable medications (e.g., insulin), portable oxygen and similar medical interventions that would ordinarily be carried out by the individual at home with minimal assistance. There are no arbitrary barriers to access to crisis services based on the presence of an ambulatory medical condition and associated treatment needs.
 - » **Access for individuals with infectious diseases:** For individuals with common infectious diseases (e.g., TB, HIV, hepatitis, COVID-19), there are provisions available to maintain safety with regard to disease transmission to other individuals in behavioral health crisis who may be in the same program. This includes provision for on-site testing, availability of personal protective equipment and procedures for quarantine in the event of positive testing, as for COVID-19.
 - » **Access for individuals with physical disabilities:** The crisis system is a full continuum of services that are accessible by those with disabilities. Further, the crisis system is able to serve individuals who have ambulatory impairments and those who are visually or hearing impaired throughout the continuum and make provision for service animals, American Sign Language (ASL) translation and other supports as needed.
 - » **Access to ambulatory medical services:** For individuals who may be in crisis residential settings, there is routine provision for access to medical services that would normally be provided on an outpatient basis. This may include visits with medical providers, access to home nursing and access to routine laboratory or imaging services.
 - » **Coordination with medical providers:** Crisis system providers are expected to identify, notify and maintain contact with individual's primary care providers and other specialty health providers who may be actively involved in the individual's current care for the purpose of coordinating all aspects of health and behavioral health care in an integrated fashion during and after the crisis.
- **Continuum of crisis response for co-occurring behavioral health and cognitive needs:** The accountable entity establishes the following criteria for individual crisis providers and for the system as a whole:
 - » **Access for individuals with cognitive conditions:** The crisis continuum welcomes the opportunity to provide behavioral health crisis services to all individuals whose crisis needs may coexist with the presence of a chronic cognitive condition such as an intellectual/developmental disability, dementia or acquired brain injury. Individuals with acute delirium or acute cognitive impairment generally will require a medical evaluation and intervention. For those with chronic conditions, there should be no arbitrary exclusion criteria based on IQ level or similar intellectual measurement parameter. The criteria for access should be that the individual's acute behavioral health crisis need is more severe than can be managed by their current service providers and/or current service setting. For individuals who are non-verbal, the behavioral health crisis system will respond to provide consultation and collaboration with the individual's current service or support providers to help to assess and manage the crisis.
 - » **Crisis system capability to assist individuals with chronic cognitive impairment:** All crisis intervention services must have the basic capacity to work with individuals who have intellectual or cognitive disabilities and their caregivers. This involves having basic competencies for how to provide and modify interventions based on cognitive ability, as well as access to supervision and specialty consultation for assistance with ID/DD, BI and dementia.

- » **Coordination with cognitive disability service and support providers:** Crisis system providers are expected to understand the respective responsibilities of the behavioral health crisis system and any existing crisis systems or services for individuals in the ID/DD, BI and/or aging/neurocognitive disability systems of care, including skilled nursing facilities, nursing homes, assisted living facilities and rehabilitation facilities and to coordinate and collaborate with those service providers so that the individual is managed in the best location in a collaborative fashion. At no point should the behavioral health system deny service when the collaborative system states that it is unable to manage the individual's behavioral health needs. In addition, the behavioral health crisis providers must identify, notify and coordinate immediate and ongoing service planning with the individual's primary caregivers and support providers as well as other specialty providers who may be actively involved in the individual's current care, for the purpose of coordinating all aspects of behavioral health care and cognitive/social supports in an integrated fashion during and after the crisis.

CRISIS CONTINUUM FOR PEOPLE WITH CULTURAL/LINGUISTIC CHALLENGES

Because of the frequency that individuals presenting with crisis may have linguistic barriers to accessing crisis services, unique cultural needs and/or immigration status challenges, the crisis continuum must respond with cultural/linguistic fluency and appropriateness to the full array of individuals/families who are likely to present in their community. This is a certification requirement for CCBHCs.

Measurable Criteria for an Ideal Crisis System

- **Continuum of crisis response for linguistic needs:** The accountable entity establishes the following criteria for individual crisis providers and for the system as a whole:
 - » **Access for individuals who speak threshold languages:** The crisis continuum provides adequate regular and on-call bilingual crisis staff to serve individuals and families who speak threshold languages other than English, including ASL, 24/7 in all levels of care in the continuum.
 - » **Access for individuals who speak non-threshold languages:** The crisis continuum provides access to 24/7 translation services for individuals in crisis who speak non- threshold languages and are unable to receive effective services in English.
 - » **Access for individuals from different cultures:** The crisis system has a baseline expectation for all providers to understand and counteract the impact of racism and associated micro-aggressions on service recipients and demonstrate and continuously improve cultural competency, fluency and appropriateness for important cultures and populations. These include cultures based on race and ethnicity, religion, veteran status, sexual orientation, gender identity and immigration status. Crisis system providers will be required to demonstrate routine baseline training for all staff in cultural issues and utilize an annual measure of cultural competency as a component of their quality improvement. Crisis system responses and outcomes and individual provider responses and outcomes will be regularly monitored for evidence of disparity in response or results for different cultures and populations.
 - » **Access and intervention for documented and undocumented immigrants:** Individuals who are recent immigrants, particularly those who are displaced refugees and/or undocumented, have unique challenges asking for help during a behavioral health crisis and accessing ongoing support and assistance for continuing care. All components of the crisis systems will be expected to have capacity to welcome immigrant populations of all types, respond in an appropriate manner to individuals who may be undocumented and provide the full range of needed services. All crisis programs will also be expected to have access to specialty assistance working with immigrant and refugee populations that might be prevalent in their community.

- » **Access and interventions for individuals who identify as transgender or gender non-confirming:**
 - Establishing policy and ensuring staff understand important of asking client about correct pronouns. Ensuring staff refer to and call client by correct name, even if different than on birth certificate or ID card. Ensuring medical record can correctly indicate gender identity and name.
 - Ability to continue gender-affirming hormone treatment.
 - Ability to refer to provider who is competent in doing initial workup and initiating gender affirming hormone treatment.
 - Help ensure client confidentiality and respect degree to which client wishes to be “out.”
 - Facilitate rooming and bathroom use to be in wing aligned with client’s identified gender, if there is a separation on the unit.
 - Ensure staff understand that packers, binders and other gender affirming instruments are necessary.
- » **Coordination with culturally specific providers:** Crisis system providers are expected to have the ability to identify culturally specific resources available in the community for continuing behavioral health care needs as well as provision of social support and be able to facilitate ongoing connection and coordination of care for populations who need and prefer such services.



SERVICE COMPONENTS

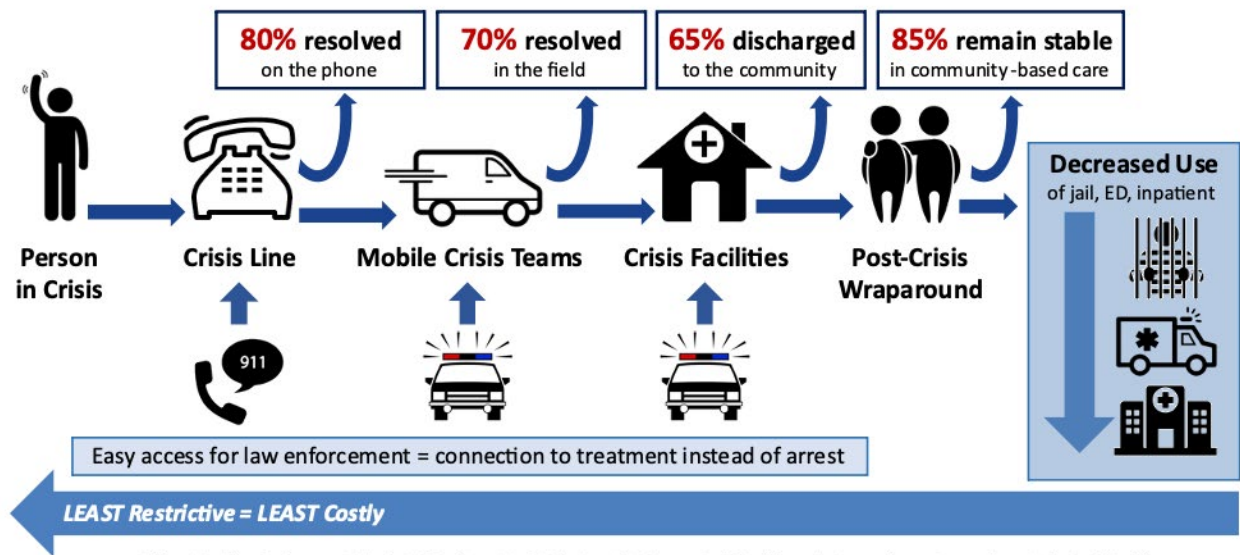
DESCRIPTION OF CONTINUUM OF SERVICES

In the ideal crisis system, people have access to effective and helpful services and supports in a broad continuum of settings. The choice of which type of service or setting may be most appropriate at any given time should be largely driven by considering safety, effectiveness, the least restrictive setting and resource intensity/cost. There should be fluid movement in both directions along the array (e.g., from least to most restrictive and resource-intensive) as a function of the person's needs.

Measurable criteria for an ideal system: The accountable entity works with the community collaborative and crisis providers to design, fund and implement a full continuum of crisis services with sufficient capacity to meet network adequacy standards designed to support and serve individuals of all ages, their families and collaterals and the behavioral health providers who serve them, with provision for seamless flow, information sharing, client tracking and telehealth through the continuum and that incorporates the following minimum elements (See below "Elements of the Continuum" for a more detailed description.):

- Crisis hub
- 24-hour (988) call center/crisis line.
- Deployed crisis-trained first responders.
- Medical triage/screening - Non-ER and ER.
- Mobile crisis teams.
- Behavioral health urgent care.
- Intensive community based continuing crisis intervention services.
- 23-hour observation and extended evaluation.
- Residential crisis program continuum, including peer crisis respite and sobering support.
- Peer respite and sobering support services.
- Hospitals: ERs, psychiatric consultation, psychiatric emergency services.
- Psychiatric hospitalization.
- Intensive outpatient continuing crisis intervention services.
- EMS and non-EMS transportation.

Crisis System: Alignment of services toward a common goal



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>

(Balfour, 2020)

CONTINUITY OF CARE AND SEAMLESS VERTICAL AND HORIZONTAL FLOW

Crisis is not a discrete event; it is an episode encompassing a continuum of needs that can include low acuity early crisis warning signs, high acuity acute emergencies, moderate acuity respite or step-down programs and post-crisis wraparound services to ensure successful handoff to the traditional outpatient system. During the crisis episode, an individual's progress is not always linear and their needs may fluctuate. There might be a brief period of improvement followed by a period of regression, or vice versa.

In many communities, it is difficult for individuals to flow smoothly to higher or lower levels of service intensity as their needs change. Even more problematic, many individuals in crisis, their families and supports experience multiple disjunctions and transitions in care during the crisis episode at a time when they are most vulnerable and distressed. These transitions are often associated with multiple repetitive assessments, changes in diagnosis and variations in treatment plan from one day to the next or one program to the next. This lack of continuity through the crisis episode results not only in diminished experience of care for primary customers, but can lead to poorer outcomes because the information often does not flow efficiently as the client moves through the continuum.

For these reasons, continuity of care through the crisis episode and facilitation of smooth transition through different levels of service intensity in the crisis continuum are both essential elements of an ideal crisis system. As the needs of the individual change, protocols should be in place that make it easy for them to be transitioned through the appropriate levels of care in the crisis continuum, so an individual might be hospitalized for a few days, transitioned to a crisis stabilization bed or crisis residential bed for a few days, hospitalized again for a brief period because of a regression, transferred back to the crisis bed, and so on. These vertical transitions through the continuum should occur as smoothly as possible to meet individual needs and be associated with continuity of care by a crisis intervention team or crisis intervention coordinator that is usually based in the crisis hub and has a care coordination function throughout the continuum of services.

In addition, there is a need for seamless flow between various types of co-occurring capable mental health and SUD services for individuals with co-occurring mental health and SUD. Many crisis programs and crisis systems create distinct detox capacity and crisis bed capacity. This often results in impediments to both individual client flow and flexible utilization of limited resources. Individuals with co-occurring conditions in crisis who need help with withdrawal management can receive such support in a crisis bed. Individuals who present with requests for assistance with SUD often have co-occurring mental health conditions as well. Further, individuals with active SUD who need a safe place to stop using, to address mental health and social concerns and to consider the next steps in recovery should not be required to present with intoxication in order to access the support services labelled as detox. Therefore, within the bounds of state regulations, efforts in the ideal crisis system should be made to eliminate the artificial distinction between crisis beds and detox beds in favor of a more fluid system that meets the needs of all individuals with any combination of mental health and substance use needs.

Measurable Criteria for an Ideal Crisis System

- **Full continuum:** The accountable entity ensures that there is a full continuum of services to cover the needs of individuals throughout their crisis episode, including step-down from inpatient levels of care. Procedures are in place within all programs of the continuum that guide both “step-down” and “step-up” as needed through the continuum.
- **Consistent LOC criteria:** The accountable entity employs consistent criteria (e.g., [LOCUS](#) or CALOCUS) to match individuals to the right level of care/service intensity within the continuum.
- **Transition protocols:** The accountable entity ensures there are protocols to facilitate smooth transitions from one level of care to another (e.g., data sharing and care coordination to reduce redundant assessments) and that there are no restrictions based on minimum lengths of stay required.
- **Continuity of crisis intervention:** The accountable entity ensures that there is at least one crisis provider (agency, program, team or individual clinician) that is responsible for providing continuity of crisis intervention, care planning and care coordination for each individual that may be moving through brief episodes of inpatient and crisis residential levels of care. Disruptive transitions, repetitive assessments and treatment plan discontinuity through the continuum need to be minimized.
- **Flexible response to withdrawal management needs:** The accountable entity ensures maximum flexibility in utilization of available capacity to respond to individuals in crisis who may need withdrawal management and relabels detox services as “engagement and stabilization services for individuals (with or without co-occurring mental health conditions) wishing to enter SUD treatment.”

EFFECTIVE INFORMATION SHARING CAPACITY

Individuals in crisis often move rapidly between services, so information must be effectively shared throughout the crisis continuum. In addition, availability of historical information 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. For all these reasons, efficient and effective electronic health records (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.

Measurable Criteria for an Ideal System

A comprehensive crisis system has an accountable entity responsible for oversight, contracting and quality monitoring that ensures all components of the crisis service continuum efficiently use an EHR that serves the person in crisis as well as both crisis and continuing care providers.

- The accountable entity will select an EHR that best serves people in crisis. EHRs for people with mental health challenges are preferable to those initially designed for people with primary medical and/or surgical needs.
- The EHR will be person-centered in its orientation and facilitate gathering information about mental health, SUD, cognitive conditions and medical needs.
- The EHR will support the gathering of information about the individual and all the systems in which the individual interacts that are relevant to management of the crisis.
- The EHR will be highly functional both on-site and in the field. Mobile crisis services will find the EHR serves them well as they provide services in the community, not just in the clinical setting. Access to the EHR through mobile platforms is essential.
- The EHR will be able to access data available through the local health information exchange (HIE) and data available through the local admission, transfer and discharge exchange.
- The EHR will support secure communication in real time, including the capacity to send and receive secure email, fax and text messages.
- For those providers who may not be able to afford the capacity to utilize the EHR, there are policies and procedures in place to facilitate releases of information and information sharing using existing non-electronic platforms.

CLIENT TRACKING THROUGH THE CRISIS CONTINUUM AND BEYOND

Individuals accessing crisis services are inherently at high risk and need continued tracking both individually and collectively to monitor both individual outcomes and overall system performance. Formal tracking capacity will make it less likely that any individual client at risk (e.g., post-suicide attempt) will fall through the cracks without an opportunity for outreach and reengagement. Aggregate tracking data can also be used for quality improvement purposes to identify specific populations that may not be responding well to individual crisis services or the crisis continuum as a whole. Tracking systems are also particularly important for identifying and serving individuals who have very frequent contact with crisis services and other systems (e.g., law enforcement, medical emergency services, homeless shelters) and who utilize resources at high volume and high cost, yet appear to lack resources needed to stabilize and make progress.

When possible, communities should consider using advanced technology to help manage individuals with serious mental illnesses in crisis. One such example is the DACOTA project in Miami-Dade County, Florida.

The DACOTA program is a collaboration between Miami-Dade Police Department (MDPD), the behavioral health public managing entity, Thriving Mind South Florida, the Eleventh Judicial Circuit Criminal Mental Health Project, and the Department of Children and Families. DACOTA will address the breakdown in communication between criminal justice and mental health agencies using a two-pronged approach by: (1) Developing a shared information database where both criminal justice and mental health agencies can each access data systems with summary dashboards and individual treatment histories; and (2) implementing a co-responder model whereby licensed clinician care coordinators will be in the field with first responder MDPD Threat Management Section Detectives, able to render immediate screenings, continuity of care coordination and treatment referrals on the scene.

The DACOTA program will also help eliminate the duplication of services by multiple providers by identifying individuals who are high users of services who often access multiple providers over short periods of time. Often, this has resulted in multiple diagnoses, different medications and overlapping case management services. Additionally, DACOTA will help reduce the number of individuals who will be unnecessarily transported by law enforcement to crisis treatment facilities by enabling connection in the field with existing treatment providers. These technological and operational advances will improve responses and outcomes for individuals with mental illnesses, including those with co-occurring substance use disorders.

Measurable Criteria for an Ideal System

The accountable entity establishes and funds a client tracking system that is utilized by 988 call centers and all crisis system providers. A user-friendly, portable EMR linked to a real-time client tracking system greatly facilitates continuity of care and treatment. CCBHCs have implemented such systems. Measurable criteria for such systems include:

- **The client tracking system has procedures for identifying individual clients in need of follow up.** All providers have procedures for engaging in follow-up activities and reporting follow-up data to the centralized tracking system.
- **The tracking system will have the capacity to notify involved behavioral health providers of an encounter with crisis services.** A health care provider is often unaware of a person's contact with a crisis service. In an ideal system, care providers should be notified at least 90% of the time. Notification should happen automatically, by data push, and not require a specific inquiry by the provider.
- **The tracking system will have the capacity to create and access care plans for individuals who may need care coordination.** Care plans can be created in an EHR and shared in the crisis continuum data sharing procedure and/or the local HIE. Adequate care plans have the capacity to direct any provider to the primary provider or to the primary care coordinator care manager. Care plans can also give guidance on how to best serve the person in need, as well as save time and resources on redundant assessments or on interventions demonstrated to be ineffective.

- **The client tracking system reports quality improvement data on an aggregate basis for quality improvement purposes, and utilization of that data is included in the crisis system quality assurance/performance improvement plan.** The accountable entity reviews performance data with crisis providers and with the community crisis collaborative to identify potential priority areas for improvement and to develop and measure results of improvement strategies.
- **The client tracking system has mechanisms for identifying individuals who have patterns of frequent utilization of crisis services.** The accountable entity will work with community partners to identify a defined threshold for high utilization. Although there is no standard definition of high utilization, one approach is to define it as two standard deviations above mean utilization (top 5%) for a given population. Another approach is to have a set number of crisis visits or a set total cost of crisis services to follow utilization.
- **The accountable entity will identify individuals with high utilization patterns as priorities for intervention in its quality improvement activities.** The accountable entity will have immediate notification of any person who seeks crisis services and has the capacity to count and track an individual's crisis service use. This information should be shared with those who have a role in helping meet the needs of high utilizers. Providers working with identified high utilizers or other clients at risk will be expected to access care plans or crisis plans in the EHR and work collaboratively to support the identified intervention that is designed to promote engagement and reduce crisis presentation.
- **The accountable entity will work with the tracking system to facilitate the ability for other systems to share utilization data about selected high utilizing clients.** Secure communication including secure texting through a system such as DocHalo must be available and encouraged. Secure/encrypted email and faxing should also be implemented. These mechanisms may permit sharing and aggregating arrest data, medical visits, homeless information system data, etc., to provide a more complete picture of individual utilization patterns and costs, which in turn will promote more effective care planning and resource allocation.
- **Factors that lead to patterns of high utilization should be researched and made the subject of quality improvement.** As technology advances, those advancements should be employed to better predict those at risk of becoming high utilizers and target appropriate interventions for them. Artificial intelligence is improving in its predictive capacity in other areas of medicine and can be employed to help predict those at risk of becoming high utilizers.
- **The accountable entity demonstrates the ability to work with crisis providers and other systems to fund creative approaches to meet the needs of individuals who are identified as “at risk” or “high risk” through the tracking system.** Client tracking data tracks progress in outcomes, utilization and cost.

A user-friendly, portable EHR linked to a real-time client tracking system greatly facilitates continuity of care and treatment.

FAMILY AND COLLATERAL OUTREACH AND ENGAGEMENT

A comprehensive behavioral health crisis system with a complete continuum of services is essential to any community. When behavioral health crises occur, they impact not only the person in crisis but also the family (with the definition of family expanded to include significant members of the individual's natural support system). Families are typically the first to realize that a problem is developing. Families with limited knowledge of mental health and/or substance use conditions may be unsure what is happening, especially early in the course of psychiatric disorder, and may not know how to initiate a request for assistance. When an initial – or subsequent – behavioral health crisis occurs, families often have no idea how to seek help from the crisis system. Consequently, crisis system capacity must be designed to include consideration of the needs of the family before, during and in the immediate aftermath of a behavioral health crisis. To the greatest degree possible, crisis services should work in collaboration with families and other collaterals (e.g., caregivers, supports like friends, faith-based providers) to facilitate the best possible outcomes.

Measurable Criteria for an Ideal System

The accountable entity – and all crisis system providers – have procedures governing family and collateral outreach and engagement as routine features of crisis care:

- In an active crisis, families should be contacted and involved in crisis care to the greatest extent possible. Each program in the crisis continuum has procedures for ensuring this occurs. (See “Name of Section” in Section 3 – the one which describes standards on Information sharing with families).
- During the crisis and each component of the crisis continuum, there is a care coordinator who works with the family and collaterals in a continuing partnership. The care coordinator's role is to help the family and collaterals contribute to the client's treatment and disposition planning to the greatest possible extent.
- During the crisis episode, families routinely receive information about behavioral health crisis assessment, crisis intervention programming and/or hospitalization presented in a clear and supportive manner, including information on rules of the unit along with explanations for the reasons for those rules.
- All crisis system staff are trained in the importance of strength-based approaches to family involvement during crises and can communicate importance of family involvement to clients, family members and other collaterals.
- All crisis programs recognize the needs of families and other collaterals and directly provide or facilitate access to a variety of services to assist or support the family during and after the crisis.

The accountable entity, working with the community collaborative that shares responsibility for crisis system performance and with crisis system providers, develops a comprehensive program for educating the community about how to access crisis services for their family members and loved ones.

This education program includes a comprehensive system of community education for families prior to any crises through community outreach including via health fairs, non-behavioral medical settings and faith-based groups as well as media, the internet and social media.

- Education programming provides families and the public with accurate information about:
 - » Identifying behavioral health problems and addressing fears about dangerous behaviors.
 - » Steps to take in a crisis, including how to contact the crisis continuum call line and information about the array of crisis services available, including hotlines, mobile crisis teams, crisis access center, crisis stabilization beds and procedures to facilitate involuntary hospitalization.
 - » Available resources for urgent or routine care, such as community behavioral health provider organizations.
 - » Available resources for family-to-family support (e.g., National Alliance on Mental Illness [NAMI]).

The accountable entity, crisis system providers and community crisis collaborative adopt quality metrics to measure family/collateral satisfaction with involvement in the crisis system and to measure the degree to which family/collateral outreach and engagement do and do not occur.



IN THE STORY OF MR. Y: There seems to have been no involvement of his family and the criminalization of his behaviors may have cut him off from valuable supports.

OUTREACH AND CONSULTATION TO COMMUNITY PROVIDERS

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. An essential component of the continuum of care is a crisis system that not only reacts to crisis, but engages in outreach and consultation with all elements of the community service system to address risky situations and prevent crises or escalation of crises.

Measurable Criteria for an Ideal System

There is a comprehensive crisis system with an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for provision of direct services and/or coordination of all service elements that incorporate the following expectations into contracting, with associated quality indicators and metrics of success:

- **Mechanisms for outreach and consultation:** The crisis coordinator and crisis system providers will ensure there are formal mechanisms for routine and as-needed outreach and consultation to all community service providers.
- **Training on identification of need, access to crisis services and de-escalation:** The crisis coordinator will identify crisis system providers to provide training in how to best identify and respond to needs (e.g., MHFA), how to access crisis services in the most proactive manner and how to engage in crisis de-escalation and behavior management, (e.g., Crisis Intervention Team [CIT] training and MHFA for First Responders).
- **Routine consultation to high-risk settings:** The crisis coordinator will identify crisis system staff to develop routine consultation relationships with community providers who work with individuals and families at high risk for crisis response, including residential programs, schools, ACT teams and emergency rooms. By having regular meetings with these high-need, high-risk and high-volume providers, the crisis system builds relationships that reduce crisis acuity and promote collaboration during crisis situations.
- **Proactive consultation and case review:** The crisis system has an identified process by which there is proactive consultation provided for programs and/or individuals/families who are having a difficult time. The crisis system will document a mechanism for proactive case review and provide or arrange consultation services to the program and/or regarding the client in order to implement an improvement plan that both reduces the need for crisis response and promotes better outcomes for people served.
- **Quality indicators:** The presence of these structures, processes, activities and results are incorporated into quality indicators and metrics of success for the crisis system as a whole and for individual crisis providers as relevant.

TELEMEDICINE, TELEHEALTH AND TELEPSYCHIATRY

For any system of care to work, clients need reliable access to treatment. Rural and underserved urban areas may be hard for clients to access and/or have an insufficient number of providers available. Telepsychiatry and telehealth, including audio-only interactions for those that might not have videoconferencing capability or bandwidth, can facilitate 24-hour access to medical and psychiatric staff, clinicians and other staff for crisis evaluations and on-going treatment. For younger individuals and/or persons living in unstable environments, like shelters, text/chat capability for accessing crisis services can be particularly valuable. Telepsychiatry and telehealth can greatly reduce waiting time and time to initiate treatment. Telepsychiatry can also be used for clinical supervision, clinical rounds, case conferences and team meetings.



Increasingly, telepsychiatry technology can support mobile crisis team interventions in the field by facilitating psychiatric evaluations direct to client via secure tablet platforms. Using this technology significantly improves the reach of mobile crisis services.

Because the rules and regulations that govern telepsychiatry vary by locality and state, the specific local requirements for licensing, billing, electronic prescribing and malpractice insurance must be considered when implementing telehealth or telepsychiatry services within the crisis continuum. However, increasingly, telehealth should be considered a standard component of crisis systems, and the general concepts and operational procedures can be set up in almost any place that has internet access, supporting clinicians and technical assistance. Use of telemedicine during the COVID-19 crisis has been well-established with considerable satisfaction noted by clients and providers. The duration of modified billing regulations by the Centers for Medicare and Medicaid Services is uncertain.

Measurable Criteria for an Ideal System

The accountable entity implements standards and creates incentives to insure:

- All crisis programs, particularly mobile crisis teams, have comprehensive telemedicine and telepsychiatry capacity, including text/chat and audio-only, that can project medical, psychiatric and crisis evaluations into multiple types of crisis intervention settings, including shelters, forensic settings and homes. Telehealth should be part of a continuum of care with capacity to reciprocally share information with other provider networks in the community, including emergency medical services, in-patient and out-patient services, criminal justice services and housing programs and support mobile crisis teams in the field, clients' homes and other locations.
- All crisis systems apply state-of-the-art telehealth technologies to maximize effectiveness of interventions in all settings.
 - » Crisis programs have appropriate space to conduct telehealth evaluations and videoconferencing consisting of a room or private area where personal information can be exchanged without violating privacy and complying with HIPAA regulations.
 - » Properly encrypted videoconferencing technology with a business associate agreement in order to remain HIPAA-compliant, including tablet-based technology that can be carried in the field by mobile crisis workers and law enforcement CIT teams.
 - » On-site technical assistance staff trained in troubleshooting the technology are available as needed to assist with client access.
- There are procedures for connecting clients evaluated through telehealth to urgent in-person medical or psychiatric evaluation when indicated.

- » If a client being seen through telehealth becomes acutely distressed and in need of medical emergency services, there are other clinicians or staff available onsite to facilitate the transfer of care.
- » Clinicians, ideally a registered nurse (RN) or licensed practical nurse (LPN), are available to assist in the onsite initiation of medical treatment prescribed by a telemedicine or telepsychiatry provider. The medical backup for telehealth crisis intervention can be a primary care physician, nurse practitioner, psychiatrist or other health care provider depending on state licensure and scope of practice regulations.
- Telehealth should be a routine feature of connecting crisis workers and other resources in the community and can be used by multiple participants at one time. Clinicians, family members, peers, social supports, housing and other resource or service providers can potentially conduct a team meeting with or without the client present.
 - » Clinical meetings can be managed with members of the team remotely.
 - » Clinical assessment can be done in the field with remote access, where first responders are linked to the crisis assessment center through telehealth.

Telepsychiatry can be a valuable tool for creating state of the art crisis systems in rural areas.

For over 10 years, Burke, the local mental health authority in Lufkin, Texas, serving a 12-county rural area in East Texas, has operated Burke's Mental Health Emergency Center (MHEC), a ground-breaking program that has significantly improved crisis mental health services in East Texas while serving as an award-winning model for other regions throughout the state.

Burke's MHEC was the nation's first rural freestanding comprehensive psychiatric emergency service and the first to depend entirely on telemedicine for psychiatric care. MHEC performs emergency psychiatric evaluations of individuals who are both voluntary and involuntary, and also offers short-term residential crisis services. Before the MHEC was established, people in mental health crisis often waited for extended periods in hospital emergency rooms - or sometimes in jails. With the MHEC, access to care is available locally with follow-up services scheduled as needed. Since it opened, MHEC has served over 11,000 people.

MHEC came about through the hard work of many stakeholders. The T.L.L. Temple Foundation donated the land and funded construction of the MHEC facility. The Stephen F. Austin School of Social Work has been an incubator of ideas. They initiated the work that became the Rural East Texas Health Network, an organization made up of county officials, judges, law enforcement, health care providers, and hospital administrators who work together in each county to coordinate and improve mental health crisis services. (from Burke website, accessed on November 18, 2020: <https://myburke.org/burkes-mental-health-emergency-center-celebrates-10th-anniversary/>)



ELEMENTS OF THE CONTINUUM

Elements Of The Continuum			
	Crisis Center or Crisis Hub		Intensive Community-based Continuing Crisis Intervention
	Call Centers and Crisis Lines		23-hour Evaluation and Extended Observation
	Deployed Crisis-trained Police and First Responders		Residential Crisis Program Continuum
	Medical Triage and Screening		Role of Hospitals in Crisis Services
	Mobile Crisis		Transportation and Transport
	Behavioral Health Urgent Care		

In contrast to the previous section, which describes general capacities or capabilities within the crisis system, this section describes the specific programmatic elements or components of an ideal crisis continuum.

The ordering of this continuum begins with the recommended centerpiece of the ideal crisis continuum, which is often termed a crisis hub, 988 crisis call center, crisis access center, crisis assessment center or crisis response center. The crisis hub provides both a specific set of services and, in an ideal system, may coordinate the other services in the system or continuum.



CRISIS CENTER OR CRISIS HUB

In an ideal system, there needs to be a secure physical location (crisis center) that provides a place for people in behavioral health crisis to go or be brought by law enforcement or other first responders that is an alternative to going to an ER or to jail. In some communities, this location may also represent a crisis hub and function as the centerpiece for coordination of all the crisis services provided in the community. In other communities, the crisis coordination or hub function may be assigned to a crisis call center which may operate at another location and/or may coordinate multiple crisis centers (as in a large urban area). The crisis center - which may also be called a crisis access center, crisis response center or other term - is the ideal system go-to location for 24/7 behavioral health crisis response and crisis system coordination in most communities. In some communities, the current crisis center is an adaptation of an ER-based psychiatric emergency service, such as an EmPATH model.

Although these can be very effective – and certainly better than not having such services – it is generally recommended to have crisis centers that are not based in hospital ERs and to have psychiatric capacity in ERs as well (see [Psychiatric Emergency Services in Role of Hospitals in Crisis Services](#) for more information).

This is a culture change. If individuals in behavioral health crisis are taken to, or advised to go to hospital ERs, hospitals are seen as the appropriate places for these issues to be addressed. If there is another community entity responsible for where the vast majority of people in behavioral health crisis are brought that also coordinates access to a complete continuum of services and has dedicated resources that allow for high quality medical triage and ambulatory intervention, mental health and/or substance use disorder evaluation, observation, initiation of treatment and connection with community-based resources, the system culture shifts dramatically to a different and more efficient and effective conceptualization of how to respond to people experiencing a behavioral health crisis.

While the evidence base regarding the effectiveness of specific non-hospital based crisis services remains limited, available studies demonstrate reductions in hospital admissions, as well as short- and longer-term subjective and objective improvements in mental state, favorable client satisfaction and reductions in family/natural support burden relative to hospital-based services (Lloyd-Evans, 2009; Murphy, 2015).

When calling a behavioral health service provider, it is extremely common to hear a voicemail that says something like, “If this is an emergency, proceed to the nearest emergency room.” In many, if not most, communities, hospital ERs remain the most common “front doors” to behavioral health services. Unfortunately, they often lack the capacity to make the most appropriate linkages to effective community services and supports, and as soon as one walks through that front door, their likelihood of being hospitalized goes up enormously.

There is a vital role for both ERs and inpatient hospitalization within the crisis services continuum, typically for those with high acuity and/or imminent dangerousness. In the absence of a full array of crisis services, those beds are often unavailable to those who need them most, as they are often utilized by patients who could be safely served in less restrictive settings. This results in long waits and boarding in emergency rooms, (Nordstrom, 2019; Schwartz, 2016) often without initiation of optimal treatment and/or transport to other hospitals that may be far from the person’s community and natural supports.

The crisis hub is the virtual center of a functional crisis system. This is the command and control center that keeps all the other components functioning collaboratively and effectively. Three examples:

1. A crisis hub example is Common Ground in Oakland County, Michigan, which incorporates a call center with triage and dispatch, suicide prevention hotline, “air traffic control” care coordination, 24-hour behavioral health urgent care, secure police drop-off with 23-hour observation and intervention, medical/nursing intensive residential crisis services, sobering support unit and intensive crisis intervention follow-up. This program serves all ages, has been operating for nearly two decades and continues to grow and expand. It has demonstrated significant impact for both public and private payers in reducing hospitalization rates.
2. A crisis center that does not manage all the hub functions example is the Crisis Response Center in Tucson, Arizona. It provides a continuum of services that includes behavioral health walk-in urgent care, 23-hour secure observation and residential crisis services, ideally for both adults and children. Services include state-of-the-art psychiatric specialty ER, including capacity for rapid police drop-off, seclusion and restraint if necessary and 23-hour observation (for all ages), but is not in a hospital. It also has 24-hour walk-in urgent care and adult residential crisis capacity.
3. The Comprehensive Psychiatric Emergency Program in New York, available on a limited basis across the state, offers a mixture of crisis center services, such as secure 23-hour observation and mobile crisis outreach, while coordinating with other types of residential crisis services. It does not have a formal role as a community crisis center hub, however. See Appendix X for a more detailed description.

This is another culture change. If individuals in behavioral health crisis are taken to, or advised to go to hospital ERs, hospitals are seen as the appropriate places for these issues to be addressed. The system culture can shift dramatically if another community entity is responsible for caring for the vast majority of people in behavioral health crisis that also coordinates access to a complete continuum of services and has dedicated resources that allow for high quality medical triage and ambulatory intervention, mental health and/or substance use disorder evaluation, observation, initiation of treatment and connection with community-based resources. This model represents a more efficient and effective conceptualization of how to respond to people experiencing behavioral health crisis.

In most larger communities, the ideal crisis center is a freestanding 24/7 entity that may or may not be proximal to other 24-hour locations, such as ERs or police stations. The nature of the crisis center may vary depending on the type of community. In some communities, crisis centers will serve both children and adults; in other communities, there may be separate settings for children and adults. In some smaller communities, the freestanding crisis center may be open for less than 24 hours and because of low volume of need, coverage is provided through mobile crisis support and/or telemedicine – possibly from a regional crisis hub – at a local ER during the night shift. In more remote systems, a regional crisis hub may project services through telehealth to locations that serve multiple functions. As previously noted, in some communities many of the components of the crisis continuum, including crisis care coordination, are located within the crisis hub location; in other communities, most of those components are located elsewhere and/or operated by different provider organizations.

Finally, there can be different arrangements for providing crisis coordination for the crisis system – in this report, it is termed the “hub function.” While it is common and convenient for the crisis coordination function and the individual role of the crisis coordinator to be co-located and conjoined with the crisis center, those functions can be physically separate in some communities, and may be provided by different contracted agencies. This might be relevant, for example, in a large urban county in which there are four regional crisis centers, each one provided by a different vendor and coordinated through a hub that is provided by either the accountable entity directly or by another vendor to avoid bias or conflict of interest. This might also be relevant in a rural region where clients and services are geographically spread and the hub function is designed to coordinate across multiple small crisis centers that in turn coordinate services in their own geographies, but none is large enough to serve as a regional service hub or access center in its own right.

Regardless of the relationship among the different components of the continuum, the core secure crisis center function is an important centerpiece of the total continuum with characteristics described in this report.

With the exception of a requirement for operating a non-hospital secure facility, the functions of a crisis center related to 24-hour access and response are all certification requirements for CCBHCs. Those CCBHCs without non-hospital secure crisis centers may collaborate to provide these services through relationships with medical emergency rooms, first responders and other community partners.

Measurable Criteria for an Ideal System

The accountable entity works with its community crisis collaborative to design, implement and finance one or more secure non-hospital crisis centers that serve its region in accordance with network adequacy and geographic access standards (see “[Accountability and Finance](#)”), the crisis centers are adequately staffed (see “Adequate Multidisciplinary Staffing”) and provide the following minimum array of services, either directly or through telehealth, as appropriate:

- 24/7 telephone access.
- 24/7 walk-in services.
- 24/7 access for first responders, including for clients are who brought in on involuntary status.
- Medical triage, screening and intervention for individuals without emergent medical concerns.
- Assessment, intervention, care coordination and disposition for individuals of designated ages with any combination of behavioral health concerns.
- Capacity for extended evaluation and continuing observation.

- Access to emergent psychiatric intervention and initiation of MAT for addiction.
- Access to peer-support workers to provide outreach and engagement.

The accountable entity identifies one or more crisis centers or, in some instances, an independent vendor in a separate location to serve as hubs for the designated community or communities. The hub oversees the functioning of the crisis center services and also oversees and coordinates the activities and services of the full crisis continuum, some of which may be provided on-site as part of the crisis center or housed at the crisis center location, including:

- Crisis coordination for the whole system.
- Crisis call center, including warmline, suicide prevention hotline, 911/988 triage.
- 911 dispatch with capacity to triage calls to 988 and the crisis call center.
- Client tracking and care coordination.
- Mobile crisis teams.
- Co-response teams with first responders.
- Medical screening and intervention and coordination with ERs.
- Telehealth and telepsychiatry consultation to general ERs and other locations.
- 23-hour observation beds.
- Crisis stabilization, crisis residential and peer respite services.
- Crisis/respite housing.
- Substance use disorder stabilization and treatment.
- Psychiatric inpatient services.
- Follow-up clinics.
- Intensive community crisis intervention (individual and team-based services, office-based and home-based services).

The accountable entity ensures that the crisis hub assumes responsibility for coordination and information sharing between the various services, client tracking through the continuum and the collection of relevant data that contributes to performance monitoring of identified quality metrics (see [“Quality Metrics”](#)).

The types of services within this continuum have been evolving and expanding in response to the frequent over-reliance on the most costly and restrictive settings, specifically emergency rooms and in-patient hospital units (Allen, 2002 and Substance Abuse and Mental Health Services Administration [SAMHSA] Crisis Services, 2014).

The following sections represent the core elements of the array of crisis services that have been shown to be both clinically- and cost-effective and should be available to all individuals within a community (TAC, 2005; Pinals, 2017; Lloyd-Evans, 2009) Any missing component along the continuum logically leads to an over-reliance on the next, more resource-intensive service.



CALL CENTERS AND CRISIS LINES

In an ideal system, there is specific capacity for individuals in crisis to contact the crisis system for assistance at any time with ability to respond based on the level of intensity and urgency of need. This includes a variety of different types of services that can be connected or coordinated with each other as well as connected to the capacity to dispatch law enforcement, EMS or mobile crisis outreach or arrange for transportation to the appropriate crisis center. These services have various labels and functions, including helplines, warmlines, suicide prevention lifelines, 988 crisis lines and 911 dispatch coordination. Each type of service provides a useful function in an ideal system and all such functions should be provided for through the accountable entity and the community crisis collaboration. The rationale and description for each type of service are:

- **Call centers and crisis lines:** A crisis call center is a 24/7 accessible phone number (e.g., 988) for people in behavioral health crisis and preferably incorporates phone, text, videoconferencing and web-based chat capability. In an ideal system, the crisis call center welcomes all types of calls and triages them appropriately to trained call responders who are well-trained in the resources of the community behavioral health crisis system. Remote call centers that are not connected with the community continuum are less than desirable. Having separate numbers for different types of calls can be confusing for those calling for help. Warmlines or helplines imply that the caller is not in an urgent situation and merely wants to access support. Crisis lines or hotlines imply that the caller needs more urgent help and are a direct access into the full continuum of crisis services.

One form of hotline is a suicide prevention lifeline. There are currently 161 certified in the United States and each adheres to a set of practice standards for certification. When all these types of service are accessible through a common number, it is easy for the call line staff to triage callers seamlessly to the appropriate response. In an ideal system, the helpline number is the go-to behavioral health crisis number that the whole community is educated to use, rather than calling the emergency room or 911. Recent federal legislation is directing planning for implementation of a 988 National Suicide Prevention Lifeline line, which will be a valuable approach to ideal crisis system development nationally.

The common goal of these helplines is to serve as an initial mode of engagement, triage and support to try to establish some connection with the caller, helping them feel comfortable to discuss their situation and assess the urgency and most appropriate next steps, which could include recommendations ranging from no follow-up to anything along the full continuum of crisis services. No matter what they are called, how they are staffed or what medium is used, these helplines should have the following features:

- » **Widely known in the community:** These helplines are only effective if people know about them. It is often necessary to invest resources in getting the word out and keeping the service in front of people's minds, especially when the service is relatively new to a community. Just as everyone knows to dial 911 in an emergency, they should know the number to call (988) in a behavioral health crisis.
- » **Easy access:** People calling don't have to go through a series of different operators or automated questions (e.g., "...press 1 if you are suicidal, press 2 if homicidal..." etc.) to get help. As engagement is critical, best practices in customer service should be prioritized and followed.
- » **24/7/365 access:** These services should be available at all times. If there is not local capacity to do so, arrangements should be made to have the calls forwarded to another entity during any locally uncovered hours in a manner that does not make it more difficult or complicated for the caller. In that case, a system of warm handoffs should be in place between the covering entity and the local crisis center.

- » **Practice guidelines and core competencies:** Helpline staff, regardless of professional background, should have training and demonstrated capacity in triage, engagement (e.g., motivational interviewing training) and intervention and risk assessment and intervention, preferably using National Suicide Prevention Lifeline guidelines [Microsoft Word - NSPL Suicide Risk Assessment Standards and Prompt Questions_rev as of april 17, 2007_.doc \(suicidepreventionlifeline.org\)](#). Processes that impede engagement, such as standardized or scripted questions, should be minimized.
- » **Linguistically competent:** These services should be able to respond directly, without need for translation, to at least the two most commonly spoken threshold languages in the service area and have capacity for translation services across a broad spectrum of languages.
- **911 call dispatch coordination:** As part of the ideal crisis system, 911 calls are triaged. If they are primarily behavioral health-oriented and there is no immediate life-threatening emergency requiring police or EMS, the call is triaged to the crisis call line center to initiate the behavioral health crisis response process, just as if the individual had called the “crisis call line” in the first place. If law enforcement response is indicated, the dispatchers are trained to connect the call to CIT-trained officers and/or mobile crisis/law enforcement response teams. Both these call response systems are necessary and complementary. Dispatchers for 911 are trained to identify critical information to direct calls to the appropriate responders and inform the nature of law enforcement response. When 911 call-takers receive a request for service that they suspect involves a person with a mental illness, they gather descriptive information on the person’s behavior, if there is evidence that the person poses a danger to themselves or others, if the person possesses or has access to weapons and if the person has past or current involvement in mental health or substance abuse treatment. This helps to triage whether law enforcement involvement is needed, and if so, to provide law enforcement with information that is more likely to result in diversion from the criminal justice system.

Measurable Criteria for an Ideal System

The accountable entity ensures the design, implementation and continuing funding of a 988 call center for the crisis continuum that includes warmline and crisis line functions and meets [Suicide Prevention Lifeline Center](#) certification standards:

- The call center number (988) is widely disseminated to the general public and human services providers through a public education campaign.
- The call center operates 24/7, and staff are trained in appropriate triage and facilitating access to the full continuum of crisis response, including mobile outreach.
- The call center is responsible for tracking data on type of calls, length of calls, outcomes of calls and other relevant metrics for the purpose of continuous improvement of response.
- The accountable entity ensures development of the technology and competencies that support behavioral health crisis triage within the community’s 911 dispatch function.
 - » There are clear protocols so 911 personnel know when and when not to dispatch law enforcement, as well as which officers and/or mental health co-responders are available to respond to calls that may involve a person with a behavioral health crisis.
 - » The 911 computer-aided dispatch system has a unique code for mental health calls for service and is capable of flagging:
 - Repeat addresses associated with mental health calls for service.
 - People with mental illnesses who are repeatedly in contact with law enforcement.
 - People who pose a verifiable threat to officers.



DEPLOYED CRISIS-TRAINED POLICE AND FIRST RESPONDERS

In the United States, the primary responder to a mental health crisis is often a law enforcement officer. In Florida, law enforcement officers initiate more involuntary commitments annually than the total combined number of arrests they make for robbery, burglary and grand theft auto. Other first responders that may be under the auspice of the fire department or independent providers, notably the EMS systems, are often on the scene as part of behavioral health crisis response as well. Although one goal of the ideal crisis system is to shift the bulk of crisis “first response” to behavioral health clinical crisis settings, law enforcement and other first responders will still be initial or early contact in many crisis situations. In some systems, emergency medical technicians (EMTs) have been trained to provide mobile crisis services and/or to provide continuing crisis visits to high utilizers.

As long as law enforcement officers and other first responders are part of the team of primary responders to behavioral health crises, it is critical that they are appropriately trained to use best practices in a coordinated and collaborative fashion with other crisis providers and community stakeholders. There are standard training packages that all first responders should be introduced to and selected first responders should receive in full and be deployed to be available preferentially for crisis response – CIT training is a notable example. In addition, there are identified standards for how police and first responder training and deployment should occur as part of community crisis planning. These standards should be followed in an ideal crisis system.

Measurable Criteria For An Ideal System

The accountable entity works with the community collaborative, especially first responders (e.g., law enforcement agencies, EMS) to develop and implement a plan for first responder training and deployment, as follows:

- **Collaborative planning and implementation:** Police and first responder success and effectiveness in responding to a mental health emergency depend on the commitment of stakeholders throughout the community. Cross-system collaboration is essential for the transition from the criminal justice system to the community mental health system. Program operations must rely on collaboration among community stakeholders including: the State Attorney’s/District Attorney’s Office, the Public Defender’s Office, the County Department of Corrections and Rehabilitation, the States’ Department of Children and Families, the local behavioral health authority, the Social Security Administration, public and private community mental health providers, law enforcement agencies, local school systems, colleges and universities, emergency medical technicians, family members and mental health consumers.
- **Bureau of Justice Assistance (BJA) 10 Steps:** BJA developed a Police Mental Health Collaborative guidance document and identified 10 essential elements necessary for an effective law enforcement response to people with mental illnesses:
 - » Collaborative planning and implementation.
 - » Program design.
 - » Specialized training.
 - » Call-taker and dispatcher protocols.
 - » Stabilization observation and disposition.
 - » Transportation and custodial transfer.
 - » Information exchange and confidentiality.
 - » Treatment supports and services.
 - » Organizational support.
 - » Program evaluation and sustainability.

The “first touch” in a crisis should be warm and informed. Behavioral health training for first responders is crucial – for safety and well-being of both people in crisis and the first responders themselves.

- **Deployment of adequate numbers of CIT trained officers:** Communities should adopt the CIT training model developed in Memphis, Tennessee. Known as the Memphis Model, the purpose of CIT training is to set a standard of excellence for law enforcement officers with respect to treatment of individuals with mental illnesses. All officers should have basic exposure to an introductory curriculum on behavioral health such as MHFA for Public Safety. CIT officers receive more intensive training, including 40 hours of specialized training in: psychiatric diagnoses, suicide intervention, substance use disorders, behavioral de-escalation techniques, trauma, the role of the family in the care of a person with mental illness, mental health and substance use disorder laws and local resources for those in crisis.

CIT officers perform regular duty assignment as patrol officers but are also available and deployed to respond to calls involving mental health crises. In many systems, CIT officers are deployed with mobile crisis workers in co-responder teams. In other systems, the CIT officers and mobile crisis collaborate but work independently. In either case, CIT officers must be skilled at de-escalating crises involving people with mental illnesses while bringing an element of understanding and compassion to these difficult situations. When appropriate, individuals in crisis should be transported to a crisis center in lieu of being arrested and taken to jail.

Law Enforcement: Organizational approach to serving community members with behavioral health needs



Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf> (Balfour, 2020)

- **CIT homeless resource officers (HROs):** This new type of unit focuses on the most chronically ill homeless population with a history of mental health and substance use. The HRO identifies individuals meeting criteria for this unit. A case file includes a photo of the client, criminal history printout, mental health and substance use-related arrests and court/provider related documents. If the individual meets criteria, the HRO:
 - » Files a Petition for Involuntary Treatment with courts and attends court proceedings.
 - » Contacts the behavioral health entity in reference to a treatment bed.
 - » Continues engagement until a treatment bed becomes available.
 - » Transports client to treatment facility.
 - » Participates in weekly follow-ups/case staffing on clients' progress.
 - » Informs area officers of the clients transitioning into treatment.
 - » Attends monthly meetings at police headquarters with behavioral health entity, area police commanders/city's Homeless Outreach Team.
 - » Follows client until graduation.

- **CIT coordinator:** A CIT coordinator should be selected outside the local law enforcement department and assigned to the local accountable behavioral health entity or crisis hub provider. The coordinator should be responsible for planning, coordinating and implementing all CIT-related classes, including the 40-hour CIT class, roll call training, recurring training, 911 call-taker training and executive training for the chief/sheriff and their majors. The CIT coordinator should also be trained and prepared to field referrals from law enforcement officers for their own personal mental health treatment needs.
- **CIT liaisons:** CIT liaisons from each department and police station should be selected to meet quarterly with the CIT coordinator and behavioral health providers to share information about situations and cases that need further coordination and intervention. CIT liaison officers should attend all community behavioral health/criminal justice coordinating meetings. When practical, the community should recognize and award CIT Officers of the Year.
- **Avoidance of law enforcement transport:** When appropriate, behavioral health professionals should become the first responders to mental health emergencies and CIT-trained law enforcement officers should serve as backup, if needed. When appropriate, transportation for an involuntary examination should be by a behavioral health professional in a civilian vehicle or ambulance, not in a marked police vehicle.
- **Jail diversion continuum:** CIT should be part of a larger coordinated community diversion program to keep individuals with serious mental illnesses out of the criminal justice system when appropriate and in the behavioral health treatment system. Description of all elements of a continuum of jail diversion services in accordance with the sequential intercept model is beyond the scope of this report.



IN THE STORY OF MR. Y: A crisis call center would certainly have dispatched more appropriate first responders to Mr. Y and avoided his arrest and transportation by police to a law enforcement facility.



MEDICAL TRIAGE AND SCREENING

In many communities, requirements for medical screening (often called medical clearance) before receiving services from a behavioral health crisis program or being admitted to a behavioral health crisis facility (e.g., residential crisis program, psychiatric inpatient unit) can be excessive (e.g., mandatory urine screens, laboratory testing before being seen) or unavailable (e.g., no medical screening capacity except in an ER) and create significant overuse of medical emergency rooms and barriers to easily accessible behavioral health crisis intervention.

Medical screening guidelines have been established by consensus between the American College of Emergency Physicians and the American Academy of Emergency Psychiatrists. (Lukens, et al., 2006). These guidelines indicate that the purpose of medical screening for individuals experiencing behavioral health crisis is to identify issues that require emergency medical intervention or medical hospitalization, not diagnose or rule out any possible medical condition.

These guidelines further indicate that no routine laboratory tests should be required for medical screening of otherwise physically healthy adults with behavioral health presentations. Decisions about laboratory studies are based on clinical presentation and the judgment of the medical screening practitioner. Additional laboratory studies can be obtained as a courtesy or convenience but should not delay crisis intervention and disposition pending results, which would be subsequently forwarded to the receiving program. If an individual's medical condition is sufficiently manageable, and they would be discharged home if it weren't for their behavioral health condition, they should be able to be served in any type of behavioral health crisis service that would make provisions to coordinate further evaluation and intervention for their medical condition.

Using these guidelines, an ideal behavioral health crisis system should establish the ability to facilitate medical screening as much as possible to avoid unnecessary treatment delays and unnecessary ER visits. These services can occur both in-person and through telehealth. An essential component of the continuum of care is for the crisis system to have the capacity in all crisis center settings to routinely triage for emergency medical need and provide routine medical screening examinations as needed without requiring all individuals in behavioral health crisis to go to an ER or medical screening.

Measurable Criteria for an Ideal System

The accountable entity ensures that the crisis hub provider and other crisis providers who receive walk-ins or direct referrals from the community will have the following capacities funded and available:

- **Routine medical triage:** All crisis workers, including first responders and mobile crisis, will be able to triage those medical emergencies that require direct referral to an emergency room and those that do not. Criteria for medical triage by non-medical staff are based on what would commonly require ER evaluation and not on policies and procedures that require ER evaluation of any possible medical risk prior to access to crisis services. Avoidance of unnecessary ER visits is measured as a systemwide and provider-specific quality metric.
- **Access to medical screening:** The crisis hub and other direct access crisis settings will have access to capacity to provide a routine medical screening examination, obtain blood and urine specimens to send to a laboratory and provide immediate medical response for conditions that can be managed in an ambulatory medical office. These services can be provided by crisis center physicians, nurses or by contracted collaboration with a primary care clinic or urgent care center partner. Telehealth can be utilized as appropriate, with crisis staff trained to perform basic tasks, such as obtaining vital signs.
- **Reimbursement for medical interventions:** Unlike in a psychiatric inpatient unit where medical consultations and interventions are part of the all-inclusive rate, other than possible separate physician billing, payment for crisis services at any level of care outside of an ER should be constructed so routine medical screening and intervention can be billed and paid separately. For indigent populations, payment for these services should be coordinated through health services in the community that provide medical care to indigent populations.
- **Quality indicators:** The presence of these structures, processes, activities and results are incorporated into quality indicators and metrics of success for the crisis system as a whole and for individual crisis providers as relevant.

General medical screening does not require an ER visit. Screening in the field, at behavioral health urgent care or at the crisis center can speed up access to behavioral health crisis treatment.



MOBILE CRISIS

Mobile crisis, working independently or as co-responders with law enforcement, has become established as a necessary element of any ideal crisis continuum. (SAMHSA, 2020). Mobile crisis services are a certification requirement for CCBHCs. In this model, the client is seen in person, where they are (i.e., the help comes to them). Mobile crisis can provide proactive engagement and outreach not only to a wide variety of service settings (e.g., emergency rooms, clinics, housing programs, criminal justice settings), but can also prioritize crisis response to individuals and families in their own homes or even on the streets.

Responsive mobile crisis (conducted without law enforcement as much as possible) makes access to help easier and decreases the likelihood of unnecessary ER visits and arrests. The rapidity of response is critical: help should be able to be on-site within one hour of the request, preferably sooner. The expectation is not that the crisis will be fully resolved by the visit, but that the acuity of the crisis can be de-escalated to the extent that an initial evaluation can be done on-site and a plan can be established for appropriate, short-term follow-up.

Smart Justice Project - Improving The Crisis Continuum In North Texas

In Dallas, Texas, the W.W. Caruth Jr. Foundation at the Communities Foundation of Texas provided a \$7 million multiyear grant to fund the Smart Justice Project, a collaborative effort between Meadows Mental Health Policy Institute, the Caruth Foundation, the City of Dallas, Dallas County, Parkland Health and Hospital System and other community stakeholders. The goal of the project was to transform crisis services and improve continuity of care for people in Dallas with mental health needs. It aimed to embed the psychiatric crisis response system within the emergency system response to medical crises; improve identification, assessment, and diversion to community treatment of individuals admitted to the Dallas County Jail; implement a real-time data system to quickly identify individuals with more intensive needs when they present for crisis services and then link them to appropriate care; and expand the continuum of psychiatric services in Dallas County.

Since 2015, the project has made significant progress towards its goals. It expanded assertive community treatment (ACT) and Forensic ACT services in Dallas and established two intervention and treatment programs for those experiencing early psychosis. The project also established a psychiatric extended observation unit at Parkland Hospital and a multidisciplinary team, consisting of a paramedic, law enforcement officer, and mental health professional, that responds to people with mental health needs in crisis in the community (the Rapid Integrated Group Health Team Care or RIGHT Care). In addition, the project helped Dallas County officials and the Dallas County Criminal Justice Department to improve mental health triage processes in the Dallas County Jail. Furthermore, Loopback Analytics (a private company), along with the Dallas-Fort Worth Hospital Council and the North Texas Behavioral Health Authority, created a data analytic platform that notifies in real-time when a potential Smart Justice client enters an ER, which has resulted in nearly 5,600 notifications. The result of these efforts has been the expansion of the crisis care continuum in North Texas.

Given the increasing concern about adverse outcomes resulting from law enforcement involvement in behavioral health crises, reconceptualization of the role law enforcement should play in mobile crisis services is imperative. The mobile crisis team can work in concert with police to minimize risk of aggression and facilitate next steps, support the individual in crisis if the person is able to remain in the community, divert from inpatient hospitalization to less intensive interventions (such as crisis beds) when possible and facilitate non-traumatic, supportive transportation to crisis center or hospital when necessary and appropriate. To maintain people in the community, a critical component of mobile crisis services is its capacity for rapid follow-up and short-term case management to maintain close and frequent contact with the individual while facilitating linkage with appropriate community-based services and supports.

If the person in crisis cannot or will not come to the crisis hub or crisis center for assessment, the mobile crisis team can bring the assessment to them – in the community.

Mobile crisis staff must be trained and skilled in engagement and de-escalation strategies. They also tend to work best in pairs. In many settings, mobile crisis teams are tied to the 911 response system and a mental health mobile crisis worker will go on-site along with a CIT-trained first responder (e.g., law enforcement officers). When traditional 911 responders are not a part of the team, mobile crisis typically requires that the client indicate willingness to accept the on-site visit. It is important, however, that the mobile crisis balances care about entering unsafe situations with a proactive willingness to engage with people in trouble, without creating unnecessary or arbitrary rule that limit the scope and effectiveness of the team (e.g., there is not a rule that precludes a mobile crisis team from visiting someone who may be using substances).

In an ideal crisis system, mobile crisis team coverage is usually available 24/7. However, in some smaller systems, low utilization in certain time slots (e.g., midnight-8 a.m.) may result in limitation of mobile crisis coverage to 16 hours per day.

Measurable Criteria for an Ideal Crisis System

The accountable entity should work in coordination with the community crisis collaborative, the crisis hub and crisis providers to fund and implement adequately staffed mobile crisis team coverage for the community. The mobile crisis team should meet the following criteria:

- **24/7 coverage with two people and/or co-responder teams.**
- **Clear protocols that guide or limit response to unsafe situations, but do not have arbitrary rules that limit access** (e.g., no visits to anyone with active substance use, no visits to anyone with a history of violence and/or no visits to anyone with a medical history).
- **Clear protocols and metrics for providing mobile crisis response in a full range of locations, such as homes, shelters, schools, housing programs and on the streets.**
- **Capacity to respond to calls within one hour more than 90% of the time.**
- **Close coordination with the crisis hub and all the other components of the crisis continuum:** Commonly, mobile crisis base of operations is co-located with the crisis hub.
- **Staffing includes multidisciplinary team** with peers, access to senior clinical back up, and access to psychiatric care providers ideally through telehealth platforms that can be brought to the scene and can also facilitate documentation and communication.
- **Capacity to perform the following functions in the community:**
 - » Assessment.
 - » Crisis intervention (including de-escalation and development of crisis plans).
 - » Supportive counseling.
 - » Collaboration with families and natural supports.
 - » Information and referrals (including to community-based mental health services).
 - » Transportation (directly or indirectly).



IN THE STORY OF MR. Y: A mobile crisis team would likely have been able to effectively work with Mr. Y and the store owner to resolve his behavioral health crisis



BEHAVIORAL HEALTH URGENT CARE

As noted previously, an ideal crisis system recognizes that a crisis does not begin with a call to 988 or 911. A crisis is commonly a continuing situation that may evolve over time and last for weeks, not a single, brief emergency event. An ideal crisis system has provision for both services that can respond quickly in the pre-crisis phase to avert decompensation, as well as post-crisis services that continue after the most acute aspects of the crisis have passed. Walk-in behavioral health urgent care services, conceptually equivalent to medical urgent care services, are therefore an important component of an ideal crisis system.

Behavioral health walk-in urgent care can provide easy access to a crisis response that does not initially require intensive or secure intervention. Individuals and families can access these services on their own, in convenient locations in the community or be directed to urgent care centers by the call center or crisis line (when that option is more appropriate than mobile crisis). Following hospitalization or other intensive crisis treatment episodes, behavioral health urgent care can be a valuable safety net in the event there is a breakdown in continuity of care such as a need for an early prescription adjustment or refill.

Behavioral health urgent care provides a valuable cost-effective alternative to ER utilization for behavioral health crises, just as medical urgent care provides similar value for diverting individuals with urgent but non-emergent medical needs. One of the major reasons emergency services are over-utilized for behavioral health is that access to timely care is inadequate, both pre- and post-crisis. Even in an urgent situation, it is not at all uncommon for waits on the order of a month or more to see a therapist and often longer for a psychiatrist. Individuals and families may need to access 911, or simply wait for decompensation, before the system responds. In an ideal crisis system, the moment of the ask is the optimal moment for the response. What may begin as a healthy recognition of the need for help can escalate to a crisis if help appears to be out of reach. Consequently, just as quick care or urgent care centers are becoming increasingly available for medical needs, the same need exists for behavioral health. For this reason, walk-in urgent care is a certification requirement for CCBHCs.

In most communities, the need for behavioral health urgent care requires multiple urgent care options distributed by geography. Each community needs to analyze population need and distribution to determine how best to allocate access to these services.

At the time of this writing, Kent County, Michigan, which includes the city of Grand Rapids, has a population of approximately 600,000, with two behavioral health urgent care centers. It has recognized the need for — and is planning implementation of — a third, to serve the high need downtown population. Even with limited hours of operation, one suburban behavioral health urgent care center, operated by Pine Rest Christian Services, sees up to 9,000-10,000 visits per year.

There are multiple options for developing behavioral health urgent care services:

- Include urgent behavioral health capacity within a general urgent care clinic. This may be achieved through a variety of collaborative care methods, including adequate training and support for the general practice provider, ideally including access to mental health specialty providers either in person or virtually as needed.
- In more dense population areas, dedicated behavioral health urgent care clinics may be created. These are commonly part of larger behavioral health organizations, and certainly part of CCBHCs. Such centers typically operate at a minimum during typical business hours and may have expanded hours, including weekends or evenings, but they are not typically 24/7. They include capacity to engage and triage, prescribe medications and link clients with appropriate follow-up and community resources.
- There is commonly an urgent care walk-in component that is part of a crisis hub or secure crisis access center. This permits the crisis center to provide a safety-net backup for individuals at risk of decompensation due to urgent need for medication refill or adjustment, for example, and provide quick warm handoff for crisis follow-up for individuals who need urgent ambulatory care.

Behavioral health urgent care centers may have variability in their capacity. The more capacity or capability built into these services in the beginning, the better they will provide alternatives to ERs or other intensive interventions. Examples of variable capacity include:

- **Hours of operation:** 12 hours, 16 hours, 24 hours. In a large community, at least one such center should be accessible 24/7.
- **Medical screening:** Availability of on-site or telehealth medical screening reduces the need for diversion to emergency rooms for that purpose.
- **Laboratory and pharmacy:** Availability of on-site or rapidly accessible laboratory testing, as well as access to a pharmacy for provision of medications can facilitate response to a wider array of situations.
- **Observation space:** Having space on-site for observation and intervention over a period of hours can allow for the urgent care center to provide for extended evaluation, stabilize intoxication, observe for signs of withdrawal and observe response to initial interventions.

Measurable Criteria for an Ideal Crisis System

The accountable entity works with the community collaborative and the crisis provider network to design, fund and implement an adequate array of walk-in/urgent care clinics for both adults and children throughout the catchment area.

- **Geographic access:** Urgent care services are located within a 30-minute drive of all residents in urban areas and one hour in rural areas for both adults and children. Services are accessible by public transportation. Ideally, each crisis center provides urgent care capacity directly or through coordination with a nearby community provider. All services welcome the opportunity to work with individuals who are actively using substances.
- **Availability:** Services are available at least 16 hours per day and 24 hours daily at a minimum of one site.
- **Capacity:** Medical screening is available at all sites, either directly or through telehealth. All sites have the capacity for observation of several clients for a period of 2-4 hours.
- **Medication evaluation:** All services provide routine access to medication evaluation and re- evaluation, in person or through telehealth.
- **Volume and adequacy:** The accountable entity monitors ER utilization and urgent care utilization to continuously improve appropriate diversion of behavioral health ER volume to urgent care. The accountable entity monitors call center referral protocols to assure adequate diversion to urgent care and successful follow-through at urgent care.



INTENSIVE COMMUNITY-BASED CONTINUING CRISIS INTERVENTION

A behavioral health crisis episode is not a single event and is rarely resolved with a single intervention. Whether the individual is presenting early in the crisis process to seek services at a behavioral health urgent care center or is in a post-crisis phase transitioning out of a crisis center, 23-hour observation unit or residential crisis program, there is frequently a need to provide a continuing bridge of best practice crisis intervention at an appropriate level of intensity – usually for days, weeks or even a few months – until the individual or family is sufficiently stabilized to continue in more routine care at the appropriate level of intensity, ranging from ACT to routine outpatient. Many individuals and families with complex challenges who present with an immediate crisis that needs urgent resolution (e.g. acute suicidality, psychosis), will remain far too unstable to participate in routine community care, even after addressing the most acute need. These may be individual adults who are homeless or unstably housed, who have active substance use with poor adherence to medications, who have complex unstable relationships, who have difficult medical and physical disability issues or who have cognitive challenges, and so on. These may also be families with multiple problems whose situation remains unstable even after addressing the child's acute need.

For some of these adults or families, there will be an eventual need for a long-term intensive community-based service (LOCUS Level 4), such as ACT or wraparound, but for many of them, a shorter term of two weeks to three months of intensive community-based crisis intervention (also LOCUS Level 4), using evidence based strategies such as critical time intervention or (for families) multisystemic therapy or functional family therapy will provide enough stability for the clients to continue in ongoing care at lower intensity. One way to think about these teams is that they essentially have many of the features of an ACT team (e.g., multidisciplinary team with psychiatric care providers, nursing, case managers, clinicians and/or peers with capacity for office based or home-based visits up to several times per week), but they are organized for short-term crisis work rather than long-term work with individuals with very chronic disabilities. These services are essential within the ideal crisis continuum because otherwise the individuals and families who need these services continually fail to make the transition from higher end crisis intervention (e.g., crisis center, crisis bed, hospitalization), to more routine outpatient care and cycle back into crisis or get into trouble in other areas (e.g., arrest, homeless, child welfare involvement).

In some systems, there is provision for intensive outpatient crisis services in the form of partial hospitalization programs (PHP) that are commonly 20 hours per week or mental health intensive outpatient group programs (IOP) that are commonly nine hours per week. These can also be effective for those individuals in crisis who are able to participate effectively in group structure. The development of these programs is often influenced by available reimbursement models rather than by a comprehensive assessment of the needs of individuals in crisis. In an ideal system, the intensive outpatient crisis service includes a combination of flexible team based wraparound care along with opportunities for engagement in structured groups that can be embedded in the intensive crisis team services or included in a separate PHP or group-based IOP depending on the size and availability of resources in the community being served. Intensive community-based intervention is a certification requirement for CCBHCs.

Oregon's Crisis And Transition Services Model Intensive Community-Based Crisis Intervention For Youth

The Crisis and Transition Services (CATS) program is an innovative partnership between the Oregon Health Authority, Oregon Health & Science University (OHSU), county mental health programs and community-based clinical and peer organizations. CATS provide rapidly accessible short-term intensive transitional community-based care for youths and families after a youth in mental health crisis has presented to an emergency department. CATS serve youths up to age 18 who meet criteria for psychiatric inpatient admission but have the potential to safely transition home with sufficient support after initial evaluation and safety planning in the emergency department. The program lasts 14–60 days and serves as a bridge from ED discharge to engagement with long-term outpatient providers.

The goal is for the program to be “insurance blind” and to balance adherence to uniform state guidelines with local flexibility. Generally, urban programs have a stronger focus on providing intensive clinical stabilization and connections to longer-term services, whereas rural programs focus on crisis response and coordinating rapid access to community providers. The programs providing clinical care generally use master's-level clinicians and psychiatric providers, whereas most rural programs utilize qualified mental

health associates. OHSU has provided ongoing program implementation support, including a learning community across the state, as well as program evaluation. Strong collaboration among stakeholders has helped to expand the program's funding and availability. Funding began with collaboration between Oregon Health Authority (Medicaid) and local funds, but now commercial insurance plans have begun to develop reimbursement for CATS (Ribbers, 2020).

Measurable Criteria for an Ideal Crisis System

The accountable entity works with the community collaborative and the crisis provider network to design, fund and implement adequate capacity for intensive community-based crisis intervention for both adults and children, that includes both home-based and office-based capability. The ideal system includes:

- **Adequate access:** Intensive community-based services are located within 30-minute drive or one-hour in rural areas for both adults and children and/or can be provided through home visits and telehealth. All services welcome the opportunity to work with individuals and families who may continue to actively use substances.
- **Rapid access:** Services are expected to be initiated within 72 hours of request.
- **Intensity:** The intensive community crisis services can see clients up to three times per week and provide/plan daily support if indicated.
- **Medication evaluation:** All services provide routine access to medication evaluation and re- evaluation, in person or through telehealth.
- **Length of stay:** All services can be provided for brief periods of two weeks up to three months, during which time transition to continuing services at the right level of intensity can be arranged.
- **Volume and adequacy:** The accountable entity monitors access and utilization of intensive crisis intervention services to ensure there is rapid access from both front-end services – mobile crisis or urgent care – and step-down. The accountable entity monitors services for both adults and children/families to ensure that all who need these services can receive them (office-based, home-based or telehealth), while maintaining effective transitions to routine service provision so that capacity continues to be available for initial referrals.



23-HOUR EVALUATION AND EXTENDED OBSERVATION

Twenty-three-hour evaluation and extended observation programs or services - sometimes referred to simply as 23-hour observation beds - provide a safe and secure space with the capacity for ongoing evaluation, observation and intervention by a multidisciplinary team, including psychiatric care providers, nursing personnel, crisis intervention specialists and/or peers for up to 23 hours during the acute phase of the crisis. Availability of this service for all individuals who need it, regardless of age, is an essential component of an ideal crisis system. The rationale for extended observation is threefold:

First, effective crisis evaluation and planning takes time, usually at least 2-4 hours, even in relatively straightforward cases. This requires a safe space designed for individuals in behavioral health crisis where crisis team members can engage clients and their natural supports to conduct a useful evaluation and determine the next best steps. For this reason, one of the essential features of a crisis hub or crisis center is the space and time to provide for an effective evaluation.

Second, the clinical picture can be very fluid during a crisis, especially within the first 12-24 hours.

Clients often present late at night at the culmination of a series of difficulties, many times in the context of intoxication and/or lack of sleep. At the time of presentation, they may express thoughts of violence or self-harm and/or may be agitated and/or disorganized in their speech and behavior. If such a presentation occurs within a setting or system with no capacity for extended observation (e.g., medical ER, walk-in center at an outpatient clinic), it is not at all uncommon for such clients to be admitted to inpatient units for safety, only to wake up the next morning in a very different state - calm, contrite, embarrassed or frustrated about being admitted. Conversely, individuals can present in a way that suggests the only problem they have is intoxication, but that presentation may be masking serious suicidality or psychosis. The 23-hour observation bed, associated with the evaluation and intervention capacity provided by the multidisciplinary team, can avoid unnecessary hospitalization and, conversely, prevent inappropriate discharge.

Third, access to a 23-hour observation bed allows individuals in acute decompensation to receive a more thorough evaluation and initiation of treatment. Like people presenting with medical crises, the response to initial interventions during the crisis can significantly determine the best next step. Rapid response to antipsychotic medication and an opportunity to sleep may mitigate a decompensation to the point that referral to a residential crisis program or even outpatient service can be an alternative to hospitalization. Similarly, observation beds can provide a safe place to initiate treatment for SUD withdrawal syndromes or to attempt to engage individuals who have presented with opioid overdose and responded to naloxone. Engagement of collaterals in crisis intervention can determine whether the individual can safely return home or if an alternative disposition is required.

The location of extended observation services can vary and 23-hour beds can, ideally, be outside a hospital setting. The more crisis services are hospital-based, the lower the percentage of people successfully diverted from hospital admission.

Sometimes crisis de-escalation takes a bit more time and support. Crisis residential programs can provide this extra time and support.

The Tucson Model: A Collaborative Approach to Behavioral Health Crisis and Public Safety

Pima County, Arizona, has developed a robust crisis system over the past 20 years, beginning with CIT training for law enforcement in 2001. The evolution of the crisis system has been a collaboration between many diverse stakeholders, with the County and Regional Behavioral Health Authority acting as the primary conveners.

With a population of just over 1 million, Pima County is one of the oldest continually inhabited counties in the US, and one of the largest at 9,187 square miles. About half the population resides in Tucson, with the remainder living in small towns, Native nations, rural areas. Pima County shares 130 miles of international border with Mexico. The population is 51.2% White non-Hispanic, 37.8% Hispanic, 4.4% Native American, 4.3% Black and 3.3% Asian.

While it was the last state to implement Medicaid, Arizona was the first to finance Medicaid via a statewide managed care waiver. The state is divided into geographical service areas, and a Regional Behavioral Health Authority (RBHA) is selected via a competitive bid process to fund and oversee a variety of behavioral health services, including crisis services. The RBHA receives funding via Medicaid, SAMHSA block grants, and other state and county funds, and it uses this braided funding stream to contract with various provider agencies to deliver crisis services to anyone in need. By serving as a single point of accountability, the RBHA is able to ensure that its subcontracted providers function as a coordinated system aligned toward the common goal of achieving stabilization in the least-restrictive setting that can safely meet the individual's needs. In this model, clinical and financial incentives are closely aligned, as the least restrictive levels of care also tend to be less costly. The RBHA during much of the early development of the crisis system was Community Partnership of Southern Arizona (CPSA), a non-profit owned by multiple service providers. In 2015, the RBHA contract was awarded to Cenpatco Integrated Care, now known as Arizona Complete Health, a subsidiary of Centene Corporation.

Pima County also plays an important role as a leader and convener. As the operator of the jail and a primary funder of the safety net hospital emergency department, the County has long had an interest in improving care for individuals with behavioral health needs. The County created a dedicated Behavioral Health Department in 2010 to oversee its role in civil commitment evaluations and jail programs. As part of the MacArthur Foundation Safety + Justice Challenge, Pima County has developed data sharing agreements which it uses to identify opportunities for community-based alternatives to incarceration, and collaborates closely with the RBHA, law enforcement, and various service providers on a variety of self and grant funded programs.

By the mid-2000s, Pima County was serviced by a growing crisis system comprised of a crisis line, crisis mobile teams and a walk-in crisis clinic. An increasing awareness of the prevalence of mental illness in the Pima County jail, compounded by a series of tragic events related to untreated mental illness, created the momentum needed to mobilize the resources needed for a crisis center to service the needs of law enforcement and the community. Leaders from Pima County and CPSA (the RBHA at the time) collaborated on a bond to build a crisis center to serve as an alternative to arrest and emergency department use. The bond was passed in 2006 and the facility was completed in 2011. A few months prior to the CRC opening, Jared Lee Loughner opened fire at a community forum held by US Representative Gabrielle Giffords, killing six and wounding 14. This prompted leaders at the Pima County Sheriff's Department and the Tucson Police Department to develop approaches that went beyond CIT. Both agencies created dedicated Mental Health Support Teams that seek to prevent crisis by identifying individuals at risk and connecting them to mental health services. Law enforcement and mental health collaborations have continued to grow, resulting in multiple specialty and co-responder teams and a robust training program for jurisdictions across the entire southern Arizona region.

The Crisis Response Center (CRC) is the centerpiece of the crisis system, serving approximately 12,000 adults and 2,200 children annually. In the year following its implementation, the percentage of Pima County Jail inmates with serious mental illness decreased by half, and the number of behavioral health visits to the adjacent emergency department decreased from 750 per month to 150. The facility is owned by Pima County, licensed to Banner-University of Arizona Medical Center, and managed by Connections Health Solutions, a private behavioral health provider. Services are primarily funded by the RBHA.

Services for adults and children are provided in separate areas of the facility and include 24/7 walk-in urgent care and 23-hour observation for 34 adults and 10 youth. Most patients arrive directly from the field via law enforcement, with the remainder arriving via transfer from outside EDs, mobile crisis teams or walk-in. Reasons for presentation include danger to self/other, acute agitation, psychosis, intoxication and withdrawal. In an ED, these patients would board waiting for an inpatient bed, whereas at the CRC, 60-70% return back to the community without the need for hospitalization via rapid assessment, early intervention and proactive discharge planning. Care is provided by an interdisciplinary team of psychiatric providers, social workers, nurses, behavioral health technicians and peers. The open design allows for continuous visualization to ensure safety and provides the opportunity for interpersonal interaction in a therapeutic milieu. For those who need it, a 15-bed adult short-term inpatient unit provides 3-5 days of continued stabilization.

Law enforcement uses the CRC as their central behavioral health receiving facility, dropping off both voluntary and involuntary patients via a secure gated sally port with a turnaround time of < 10 minutes or less for adults and 20 minutes for children. There are no exclusionary criteria for behavioral acuity, and officers are never turned away. Highly agitated or violent patients are cared for without the use of security by trained behavioral health technicians, with seclusion/restraint rates often lower than the national average for inpatient psychiatric facilities.

The CRC is part of a unique campus that has received national recognition for both its architectural design and multi-agency collaborative clinical model. In addition to the crisis services described above, the CRC houses the crisis call center for southern Arizona, which serves an “air traffic control” function, dispatching over a dozen mobile crisis teams throughout Pima County. A covered breezeway connects the CRC to the Banner emergency department and 66-bed inpatient psychiatric hospital, which contains a courtroom that is used for civil commitment hearings and some criminal matters. The CRC also contains space for co-located community partners, such as behavioral health clinics that can immediately enroll patients, and a peer run program that provides post-crisis wraparound services.

The governance and financing structure in southern Arizona has supported the continued development and oversight of the crisis system. The result is a robust continuum of crisis services, operated by a wide variety of provider agencies. A culture of “no wrong door” means that agencies work together to create a system in which anyone in crisis can get their needs met wherever they present. Regular stakeholder meetings, convened by the RBHA and the County, allow for ongoing analysis of data trends, problem solving and continuous improvement of the system.

Community-based (non-hospital based) crisis centers – particularly those in larger communities – should include 23-hour observation beds with capacity for adequate monitoring and initiation of treatment, including through telehealth. These settings should also make provision for space where children and adolescents can be served separately from adults.

In less populated areas, it is often more practical for the behavioral health crisis provider to collaborate with a local hospital to create space for extended observation near the ER and the resources it offers, but the service is in a more appropriate space than the medical ER. It is also important to recognize that in most larger communities there will be a significant volume of individuals who will present with both acute medical and acute psychiatric needs and will need to be evaluated and observed in the medical ER. The ideal response is to develop a designated psychiatric emergency service (such as the EmpATH model described on page 18 to serve those individuals. Regardless of location, 23-hour observation beds should maximize privacy and dignity on par with medical emergency services and the whole team should be focused on being welcoming, person-centered, hopeful and trauma-informed, especially in settings where there is a high volume of client flow.

Settings with 23-hour beds must also have close linkages to services on either side of the continuum, as a key outcome of the evaluation period is the determination of whether a step-up or step-down in services is indicated. The crisis system accountable entity must constantly monitor flow through the observation beds, so individuals are not backed up waiting for disposition because of lack of capacity at the next levels of care.

Although the 23-hour limit on observation is required for the service not to be considered inpatient, it is important to provide for continuation if needed. If at the end of a 23-hour period, the next best step remains unclear but there is good reason to expect that it will become clearer within the next 12 hours or so, an ideal system would allow for readmission to that level of care up to an additional 23 hours.

Measurable Criteria for an Ideal System

The accountable entity working with the community collaborative and crisis providers ensures adequate availability of extended observation capacity for adults and children, as follows:

- The community crisis center or crisis hub provides directly, or through collaboration, a location providing safe, secure extended observation for both voluntary and involuntary clients. Wherever possible, this location is outside of a medical ER.
- There is provision of separate space for adults and children.
- There is a welcoming, hopeful, person-centered, no force first philosophy that emphasizes customer experience, including for those who are involuntary.
- The capacity of the extended observation service is adequate to meet community needs and there is enough space so individuals are diverted elsewhere less often than one day per month, if at all.
- Staffing for the extended observation service includes a multidisciplinary team with 24/7 availability, including access to psychiatric care providers, crisis intervention specialists and peers.
- The extended observation service welcomes individuals with intoxication and can initiate interventions for withdrawal management and overdose reversal.
- The extended observation service welcomes individuals with psychosis and can initiate interventions for treating acute decompensation.
- Match the availability of extended observation beds to the geography of the community.
- If extended observation must be provided in an emergency room, there is separate space within the emergency room that is designed for behavioral health patients to be safe, comfortable and secure.
- Continuously monitor the flow through the extended observation service to ensure that individuals are not backed up or boarded in that setting.
- Hold inpatient units, residential crisis programs and other crisis intervention programs accountable to accept individuals who need to be transferred.



RESIDENTIAL CRISIS PROGRAM CONTINUUM

A continuum of co-occurring capable residential crisis programs or services is an essential component of an ideal crisis system. Residential crisis programs of all types are designed and staffed to work with individuals in behavioral health crisis who do not need the full resources of a psychiatric inpatient unit or other secure treatment settings. These programs add considerable flexibility to the behavioral health crisis continuum, as they can respond to individuals in less restrictive, often more home like settings, at lower cost than a hospital. Residential crisis programs may be used for both hospital diversion, which reduces admissions, and hospital “step-down,” which can shorten length of stay. Both diversion and step-down promote access to less restrictive settings for residential crisis intervention and more effective utilization of scarce resources and expensive psychiatric beds.

Residential crisis programs have been utilized successfully in locations across the United States for more than 25 years but are still relatively scarce. Most communities in the US do not have access to any residential crisis programs, let alone a continuum of different types. Yet, there is emergent data that reinforces the necessity and value of such settings in the crisis continuum: In “Crisis Now,” the National Alliance for Suicide Prevention published crisis flow data based on experience in Phoenix, Arizona, indicating that 86% of all crisis presentations were diverted from hospitalization and of the total, 54% went to some form of crisis residential setting (LOCUS Level 5: Medically-Monitored Residential Services) (See [“How Does Your Crisis System Flow?”](#) diagram). Without the availability of that level of care, it would be expected that almost all those individuals would have needed hospitalization.

In contrast to what these data imply, SAMHSA’s 2020 National Guidelines for Behavioral Health Crisis Care includes short-term residential facilities and peer-operated respite programs as “additional” but not “essential” elements of a behavioral health crisis system. However, without a continuum of residential crisis programs, there would be more reliance on scarce hospital beds for the individuals who cannot be safely discharged after initial evaluation, which makes it more likely that there will be backup in the crisis center and ineffective and inefficient use of resources. Therefore, residential crisis services should be viewed as essential.

Information about established standards for crisis residential services is still very limited and inconsistent. Each state has its own definitions and criteria, as do different public and private payers – and not all systems or payers even have criteria. TBD Solutions conducted a national survey of crisis residential providers to develop a Crisis Residential Best Practices Handbook (2018), which has been a valuable resource for delineating standards for a continuum of residential crisis programs and services for an ideal system.

**There is not
one type of residential
crisis program.**

As reflected in the Handbook (TBD Solutions, 2018), “crisis residential” is a term that covers many types of programs and services with variable levels of service acuity, intensity, medical/nursing capabilities and costs. There is no standardized language to describe all the types of residential crisis programs – what is defined as a crisis residential unit in one state may be called a crisis stabilization unit in another state and vice versa.

Residential crisis programs can vary with respect to multiple clinical design factors, as listed in Table 3.

Table 3 Clinical Design Factors In Residential Crisis Programs

- **Psychiatric monitoring:** May range from daily on-site visit to no direct access to psychiatric care providers.
- **Nursing coverage:** May range from an RN three shifts, RN some shifts and LPN/emergency medical technicians (EMTs) on others, to no nursing on-site.
- **Staffing:** Staffing ratios may vary from 1:2 to 1:8 and may be particularly thin on overnight shifts.
- **Peer staffing:** May vary from fully peer-operated and staffed, to peers in the mix, to no peers.
- **Security:** May be contained enough to prevent people from eloping, or may be completely open.
- **Size:** Usually no more than 16 beds due to Medicaid Institutions for Mental Disease (IMD) restrictions, but may be quite small (e.g., as small as 1-2 beds).
- **Medical capabilities:** May have varying access to medical care, labs, pharmacy, etc.
- **Mental health capabilities:** May range in the degree of capability to respond to higher acuity.
- **SUD capability:** May vary (e.g., sobering center with no medications, mental health, residential crisis program for people with mental health crises, with withdrawal management capability varying according to medical and nursing capacity).
- **Medication provision:** May administer meds or may require clients to self-administer.
- **Programming:** May have a full array of groups, just a few or none.
- **Crisis intervention:** May provide one-to-one service, family intervention or just assistance with discharge planning.
- **Flexibility:** May require all clients to be at the same level of care or may have a range in the same site.
- **Length of stay:** Programs may have average length of stay ranging from 3-5 days to 7-10 days.
- **Cost:** May range from \$50 to \$500 per day depending on the level of service and staff.


In addition to the clinical/staffing variables in the table, there may also be variation in the degree to which programs can accommodate people with physical disabilities, people who do not speak English or people with cognitive or self-care challenges.

Because of this variability in services and cost, an ideal behavioral health crisis continuum has a range of crisis residential settings that provide as much flexibility as possible to match services to the diversity of needs in the population in a cost-effective manner. There must be similar availability of all applicable elements of the continuum for children and youth.

The composition of the ideal residential crisis continuum is determined by the size and geographical distribution of the population being served. Based on the Crisis Now [“How Does Your Crisis Flow?”](#) diagram, a significant percentage of the total adult crisis presentations (200 individuals per 100,000 residents per month) were served in crisis residential settings. If that percentage is even as low as 30%, a community of 500,000 people would generate 300 residential crisis admissions per month and, if we assume an average length of stay of five days, that would require 50-60 residential crisis beds ($5 \times 300 = 1,500$ bed days, divided by 30 for approximate utilization).

Those 50-60 beds may be distributed in several different types of programs in a concentrated urban area. Note that the more highly staffed the residential crisis program, the more individuals can be safely diverted from hospitalization, but at higher cost. The more available lower cost options, the more individuals are able to get help earlier in their crisis less expensively. The right mix should include a balance of services that include higher acuity and lower acuity residential crisis programs as well as incorporating peer support into the crisis continuum to the greatest degree possible. Determining the right mix should be based on a data-driven assessment of community needs, including age mix and available resources under the auspice of the accountable entity and the community’s crisis collaborative.

The calculation shifts in rural areas. In a community with a lower population and/or a less dense population, there may not be enough volume to support a full range of residential crisis services. One approach in these communities is to set up programs that have flexibility to staff up or down based on need, including bringing in extra staff for individuals who are more acute. In very rural areas, the “residential crisis service” might be needed only a few times per month and can be provided by bringing in flexible on-call staff, including peers, for someone who is able to stay in a safe house on a day-to-day basis.



**How many
residential crisis
beds — and what types
of beds — does YOUR
community need?**

Categorization of Residential Crisis Programs

All residential crisis programs are considered Level 5 (medically monitored residential) on the Level of Care Utilization System (LOCUS or CALOCUS), but there is a significant range of possible service types. We are purposely not using the terms crisis residential unit or crisis stabilization unit, because these terms are used so variably across the nation. We recommend that future design of residential crisis programs within the ideal crisis system continuum utilize the following categorizations, which are intended to be more descriptive, for the purpose of service design, regulation and payment.

With the proviso that any categorization is only an approximation of the true flexibility with which these services can be designed, the following is a list of common categories:

- **Residential crisis programs with high medical and nursing involvement:** These programs are often called crisis stabilization units or crisis residential units. Unit cost is usually \$400-500 per day, compared to hospitals, which are \$800-1,200 per day. The most intensely staffed examples are facilities such as Psychiatric Health Facilities in California or Baker Act Receiving Facilities in Florida. These function as secure “receiving units” for involuntary admissions and are nearly equivalent to freestanding psychiatric hospitals. While they are helpful in providing specialized psychiatric crisis response services in non-hospital settings, they are close enough in form and function to freestanding hospitals that in this report they will be considered variations of psychiatric inpatient care that are discussed later.

Residential crisis programs with high levels of medical and nursing involvement are non-hospital based voluntary programs with lengths of stay ranging from a few days up to two weeks and allow for relatively intensive 24/7 monitoring and support, as well as provision of medical, nursing and crisis intervention. They are often in secure settings permitting admission of individuals who may be more highly acute. A typical program will have 24/7 staffing, multidisciplinary team staffing including peers, nursing, and medical monitoring; however, the type and number of staff and monitoring capacity vary widely across programs.

Size can range from six to eight beds, up to 16 beds (so as not to invoke IMD restriction on payment), and staffing ratios usually range from 1:4 to 1:8 on evenings, nights or weekends, with capacity for additional coverage for individuals who may need one-on-one care for brief periods. Some programs may have skilled nursing (RNs) round the clock, others only one or two shifts a day, with LPN and/or EMT and/or RN phone coverage at other times. Some programs may have MDs or other psychiatric care providers on-site every day, every other day or twice a week. These programs provide active treatment, including withdrawal management for mild/moderate withdrawal as well as adjustment of psychotropic medications and have 24/7 access to psychiatric care providers, whether by phone or telehealth.

- **Residential crisis programs with moderate medical/nursing involvement (crisis residential or crisis stabilization):** The unit cost is usually \$250-300 per day. These programs have lower levels of medical/nursing monitoring than high medical involvement programs and could have lower staffing ratios. There may be on-site nursing for a whole shift with LPNs/EMTs on-site at other times and an RN on call. Alternatively, the RN may only be present for a few hours a day, or only when needed. Similarly, medical or psychiatric care provider involvement is low as well and may involve visits once a week, only when needed or only via on-call.

Clients may have to visit outside providers for medical evaluation and may not be able to have their medications adjusted rapidly during their stay, though they can receive medications and be monitored for adherence and side-effects. What they do receive, however, is crisis intervention and support, including peer support, and a chance to connect or reconnect with ongoing community resources and treatment services to facilitate the resolution of a crisis. Note that even though this type of residential crisis program has less medical/nursing capability, it still will be able to admit individuals in crisis situations that, were it not for the program, would necessitate a higher level of care, such as a hospital. For example, a person may be acutely suicidal but able to be safe with staff support in the program, or the individual may be acutely psychotic due to medication discontinuation but able to restart medication and regroup under supervision. This type of program can help individuals who are using substances have a safe place to get sober with staff support and generally will have capability to provide medication and monitoring for mild withdrawal.

- **Residential crisis services with minimal medical/nursing involvement (crisis respite services):** Unit cost is usually \$100-200 per day. This is the lowest level of residential crisis service intensity. This program is appropriate for individuals who feel out of control in their usual environment but can settle down in a safe place with staff support. This can include people who are intoxicated or at risk of relapsing on substances. The program provides a viable alternative, a place to go for a few days with someone to help them think about next steps. Such a setting is typically home-like, often an apartment or a room in a house. Staffing and monitoring may range from one staff person around the clock to a person on call with staff who visit each day. Length of stay tends to be limited to a few days and no more than a week. Medical/nursing/clinician backup, if needed, is provided through an on-call system. Accordingly, effective and appropriately intensive short-term crisis case management is key (i.e., helping the person come up with realistic next step and connecting them with appropriate support services and treatment).

Crisis respite may be particularly important in rural crisis systems where individuals may be evaluated at crisis centers far from home and may need to be in a safe place to access necessary intensive ambulatory crisis services, but do not need around the clock staff monitoring once they are more stable. In many rural settings, access to crisis respite programs is infrequent, but can be provided by renting rooms on an as-needed basis, accompanied by on-call staff support. Crisis respite programs may also be valuable for families who are caring for children with significant emotional disturbances, including those who may have autism spectrum disorders. Having a safe space for children to go during periods of emotional dysregulation can provide opportunities to learn new skills and provide relief for the family. Peer support for the families provided by certified family partners can be a valuable component of this service.

- **Peer-run or peer-operated crisis respite:** The unit cost is usually under \$100 per day. These are variations on the crisis respite model in that they are either fully run and operated by peers or primarily or exclusively staffed by peers but operated by a conventional crisis program – a hybrid model.

In peer services, those who use the services are often referred to as guests rather than clients or patients. They vary in the hours they are open and the amount of time people can stay: Some are only open certain hours of the day; most, but not all, have overnight capacity and others have capacity for people to stay up to several days at a time. Medical, nursing or clinical services are accessed only on an as-needed basis. The overwhelming value of peer services is the capacity to provide hope and engagement for individuals who are frightened, traumatized and wary of professional service settings, including people who may choose not to take psychotropic medications. The availability of peer services in the crisis continuum permits voluntary engagement of individuals with great need who might not otherwise access services until involuntary intervention is required.

- **Living Rooms:** A highly recommended model is known as a Living Room, which cojoins the presence of a welcoming, no force first, highly staffed peer respite environment with the medical, nursing and clinical capabilities of one of the first two types of residential crisis programs. Sometimes peer respite programs are also referred to as Living Rooms. These programs combine the benefits of medical/nursing services for people with high levels of symptoms and acuity, with the inspiration of home and the capability for de-escalation and engagement characteristic of a peer-operated program.

The first Living Room model crisis program was established by Eugene Johnson and Lori Ashcraft at Recovery Innovations (RI) in Peoria, Arizona, in the 2000s. The following is edited from the [RI website](#): Peer-operated “Living Room” programs ensure that participants are paired with a team of Peer Support Specialists in recovery. Each guest is encouraged to work with the team and empowered to develop their own recovery plan, RI (now Recovery International) is known for creating the best possible recovery experience for people in crisis, using healing spaces with recliners, soft colors and a home-like atmosphere. The teams, comprised of doctors, nursing staff and peers with lived experience weave recovery, clinical, and medical services together, providing comprehensive care. RI makes every effort to eliminate seclusion and restraint and to serve all people regardless of level of acuity, without resorting to physical interventions.

- **Residential crisis programs with varying levels of medical/nursing involvement for individuals with SUD crises:** Often called detox programs, these sobering support units or sobering centers may provide withdrawal management capability, depending on the degree of medical/nursing/EMT involvement. Within residential crisis services, it is important to ensure a continuum of services is available for individuals who present requesting assistance with substance use disorders, many of whom also have co-occurring mental health conditions and other needs. These types of services can be categorized as Level 5 on the LOCUS but are more commonly categorized and described within the service array delineated as Level 3 by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (Mee-Lee, 2013).

These services range from residential withdrawal management or detox services, primarily intended as first steps to enter into continuing SUD treatment rather than an intervention in itself, which can include a range of levels of service intensity and medical monitoring (e.g., ASAM Level 3.7D: Medically Monitored Withdrawal Management down to Level 3.1D: Socially Supported Withdrawal), as well as simple “sobering centers” that are designed to create safe places for individuals who are intoxicated to become sober, usually with some peer support and access to counseling, but without requiring intent to receive crisis intervention or to enter ongoing SUD or mental health treatment.

Defining and Integrated Continuum of Residential Crisis Programs With Varying Levels of Medical/Nursing Involvement for Individuals With Substance Abuse Disorder

Crisis systems traditionally develop parallel service lines for people entering with mental health crises and SUD crises, but that is not essential and is not necessarily recommended for an ideal crisis system. The ideal crisis system is designed on the assumption that co-occurring mental health/SUD is an expectation and should be an integrated continuum that is matched to people’s needs and requests, not historical service divisions. What is essential is that all services – including residential crisis programs – are planned with the expectation of co-occurring mental health/SUD, with the best matched and most clinically and cost-effective and integrated capacity to respond to community needs. For example, withdrawal management can be provided in any level of medically monitored residential crisis program, which may be the best intervention for an individual with COD in acute mental health/SUD crisis who needs to stabilize but has no intention of entering ongoing SUD services in the near future.

By contrast, withdrawal management can also be provided in a co-occurring capable SUD withdrawal management or detox program that is more appropriate for someone in SUD crisis with co-occurring mental health needs whose goal is entry into continuing SUD services. Similarly, a sobering center can be a form of peer respite and there should not necessarily be a requirement that someone needs to be intoxicated (or not intoxicated) to be admitted. The community collaborative and accountable entity need to use service data to develop the most effective continuum that matches the type and volume of behavioral health crisis needs in the designated service area.

Measurable Criteria for an Ideal System

The accountable entity working with the community collaborative and crisis providers, plans, designs, funds and implements a continuum of co-occurring capable crisis residential services for all ages to meet community needs provided that:

1. There is a comprehensive array of residential crisis services for adults and youth. The components of the array are centered on a data-based analysis of community needs and resources to maximize hospital diversion and step-down and facilitate easy access for individuals in need.
2. All components of this continuum are funded with adequate cost-based rates by multiple public and private payers. Any necessary service (e.g., medication evaluation) that is not part of the cost-based all-inclusive rate should be billed separately.
3. All residential crisis services are designed so individuals can move smoothly in any direction through the continuum, including hospital step-down, and do not fall through the cracks. Each residential crisis program is monitored for quality indicators related to denial of admissions, facilitation of transitions and appropriateness of discharge.
4. All residential crisis services are monitored for co-occurring capability and designed to welcome individuals who may be actively using substances along with mental health symptoms.
5. The continuum is designed using consistent LOC criteria (e.g., LOCUS Level 5, ASAM Level 3) to determine appropriateness of utilization with the expectation that there will be minimum utilization of 50% and maximum utilization of 95%, with the programs being full no more than 5% of days each.
6. The continuum of residential crisis services has adequate volume and flexibility to meet the needs of the population. Services in urban areas require a diverse array of specific programs, while services in rural areas require flexibility to adjust capacity according to need.
7. The essential elements of this continuum include provision for:
 - » Residential crisis programs with higher medical/nursing involvement to maximize hospital diversion capability for individuals seeking services voluntarily.
 - » Residential crisis programs with lower medical/nursing involvement to facilitate access for individuals who are in less severe crises, to prevent further decompensation.
 - » Peer respite services and/or Living Rooms should have peer support incorporated in all residential crisis services, in addition to the availability of services that are peer-operated or peer-driven.
 - » Adequate services for individuals who are intoxicated, including those who need medically monitored withdrawal that may include integration of services for individuals who are intoxicated into the continuum of programs previously listed, as well as specific programs designed for individuals seeking entry into SUD treatment and/or a safe place to get sober.



IN THE STORY OF MR. Y: In the convenience store, Mr. Y was frightened and very symptomatic. While he might have required hospitalization, his behavioral health crisis might also have been appropriately addressed in a residential crisis program with medical and nursing monitoring and peer support. A Living Room model program might have been particularly effective in engaging him and helping him to overcome his fearfulness of service providers.



ROLE OF HOSPITALS IN CRISIS SERVICES

Although much of the purpose of an ideal crisis system is to divert individuals in behavioral health crisis away from hospital EDs and psychiatric inpatient hospitalization, community hospital emergency departments and medical units, ED-based psychiatric emergency services, community hospital psychiatric units and freestanding psychiatric inpatient facilities are all critically important elements of an ideal crisis continuum.

Psychiatric Emergency Service Programs in Emergency Departments

In some areas, particularly in urban settings with university-based hospitals or tertiary or quaternary care hospitals, certain emergency departments have dedicated psychiatric emergency services (PES), which can provide comprehensive evaluation, monitoring (including 23-hour beds), initiation of treatment and connection with community resources. These specialized PES programs may provide some benefit relative to community-based crisis centers for those who are especially medically complex, unstable or fragile.

More recently, the EmPATH model for ER based PES has been adapted widely for hospitals and communities of varying sizes and capacities. This type of service should be considered as an important component of an ideal crisis system, for those individuals with severe behavioral health crises who also need the services of a medical ER.

EmPATH Units

Distinct hospital-level psychiatric emergency program can be made available. This scalable solution, known as the EmPATH unit, is now being implemented at sites across North America. The EmPATH model was originally developed in John George Hospital serving Alameda County (Oakland), California.

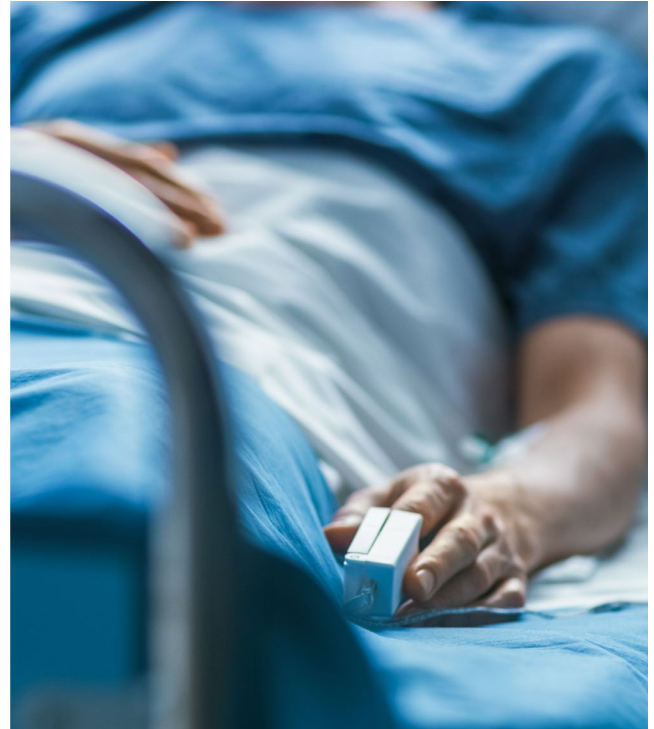
An EmPATH unit is a discrete, independently run program with its own staff, which operates in concert with the ED and under the same hospital license. Because patients are referred only after a medical screening exam in the general ED, a licensed psychiatric provider may not need to be on-site at all times. An on-demand telepsychiatrist can evaluate patients and commence treatment promptly in a cost-effective way, which can result in quick relief of patient distress.

In the most EmPATH units, patients are initially evaluated in a medical ED to rule out or stabilize emergency medical conditions and then immediately moved to the more therapeutic EmPATH setting. EmPATH units contain a layout where prompt medical intervention and supervision combine with the best features of community wellness and recovery programs. Individuals are treated concurrently in a large common milieu room, where staff are always interspersed with patients for constant and safe observation and re-evaluation. Rather than being assigned to beds, patients choose their own sleeper chairs or recliners where they can sit up to participate in activities (group or individual therapy) or fold flat to nap. Unlike the necessarily confining arrangement of a typical ED, this design allows individuals to relax, feel comfortable and move about freely. An overall focus on avoiding coercion and causes of frustration has resulted in dramatically lower incidences of physical restraints, aggression and assaults than more traditional units or EDs, even with a highly acute patient population under involuntary evaluation for dangerousness to self and/or others.

Now operating in two dozen sites around the nation, the EmPATH unit model contributes significantly to the reduction of ED overcrowding and throughput times by providing prompt transfer to an appropriate psychiatric level of care. Sites typically report 75% or higher avoidance of psychiatric hospitalizations in patients who would have been admitted in more standard ED systems. EmPATH units are presently working on any scale from eight to 48 chairs; in urban places like Los Angeles or rural settings like Lafayette, Indiana; in academic hospitals or at small community facilities. (Zeller, 2019)

Hospital-based ERs: These have the broad capacity and flexibility to respond to all kinds of medical emergencies. Clearly, this must include medical emergencies that result from behavioral health conditions (e.g., overdoses, delirium tremens), as well as individuals in behavioral health crisis who have comorbid medical conditions that require emergency medical evaluation and/or intervention, whether in the ER or the inpatient medical unit.

Although most general hospital ERs, especially those in less densely populated communities, lack the specialized behavioral health services and supports that can best help a person through a behavioral health crisis and connect them to needed resources, they are nonetheless critical partners in the ideal crisis continuum. It is important that the crisis system has a clearly defined collaboration with one or more medical emergency facilities for safe, compassionate medical screening, evaluation and intervention for individuals with behavioral health conditions who demonstrate serious medical symptomatology, as well as well-organized partnership protocols so that individuals who do not need medical admission can be evaluated by mobile crisis workers in the ER and/or quickly and safely transferred to the crisis hub.



A full-fledged collaboration with mobile crisis services (whether provided on site or through telehealth) will permit the mobile crisis workers to be credentialed in the ER and work with their own psychiatric backup to develop collaborative disposition plans with ER physicians and social workers. ERs also should have the capacity – as a crisis system partner, and in accordance with American College of Emergency Physician/American Association of Emergency Psychiatrists (ACEP/AAEP) guidelines – to initiate less urgent laboratory studies (e.g., urine drug screens, metabolic screens) that may be helpful for further behavioral health crisis evaluation and treatment, even though they may not be immediately needed for initial medical evaluation and disposition.

Behavioral health crisis consultation for medical/surgical inpatients: Another important component of an ideal crisis system is the ability to provide behavioral health crisis evaluation with psychiatric backup for medical/surgical inpatients. Common examples are individuals who are admitted medically after an overdose, self-inflicted injury, severe alcohol withdrawal, anorexic crisis or other medical/surgical issues that may need emergent intervention prior to specialized behavioral health treatment. In an ideal crisis system, the mobile crisis team, coordinated by the crisis hub, has the capacity and credentialing to evaluate individuals who are in medical/surgical units and coordinate transition to the appropriate component of the crisis continuum with the hospital's attending physician and psychiatric consultant.

General or psychiatric hospital-based inpatient treatment: One might initially imagine that inpatient psychiatric hospitalization would be unnecessary in an ideal crisis system. We might hope that if we had robust enough community services and seamless communication and transitions to those resources that everyone in crisis could be treated in the community and outside of the hospital setting. In fact, one measure of an inadequate crisis system is the overuse of inpatient hospitalization either because there aren't adequate crisis and/or diversion services and/or there are not effective linkages to connect people to those services in real time.

Although the vision of no hospitalization is appealing, it does not comport with the natural history of the acute and severe illnesses people may be dealing with in a psychiatric and/or substance use disorder crisis. Inpatient hospital treatment is, and should remain, a critical part of the crisis response continuum. Whether in a locked or open unit, this is typically the most resource-intensive setting within the continuum. Typical psychiatric inpatient units for children, adolescents or adults are appropriate for patients who are acutely in need of close and continuous medical, nursing and staff intervention and

monitoring over more than a 23-hour period, mostly for reasons involving safety, but also to treat individuals who may be psychiatrically acute and complex with medical comorbidities and/or may be resistant to participation in treatment. Hospitalization is also necessary for those for whom the safety risk remains unclear and when adequate evaluation or treatment cannot be achieved safely or effectively in a less intensive setting.

Specialty inpatient units: In addition to generic psychiatric inpatient units for adults, adolescents and children, there are populations that can benefit from specialized inpatient services. These include geriatric units that can safely treat older adults with medical and cognitive impairments, medical-psychiatric units that treat individuals of any age with combinations of acute psychiatric needs and acute medical illness and/or severe medical disability, eating disorder units, specialized units for co-occurring serious mental illness and addiction and specialized units for co-occurring psychiatric illness and intellectual/developmental disability or brain injury. In large urban areas, planning for specialized capacity should be part of an ideal crisis system design.

In less populous areas, these types of specialized services may need to be planned as regional or even statewide tertiary care services. The ideal behavioral health crisis system needs to plan for how to respond to those individuals that present in local emergency rooms or crisis centers with these specialized needs, just as in emergency medical response systems. Individuals with specialized needs are often hardest to place from emergency rooms because psychiatric facilities reject them as too difficult. Purposeful planning can overcome this under the auspice of the accountable entity. Such planning may include financial and other incentives for local units to accept these patients to relieve pressure in the ER or crisis center, followed by planful transfer within a few days to an appropriate tertiary care facility if needed.

Do we need more psychiatric inpatient beds? In general, we don't need more beds; we need a crisis system. However, the beds we have must be available geographically, including in more rural areas, and respond to the people who are most ill. Further, we may need more capacity to respond to people with higher acuity at the same time more people are diverted to residential crisis units and other crisis services.

An important challenge in defining the need for acute psychiatric hospitalization in an ideal crisis system is that there is a broad perception in most communities of too few beds (meaning psychiatric hospital beds) and a desire to invest in building inpatient hospital capacity for adults, older adults and children/youth. However, in a monograph entitled "Beyond Beds," the National Association of State Mental Health Program Directors (NASMHPD) reports that the focus on inpatient beds is misleading (Pinals, Fuller, 2017).

Communities have an accurate perception of needing more for people in behavioral health crisis, but what they need is an ideal crisis continuum, not just costly inpatient beds. Further, in the previously cited Phoenix data from Crisis Now (page 52 in the first section), of all the people who presented with behavioral health crisis who need beds, only 20% of those who needed a bed and only 14% of total crisis presentations needed psychiatric inpatient care (LOCUS Level 6). The remaining 54% of the total needed crisis residential services (LOCUS Level 5). Maximizing capacity for diversion and step-down does not replace the need for inpatient care, but it substantially reduces the amount of inpatient capacity that is needed.

Finally, it is important to note that in some systems, the ideal location for the crisis hub or crisis center, as well as observation beds, crisis stabilization beds, urgent care centers, etc., may be on the campus of a psychiatric inpatient facility because of available space and proximity of nursing/medical back up. Note that the psychiatric inpatient unit should be regarded as a full partner/member in the continuum, not isolated from the rest of the continuum, and become a regular participant in community crisis collaborative planning.

Measurable Criteria for an Ideal System

The accountable entity works with its community crisis collaborative to include hospital partners and ensure implementation of the following capacities and processes across all ages and payer categories:

- **Strong collaborations with medical emergency rooms in the community:**
 - » Each crisis center in the system has a formal collaboration agreement with a nearby ER to permit easy transfer back and forth to help clients quickly access the most appropriate setting.
 - » The crisis system has clear protocols for medical screening that determine which levels of acuity can be managed in the crisis center and which require the ER, as well as utilizing ACEP/AAEM guidelines to define and streamline ER-based medical screening examinations, reduce unnecessary delays waiting for medical tests and offer helpful initiation of testing in the ER without waiting for results to facilitate treatment in a behavioral health setting that has less medical capability on-site.
 - » There are protocols, memorandums of understanding and credentialing processes to permit mobile crisis evaluations in the ER and coordination between ER physicians and psychiatric providers in the crisis continuum.
 - » ER clearance timeframes for behavioral health patients and ER boarding are monitored as overall system performance quality indicators, with the goal that no more than 1% of psychiatric patients going to the medical ER – whether adults or children – remain in the medical ER longer than 12 hours.
 - » ERs develop formal training and protocols to respond in a welcoming, trauma-informed manner to individuals with mental health and/or SUD needs. De-escalation training is required and ERs monitor restraint episodes for continuous improvement and reduction.
- **Implementation of at least one psychiatric emergency service (e.g., EmPATH model) in a hospital emergency department.**
 - » Systems should implement EmPATH models or similar models for ER based psychiatric emergency services whenever feasible. Larger systems should have at least one designated tertiary psychiatric emergency room facility connected to one major ER. These programs should complement, not replace, the community-based crisis center.
- **Formal mechanisms to ensure crisis evaluation and coordination for individuals with acute behavioral health needs admitted to medical/surgical units:**
 - » There are formal protocols for mobile crisis and the crisis center to collaborate with medical inpatient units and hospital-based psychiatric consultants to provide emergency behavioral health crisis evaluation, intervention and disposition for medical/surgical inpatients as indicated.
 - » General hospital units have clear procedures and staff training for welcoming, safe, trauma-informed interventions (including withdrawal protocols) for individuals who present with acute behavioral health crisis as well as acute medical needs.
- **Adequate high quality psychiatric inpatient capacity for all age groups:**
 - » There should be adequate psychiatric inpatient services for children, adolescents, adults and older adults with medical/cognitive needs. Adequacy requires bed availability within one-hour drive time of each crisis access center. Adequacy volume is based on planning based on expected utilization in the context of a full crisis continuum, including crisis residential services for step down and diversion. All payers should support the full continuum of services to prevent bed access limitations for uninsured or Medicaid clients, just as there is access for uninsured individuals to medical/surgery beds. Adequacy planning should expect bed utilization to be no less than 50% and no more than 95% for any age group and all beds in the community should be full no more than 5% of the days in any year.
 - » Payment rates by all payers are no less than cost for hospitalization. There should not be a rate disparity between psychiatric acute inpatient care and medical/surgical inpatient care such that hospitals lose money on their psychiatric services.

- » There should be clear standards and criteria (based on LOCUS and CALOCUS, for example) about when inpatient hospitalization is medically necessary for both admission and continuing stay, as opposed to other levels of care in the continuum. Community inpatient units must be expected to accept involuntary patients on emergency or short-term holds, as opposed to all involuntary patients having to go to the state hospital; however, voluntary patients who meet medical necessity criteria should be accepted as well. Community inpatient units, whether hospital-based or free-standing, must welcome individuals who may have active substance use without arbitrary barriers to admission based on urine screens or blood alcohol level. Similarly, units must be able to accept any individual whose medical condition could be managed at home if psychiatric care wasn't required, as well as otherwise appropriate individuals with any level of intellectual/cognitive disability who are capable of basic self-care.
- » The ideal crisis system and psychiatric inpatient facilities should make use and duration of involuntary legal status as little as possible. This is consistent with a patient-centered and empowered system culture. Incidence and duration of involuntary status should be measured and reported as a performance indicator.
- » Psychiatric inpatient facilities should be full partners in the crisis continuum and participants in the crisis collaborative that serves the community.
- » There should be adequately staffed, trauma-informed, recovery-oriented and co-occurring capable services offered on the inpatient units including:
 - Adequate staff-to-patient staffing ratios for nurses, techs, peers, clinicians and psychiatric care providers with regularly planned interdisciplinary team meetings for comprehensive service planning in collaboration with patients and their collaterals. Treatment and treatment planning will be team-based, patient/family-centered, trauma-informed and recovery-oriented with an emphasis on hope and resilience.
 - Availability of crisis intervention, rehabilitation and other relevant psychotherapeutic interventions, both individual and group, provided by adequately trained staff who are appropriately supported with supervision, mentoring and quality improvement and adherence to evidence-based and evidence-informed practice. Capacity to individualize services for those who may not be able to participate in groups.
 - Availability of competent ancillary services in treatment such as well-trained and supported pharmacists, internal medicine providers, specialty medical consultation services, patient rights and privacy staff.
 - Full inclusion of peers/people with lived experience in inpatient services as accepted members of the interdisciplinary team.
 - Availability of, or access to, such best practices as electroconvulsive therapy, dialectical behavioral therapy and cognitive behavioral therapy.
 - Robust use of measurement tools and data to evaluate the efficacy of both the treatment of individuals (e.g., outcome measures) and the collective work of inpatient units (e.g., acuity scales).
 - Robust and competent leadership and oversight in order to appropriately lead efforts around continuous quality improvement, client experience, length of stay and quality of treatment. Many of these issues represent a tension between quality and necessarily limited resources and can only be navigated well in the context of strong leadership, which ideally is team-based and involves staff at all levels.
 - Ongoing training and competencies to create a treatment environment that is welcoming, multi-dimensional, including integrative therapeutic modalities such as yoga, art and occupational therapy, and where clinicians are skilled and up- to-date on cultural dimensions to treatment including LGBTQI competency.
 - A strong emphasis on reducing the use of seclusion and restraint and forced medications through such means as comfort rooms.

- » There are expectations and protocols for regular communication between inpatient providers, the crisis hub/ crisis tracking and community behavioral health providers immediately after admission, regularly during treatment and after discharge.
- » Transition from inpatient to community (including crisis residential step-down) is expected to occur within three business days, not the Healthcare Effectiveness Data and Information Set standard of seven days, as three days have been demonstrated to have a meaningful impact on improving continuity of care.
- » The accountable entity monitors inpatient access, utilization, transitions, collaboration, critical incidents, client satisfaction and quality of care as part of the overall quality assurance/performance improvement program, in collaboration with funders.
- » A third option is to develop an urgent care component as part of a crisis hub or crisis access center. This permits the crisis center to provide safety-net backup for individuals at risk of decompensation due to urgent need for med refill or adjustment, for example, as well as provide quick warm handoff for crisis follow-up for individuals who need urgent ambulatory care, but do not immediately have connection to a routine community behavioral health provider.

Extended inpatient hospitalization and residential rehabilitation

Adequate access to acute inpatient hospitalization for children, adolescents, adults, and older adults who need the highest level of medically managed intervention is a critical feature of an ideal crisis system. Many communities experience a lack of adequate access to acute inpatient beds because the need for such services outstrips the available supply. An ideal crisis system provides a range of alternative responses that significantly limit the need for acute inpatient beds in any community, reducing demand by as much as 70%-85% compared to no such services (Pinals, Fuller, 2017). However, the presence or absence of a crisis system is not the only variable that contributes to adequate access to acute inpatient beds. One variable is whether payment rates by public and private insurers provide adequate reimbursement (compared to payment for medical acute services) that make such services financially viable for health systems or freestanding psychiatric hospitals (see Financing Section of this report). Another important variable is access to intermediate length of stay services for individuals who have persistent needs for high levels of intervention following their acute stay, and therefore cannot be quickly transitioned to appropriate community-based interventions. Examples may include extended inpatient hospitalization (as for individuals who have serious treatment refractory conditions) as well as extended residential psychiatric rehabilitation facilities (examples are Psychiatric Residential Treatment Facilities for children or adolescents, or specialized behavioral health capable nursing facilities for older adults). Even though the percentage of all acute admissions who may require these types of services is small, when these services are not adequately available in a state system, there is significant negative impact on acute bed availability, both because longer-stay patients impede access through the front door and hospitals become more reluctant to accept admissions that might become a placement risk.

Discussion of access to extended inpatient hospitalization and residential rehabilitation facilities is beyond the scope of this report, but nonetheless is an important issue to acknowledge. As of this writing the American Psychiatric Association is engaged in creation of a model by which any community can calculate bed need by age and by acute vs. intermediate vs. long-term, based on both population characteristics and the degree to which an ideal crisis continuum and other community services are present.

- **Intensive community-based crisis intervention:** There are many individuals and families with complex challenges who present with an immediate crisis that needs urgent resolution (e.g., acute suicidality, psychosis), but who continue to need intensive intervention and support for an extended period of time following the initial crisis presentation. These may also include families with multiple problems whose situation remains unstable even after addressing the child's acute need.

For some of these adults or families, there will eventually be need for a long-term intensive community based service (LOCUS Level 4), such as ACT or wraparound, but for many of them, a shorter term of two weeks to three months of intensive community-based crisis intervention (also LOCUS Level 4), using evidence-based strategies such as critical time intervention, multisystemic therapy or functional family therapy for families will provide

enough stability for clients to continue in ongoing care at lower intensity. These services are essential within the ideal crisis continuum because otherwise the individuals and families who need these services have difficulty making the transition from higher-end crisis intervention (e.g., crisis center, crisis bed, hospitalization) to more routine outpatient care and may cycle back into crisis or get into trouble in other areas (e.g., arrest, homeless, child welfare involvement). In some systems, there is provision for intensive outpatient crisis services in the form of partial hospitalization programs or mental health IOP group programs.

- **Length of stay:** All services can be provided for brief periods, ideally two weeks and up to a maximum of three months, during which time transition to continuing services at the right level of intensity can be arranged.



TRANSPORTATION AND TRANSPORT

One of the important and often overlooked parts of the crisis continuum is how people are transported throughout the experience of a crisis episode. This begins with how an individual finds their way from wherever they are in the community when a psychiatric crisis strikes to the first point of in-person treatment and ends with how they are transported to the next destination (e.g., to an inpatient psychiatric unit or back to their home). There are many ways this part of the crisis experience can go well or go poorly. Too frequently, people who reach out for help in a crisis are unnecessarily restrained or even handcuffed in a law enforcement vehicle, often resulting in significant trauma and reluctance to ask for help in the future. Negative transport experiences have a major bearing on how a person perceives the experience of care and of reaching out for help. For this reason, providing welcoming, safe and supportive transportation is an essential service in the ideal crisis system.

Measurable Criteria for an Ideal System

The accountable entity working with the community collaborative should establish a comprehensive transportation plan for individuals in behavioral health crisis, both to the crisis center and from the crisis center, as well as between other locations in the continuum as indicated. The plan should focus on the following:

- **Transportation resources:** A comprehensive transportation plan in an ideal system maximizes transportation in the least restrictive safe setting and minimize overutilization of law enforcement or EMS for routine transport. The transportation plan includes defined capacity and roles for:
 - » Private vehicles (driven by family members, peers, volunteers)
 - » Taxis
 - » Specialty taxis
 - » Specialty mental health transportation services/vans
 - » Mobile crisis transport
 - » Emergency medical transportation
 - » Law enforcement transportation
- **Decision algorithms:** There should be clear standards and decision algorithms around which types of transportation are most appropriate with respect to time and types of psychiatric crises. Attention should be paid to how people are communicated with throughout the process – from first point of contact – with clarity and transparency about what to expect in the process.

- **Restraint reduction:** There should be a strong message to use the least restrictive form of transportation with particular emphasis on reducing the use of restraint. There are examples of innovative solutions to solve for this issue, including use of specialty mental health transportation services to replace law enforcement transportation which have resulted in the reduction or elimination of restraint. These solutions require significant coordination and communication between public and private entities and are dependent on strong vision and strong leadership.

Example of Specialty Transport In rural East Texas, a multi-county collaboration coordinated by Burke Center in Lufkin developed a plan by which off-duty or retired law enforcement officers could transport non-violent individuals to the crisis center (with payment and liability coverage) in lieu of either expensive ambulance or on-duty law enforcement being used for transport.

- **Collaborative funding:** Because in most instances, transportation is not paid by insurance, the accountable entity and crisis coordinator need to work with the community collaborative to develop a plan for payment of a full range of transportation services. This requires recognizing the value of saving time for law enforcement and avoiding over-utilization of expensive ambulance services. In addition, the crisis hub/crisis coordinator needs the ability to authorize transportation funds 24/7, when indicated, to ensure that individuals get to or from the crisis center to the crisis bed or hospital.
- **Expanded roles for EMS:** EMS systems often manage a range of transportation options of different cost levels, not just ambulances. EMTs are commonly underutilized as first responders and have much more capacity than law enforcement, given their training in making protocol-based medical decisions under pressure and in crises. With adequate resource support, they would be better positioned than law enforcement to be first contact for someone in psychiatric crisis. Further, it is essential to pursue current efforts to change insurance requirements, including CMS regulations, to permit EMS to transport patients to crisis centers and not just to ERs to reduce unnecessary ER visits simply to comply with regulation and provide clients what they need. The recently announced Emergency Triage, Treat and Transport model demonstration in Medicare is an example of this more flexible approach. [Emergency Triage, Treat, and Transport \(ET3\) Model | CMS](#)
- **Quality improvement:** Transportation access, timeliness and cost are important quality metrics that should be monitored and continuously improved as part of the crisis system's quality assurance/performance improvement (QAPI) plan.



STAFFING CAPACITY

In an ideal crisis system, it is critical to have adequate staff capacity, in terms of numbers, credentialing, background and expertise. This section focuses on the standards for staffing capacity (see "[Basic Clinical Practice](#)" for more on staff competencies and practice guidelines).

ADEQUATE INTERDISCIPLINARY MULTIDISCIPLINARY TEAM STAFFING

The staff composition of an ideal crisis continuum, and each program within the continuum, must reflect the volume of service provided and the variety of crisis needs of the community it serves. To do that, adequate numbers of staff and an interdisciplinary team of staff are required. With regard to adequate numbers of staff, precise staffing patterns will vary based on the type of program and level of service intensity provided. Discussion of exact staffing ratios for each component is beyond the scope of this paper; however, if too few staff are present, the program will not function properly and more individuals will need to be served at a higher level than might otherwise be the case.

It is helpful to discuss the importance of adequate staffing for the crisis center itself. Using the projected volume figures from the program in Phoenix, Arizona (see "[How Does Your Crisis System Flow?](#)"), crisis center staffing can be planned based on the expected crisis flow. For example, in a catchment area with 250,000 people, the expected number of crisis presentations is 500 per month (17 per day, averaging six per shift). Therefore, the capacity of front-line crisis workers needs to be able to address six crises on average with plans for routine surge capacity so the system does not get backlogged. Assuming that each individual in crisis will require three hours of intervention on average, with some requiring individual attention, it is clear that each shift needs to be planned to have no less than 24 person-hours of front-line staff availability (or at least three full-time staff members' time). Similar calculations should be applied to the whole crisis system, so that crisis response is not constantly understaffed resulting in dangerous delays for both clients and first responders.

With regard to the composition of staff teams, multiple types of expertise are required and the ability to work as an interdisciplinary team to flexibly respond to individual needs, not as parallel separate individual disciplines in separate silos. The staff must be able to collaborate easily to triage effectively; engage individuals and families who are in crisis; gather information to perform effective clinical assessment from individuals, families and other collaterals; provide urgent treatment; and assist individuals and families in crisis transition to the proper level of ongoing care. For a crisis team to work efficiently, there needs to be contribution from multiple disciplines, and all team members, regardless of discipline, must be sufficiently trained and knowledgeable to carry out their specific tasks while understanding and supporting the unique skills and knowledge of the other team members.

There should be minimal duplication of work and all team members should collaboratively provide care, treatment and education for the clients. The team should function so all team members are co-occurring competent working with people with any combination of mental health and SUD issues and cross-cover and function to support the most highly credentialed team members (e.g., physicians and nursing personnel) to help them practice to the top of their license. For example, all staff can be expected to take pulse and blood pressures, while the nurse interprets the results and makes decisions accordingly.

Measurable Criteria for an Ideal System

The accountable entity ensures that all programs in the crisis continuum have funding to support adequate staffing of an interdisciplinary team. The staffing pattern is calculated using real data for each type of program with planned surge capacity and backup plans to cover absences. Program rates are based on actual staffing cost needs to produce the desired level of service in the context of network access and adequacy and regularly reviewed as part of the system QI plan to look at instances of under- or over-staffing and continually improve. The composition of the interdisciplinary team in the crisis hub/crisis center and in other settings, as appropriate, is designed to meet the following standards:

- **Team composition:** All crisis programs are ideally comprised of an interdisciplinary team with an appropriate range of credentials and expertise. The ideal team is two or more people working cooperatively toward a common goal. Each team should have provision for an appropriately licensed or credentialed clinician (sometimes called qualified mental health professional) to be available on-site or on call to cover each shift, in accordance with the level of care provided. The higher the level of care (the greater the intensity of service provided), the higher the total number of staff per client served and the greater proportion of people with more training and experience. The essential components of a functional team include the correct mix of crisis team members with the client as team co-leader, plus engagement of collaterals such as family, friends and other non-crisis providers of care and services. The team should include capacity to incorporate all the expertise described here. The size of the team and the precise numbers of staff in each category must be commensurate with the level of need and the volume of services provided by the crisis program. The team make-up can change as the individuals' needs change. For example, if the person in crisis has housing needs, a housing specialist or housing intact person may temporarily join the team. There are, however, core team members who are consistently available for continuity, including:
 - » **Crisis clinicians:** There are clinicians who are skilled in doing initial triage, crisis assessment, provisional diagnosis, crisis planning and crisis intervention. They are commonly master's level clinicians from any discipline, frequently licensed professional counselors or licensed marriage and family therapists (LMFTs), but in some settings may be bachelor's level crisis clinicians with training and supervision that qualifies them to perform crisis intervention and crisis care management. Clinicians can also begin short-term, crisis focused and motivational treatments.
 - » **Psychiatric care providers:** The crisis team has psychiatric care providers available on-site or on call who can initiate medication treatment if needed. These clinicians can be MDs, doctors of osteopathy, advanced practice registered nurses, nurse practitioners (NPs) or physician assistants (PAs), depending on state licensure and regulations, and can distinguish between the need for emergency treatment, urgent treatment and ongoing care.
 - » **Nursing:** Nurses are essential to oversee medical screening and evaluation, provide and monitor medications and interface with nursing personnel at referring and receiving programs. Depending on the type and intensity of services, during any shift, nursing may be on-site or on call and may involve RNs or licensed vocational nurses/LPNs. There also needs to be an individual designated as a nursing supervisor, who will be on-site or off-site depending on the number of nursing staff or extent of nursing coverage.
 - » **Social worker:** Social workers, LMFTs or other clinicians trained in family engagement can gather historical information, family and social contacts and begin linkage to other services and care in the community.
 - » **Substance use disorder clinician:** There are team members who are certified or licensed SUD specialists and/or individuals who have SUD experience. These team members support the ability of all team members to work with individuals with SUD/COD in crisis.
 - » **Peer specialists:** Peers are essential team members who specialize in welcoming and engaging clients, helping educate clients about crisis program services and process and facilitating community transitions as community bridges.
- **Clinical and administrative team leadership:** There must be functional mechanisms to ensure successful team operation. A team administrator is also a clinical leader of any discipline (e.g., psychology, social work, psychiatric nursing) who has oversight of the internal operations of the program, including fiscal management, staffing and schedules, reporting and evaluation of services, tracking of outcomes, etc., and coordinates external relationships

with other services. Open and regular communication between team members with clear expectations and accountability is essential. Team members must be accountable for completing their tasks and there must be shared responsibility for risk and outcomes. In the ideal team, all members can identify and value the unique roles and contributions of other team members and trust them to carry out their roles. It is also important for all team members to actively seek out collaboration with others and to actively contribute to the overall functioning of the team. The team can share essential information through face-to-face meetings, shared medical records and supervision. The team can identify measurable goals and objectives, work collaboratively and not competitively in solving problems and cross-cover to manage immediate clinical and program needs.

- » **Medical director:** The medical director may be on the premises or off-site depending on the type of program and oversees all medical care and consults with the other team members for individuals with complex medical or behavioral health needs. The role of medical director is a certification requirement for CCBHCs.
- **Team diversity:** The team should reflect the ethnic, cultural and linguistic composition of the community served and have access to translators for any anticipated need, including American Sign Language (ASL).

CLINICAL/MEDICAL LEADERSHIP AND SPECIALTY CONSULTATION

In an ideal crisis service system, reliance on the most resource-intensive, costly and restrictive service settings, such as ERs and acute inpatient hospitalization, is minimized. The extent a full array of high-quality clinical and psychiatric services is available within the crisis setting will directly impact the degree to which emergency and inpatient settings may be avoided. Given the importance of the quality of clinical and psychiatric evaluation and intervention in the functioning of not only a crisis center, but the entire crisis continuum, it is critical that experienced clinical leaders (e.g., clinical psychologists, social workers, psychiatric nurses) and psychiatric providers are part of the leadership team in the ongoing design, implementation and oversight of crisis services. Unfortunately, in most crisis systems clinical and psychiatric leadership is not built into the design from the beginning. For this reason, it is especially important to emphasize that this is a necessary component of an ideal behavioral health crisis system, just as medical emergency services are expected to have physician leadership.

In addition to clinical medical leadership (CML) generally, there is a clear need for access to specialty consultation, coordinated by the crisis coordinator and clinical/medical director. In an ideal crisis service system, the continuum of services will respond to diverse populations who may present with varying degrees of frequency. This may include individuals of different ages, with different disabilities (e.g., intellectual and developmental disabilities (I/DD), BI, dementia), different cultural backgrounds and different conditions (e.g., OUD, eating disorders). Because it is impractical to maintain 24/7 on-site availability of expertise in all these diverse populations in all parts of the crisis system, the system needs to have a provision for accessing specialty consultation as needed.

Measurable Criteria for Clinical and Medical Leadership in an Ideal System

The accountable entity incorporates clinical and psychiatric leadership into the design of the crisis continuum. This position may be embedded in the crisis hub, working with the program leader of the crisis center, but ideally has responsibility for the functioning of the crisis continuum, working collaboratively with the crisis coordinator. The credentials and time commitment of the clinical leadership (crisis system clinical director) and psychiatric leadership (usually called the crisis system medical director) may vary depending on the size of the crisis system and usually includes a combination of on-site (or telehealth) clinical and administrative time, plus on-call availability. In some systems, particularly in rural and frontier areas, the lead clinician on-site might be a licensed professional counselor or equivalent master's professional supported by a doctoral level psychologist or more senior master's level clinician, and the lead psychiatric care provider on-site will be a nurse practitioner or physician's assistant supported by a medical director off-site, often by telehealth. In these instances, the crisis coordinator, clinical director (who may also be the crisis coordinator), lead psychiatric care provider and medical director work collaboratively to provide clinical and administrative leadership to the crisis continuum.

In addition, CML should be present throughout the entire continuum of crisis services, as follows:

- **Administrative authority:**
 - » Any agency providing behavioral health crisis services should have designated CML with a substantive role in the leadership team. This requires adequate time commitment for administrative leadership, apart from time for direct clinical service. It also requires a meaningful level of authority in the organizational hierarchy.
- **Education, qualifications, expertise and training:**
 - » The clinical leader/clinical director should be a licensed mental health clinician, such as a doctoral level psychologist, master's level social worker, master's level psychiatric nurse practitioner (following state regulations regarding scope or similar level of practice) or a psychiatric PA working in a meaningful supervisor relationship with a psychiatrist. The clinical director/clinical leader must have demonstrable clinical training from a recognized and reputable educational program.
 - » The clinical medical leader/director should be a psychiatric care provider, either an MD or DO, a psychiatric nurse practitioner (following state regulations regarding independence), or a psychiatric PA working in a meaningful supervisor relationship with a psychiatrist. The medical director must have demonstrable clinical training from a recognized and reputable educational program.
 - » The CML should have demonstrable clinical experience with the populations to be served within the crisis setting, including those with serious mental health and substance use disorders and with working in crisis and/or emergency settings.
 - » The CML should have demonstrable knowledge of community psychiatry - and systems of care generally - with the expectation of gaining a sophisticated understanding of the local systems of care.
 - » The clinical and medical leadership must be appropriately licensed and credentialed in a manner similar to that which occurs in a psychiatric inpatient setting.
- **Essential functions:**
 - » Clinical and medical leadership collaborate with each other, administrative leadership, nursing leadership and staff to ensure efficient and effective service delivery.
 - » The clinical director oversees the work of all non-medical clinical staff and establishes standards for crisis work, oversees training and competency development and ensures adherence with practice guidelines and protocols.
 - » The clinical medical director oversees the clinical work of all medical, psychiatric and nursing providers to ensure provision of highly competent psychiatric and medical practices.
 - Ensures that all clients receive appropriate evaluation, diagnosis, treatment and screening.
 - Establishes standing orders and treatment protocols for the provision of psychiatric services.
 - » Both clinical and medical leadership meaningfully participate in multidisciplinary team processes to ensure quality outcomes and standards of care are met.
 - » Meaningfully participate in quality assurance and improvement processes directed at key outcomes.
 - » Uphold and model the mission, vision and values of the organization in all interactions.
 - » Provide leadership in engaging challenging systems, families and clients.
 - » Comply with all relevant regulations, policies and procedures.
 - Follow and comply with all local, state and federal regulations, laws and standards.
 - Collaborate with administrative leadership to ensure appropriate medical records are maintained as required by regulations, internal policies and procedures, etc.
 - Play a leadership role in how personal health information (PHI) is managed that is consistent with state and federal guidelines while minimizing barriers to optimal care.

- » Meaningfully participate in identifying needed training and ongoing education for all licensed and unlicensed clinical, medical, psychiatric and nursing staff to meet position competency.

Measurable Standards for Specialty Consultation in an Ideal Crisis System

The accountable entity must ensure that the crisis hub provider has a clear mechanism for funding and arranging both emergent and urgent access as needed to specialty assistance with populations with unique needs that may not be met by the staff available on-site. This access to specialty assistance should be available to all crisis providers in the continuum.

At minimum, the following areas of specialization should be available:

- Child and adolescent.
- Geriatric.
- I/DD and BI.
- Cultural and linguistic minorities, immigrants/refugees.
- MAT for opium use disorder (OUD).
- Eating disorders.
- Forensic.

In many systems the full array of specialists may not be available in each local community, county or region and may only be available through a consultation network provided at the state level, sometimes with an academic partner that is accessible to each community crisis system as needed.

PEER SUPPORT

Although peer support is considered part of the composition of multidisciplinary team staffing for crisis services, it is essential to emphasize the importance of peer services. The participation of peer specialists (both certified mental health peer specialists and SUD recovery peer specialists, often called recovery coaches) across the continuum of care must include the expertise of people with lived experience in every program. Peer support services and staffing are certification requirements for CCBHCs.

Direct peer involvement in behavioral health treatment grew from the mental health civil rights movement of the 1980s. Peer participation in all aspects of behavioral health care hinges on the value of lived experience in providing care. In crisis intervention, peer providers who have “been there” offer an invaluable perspective to consumers, families and providers that can significantly enhance engagement, hope and safety. In the rapidly proliferating emergency service initiatives to engage individuals with SUD, especially in the context of opioid overdose and peer providers (and especially those with lived experience of MAT), offer direct intervention for individuals in crisis because of addiction, offering counseling and immediately linking consumers to treatment services, including facilitating agreement for immediate initiation of MAT.

There is extensive literature on peer involvement in providing behavioral health services. Peer involvement has, for example, been the standard of care on assertive community treatment teams since prior to the establishment of the Dartmouth Assertive Community Treatment Scale in 1998. Peer involvement is recommended by the Schizophrenia Patient Outcomes Research Team and SAMHSA.

Further, consumer peer input is essential to developing an ideal crisis system and system of care and peer/providers partnerships are key to the ongoing evolution of care.

In addition to providing direct services, direct peer involvement should be present on the community’s crisis collaborative and peers should be active in providing advocacy, education and support.

Measurable Criteria for an Ideal System

The accountable entity should purposefully work with community stakeholders to include identification, training and employment of certified peer specialists, including recovery coaches and family partners for children in crisis, throughout the crisis continuum, including participation in the community crisis collaborative.

- **Supervision and training:** There should also be provision in the crisis continuum for supervision of peer support staff, ideally by other peer supporters with more training and experience, as well as provision of peer support training in crisis work and continuing education.
- **Roles for peers that should be included in the planning and design.** The accountable entity should seek to include peers in each of these areas and to have a metric for continuous improvement of peer involvement in all areas as part of its overall QAPI plan.

Before the crisis

- Peer involvement with community education (including sharing personal narratives), education to law enforcement and providers.
- Peer involvement in interventions designed to prevent or mitigate crisis, such as warmlines.
- Peer crisis counseling programs in settings, such as high schools and colleges.

At the time of the crisis

- Peer team members in crisis centers, mobile crisis teams and emergency departments, including in implementation of Screening, Brief Intervention and Referral to Treatment and engagement of individuals with opioid overdose or frequent visits for alcohol use.
- Peer navigators in inpatient, crisis residential settings and intensive outpatient services who can advocate for consumers and assist consumers and families in maneuvering through the system.
- Peer respite programs and Living Room programs, as described earlier.

As the crisis resolves

- Peer specialists who can bridge between inpatient/acute and outpatient settings, facilitate linkages and support engagement.
- Peer specialists as treatment providers/full members of treatment teams (e.g., peer specialists on crisis intervention teams for youth or adults who have caseloads, provide services, work with clients around creation of Wellness Recovery Action Plans [WRAP]).
- Peer-run clubhouse model programs, which can provide a social context for rapid support as a crisis is resolving.
- Peer-led recovery-based educational and support programs separate from - but working in concert with - the behavioral health system.



IN THE STORY OF MR. Y: Peer support for Mr. Y at almost any point in his behavioral health crisis would have been extremely helpful. Someone with lived experience might have been able to build trust and provide Mr. Y with reassurance and an enhanced sense of safety early in the crisis and helped him navigate the system and begin mapping his recovery plan as he progressed.

SECTION III: BASIC CLINICAL PRACTICE

Core Competencies for Engagement, Assessment and Intervention	129
• Introduction.....	129
• Universal Framework: Welcoming, Hopeful, Safe, Trauma-Informed, Culturally-affirming	129
• Exploration of Open Dialogue as an Emerging Best Practice	132
• Provider Engagement of Families and Other Natural, Community and Professional Supports.....	132
• Information Sharing With Family and Other Natural, Community and Professional Supports	134
• Using Crisis Plans and Advanced Directives	135
• Basic Core Competencies for First Responder and Call Center Staff	136
• Basic Core Competencies for All Behavioral Health Crisis Staff	139
Screening and Intervention to Promote Safety	142
• No Force First: Maximizing Trust and Collaboration, Minimizing Seclusion and Restraint.....	142
• Suicide Risk Screening and Intervention.....	144
• Violence Risk Screening and Intervention; Threat Assessment.....	146
• Medical Screening and Triage.....	148
• SUD Screening and Triage	151
• Application of Civil Commitment and Assisted Outpatient Treatment (AOT)	153
Practice Guidelines for Intervention and Treatment	155
• Practice Guidelines: Multidisciplinary Teamwork and Case Sharing; Role of Peers.....	155
• Practice Guidelines: Nonpharmacologic Crisis Interventions	156
• Practice Guidelines: Psychotropic Medications	157
• Practice Guidelines: Integrated Interventions.....	159
• Practice Guidelines: Co-occurring Medical Conditions.....	161
Population-specific Clinical Best Practices	163
• Practice Guidelines: Working With Youth and Families.....	163
• Practice Guidelines: Working With Older Adults and Caregivers.....	165
• Practice Guidelines: Working With People Living With Cognitive Disabilities and Caregivers.....	166
Collaboration, Coordination and Continuity of Care	169
• Timeframes/Workflow Within the Crisis Continuum	169
• Post-crisis Continuity of Care/Critical Time Intervention	170
• Pre- and Post-crisis Planning With Community Providers	171
• Coordination of Care With Community Systems	172



CORE COMPETENCIES FOR ENGAGEMENT, ASSESSMENT AND INTERVENTION

INTRODUCTION

This section addresses the elements of clinical best practice that must be embedded throughout all components of an ideal crisis system.

Ensuring Implementation of Clinical Best Practices

The framework for this section is that the accountable entity ensures all providers are responsible for adopting and adhering to the identified best practice guidelines and ensuring that these guidelines are incorporated into training, supervision and clinical oversight, human resource and quality oversight, policies and procedures, evaluation criteria and supervision for all categories of staff ranging from physicians and other psychiatric care providers through all types of crisis workers including individuals providing peer support. In addition, the overall quality improvement activities undertaken by the accountable entity incorporate the expectation that these clinical practice guidelines define expected system performance and that lack of adherence to these practice guidelines (e.g., the crisis center refusing to evaluate someone based on their alcohol level) would trigger a quality oversight and review process.

UNIVERSAL FRAMEWORK: WELCOMING, HOPEFUL, SAFE, TRAUMA-INFORMED, CULTURALLY AFFIRMING

Crisis systems have many customers: individuals in crisis who are often brought for help involuntarily, and their families and collaterals; law enforcement; and behavioral health and human service providers. All of these customers – especially the clients like Mr. Y – engage with crisis systems at a time of great stress and vulnerability. Therefore, the first rule of clinical practice development is to ensure that every customer is treated in a welcoming manner and that those who are most vulnerable and despairing are treated with respect, gentleness, safety and hope and, to the greatest extent possible, no one is re-traumatized by the crisis service's actions. An ideal crisis system and the programs within it will only successfully welcome and treat community users if they focus on implementing the clinical practice standard known as customer service. Many of those standards are familiar to all of us. All of them should include awareness of the biases and discrimination that our customers might experience in their home communities, including racial bigotry and disrespect and disdain related to mental health challenges.

Common attributes of best practice customer service include timely and friendly service that welcomes every customer, attends to their needs and ensures quality, satisfaction and clear communication and collaboration and competent service based on the best available methods and doesn't skimp or cut corners. The same standards must hold true at an even higher standard for crisis services. The setting needs to welcome the most difficult to please individual customer – those like Mr. Y who are likely frightened, angry, reluctant, inattentive, lacking hope for a meaningful future and sometimes unaware of their service need.

**Be welcoming,
respectful and kind to
all who seek care. All
interactions should be
trauma-informed.**

The setting must also create a welcoming experience for individuals and families for whom the service was not initially built, such as those who are non-English speaking and/or represent a variety of cultures, including individuals who are immigrants or have unique needs, such as the LGBTQI and/or gender non-conforming population. The same approach must apply to frightened or angry families, overwhelmed law enforcement personnel, busy human service providers and all other partners. Creating a welcoming, hope-infused, trauma-informed and culturally affirming crisis system improves the likelihood of satisfied and well-served customers and a satisfied community. Diversity within the community and the presence of racism, micro-aggressions and differential treatment of communities' members based upon race, language, housing status, prior contact with law enforcement and other differences may trigger biased assumptions by responders. The structure and set-up of crisis services can help diminish the impact of bias on those in crisis.



Measurable Criteria for an Ideal System

The accountable entity works with crisis system providers to establish policies requiring welcoming, hopeful, trauma-informed practice and ensuring that all providers demonstrate continuous attention to implementing those practices in training, supervision, human resources and quality improvement. Specific markers include:

- **Hiring and orientation standards.** Employees set the tone, maintain the standards, invite the person in crisis into the service and ensure connection with community practices. As such, employees need to be well-suited to the work, familiar with crisis work and the needs of people with mental health and substance use issues in crisis, sufficiently and regularly well-trained, supervised, satisfied with their work, happy to be at work and consistently feel and show patience. Employees must be aware of their own biases and be willing to broaden their perspectives about culture and race and to learn from others.
- **Role playing and practice:** Staff are provided with specific guidance and role-play practice - reinforced through supervision - on how to handle challenging situations with all types of customers, including customers from culturally diverse backgrounds, in a welcoming manner. Staff use real experiences to inform their role plays.
- **Positive language:** There are guidelines for communication with customers and within the team that requires never using disparaging or despairing language to describe individuals and families in crisis, even when they are not listening.
- **Trauma-informed principles:** Systemic and provider-specific policies and procedures reflect the core principles of trauma-informed care, including:
 - » Universal precautions. Clear intentions to assume that all people have been exposed to traumatic events and experiences until proven otherwise, with universal screening practices that offer trauma-specific screening as helpful for the circumstances surrounding the use of crisis services. Inquiry about recent rape/assault/exposure to community violence fits the current assessment while earlier life exposure to abuse and neglect is not likely to be relevant to a present-based crisis assessment. Earlier life trauma exposure stories are not reviewed in these screens and staff have compassionate skill-sets that limit the retelling of these experiences as their telling tends to re-traumatize and trigger the individual in crisis, rather than inform evaluation of the crisis and time sensitive interventions.
 - » Avoidance of re-traumatizing triggers or actions whenever possible and ability to talk about the impact of triggers when they cannot be avoided.

- Examples may include the use of selective holds, administration of intramuscular medications without immediate agreement, which may involve holding part of the person's body.
- » Staff practices that acknowledge the impact of work upon the staff and work toward reducing secondary trauma to ensure staff wellness and minimize the impact of collective re-traumatization.
- **Trauma-informed care and welcoming guidelines for practice**
 - » **Protect:** Promote safety and trustworthiness, a calm environment that leads to better emotional regulation for all, transparent and direct communication and consistency and accountability.
 - » **Respect:** Engage in choice and collaboration, use motivational engagement as a foundation, employ shared decision-making at every opportunity, encourage strength-based and empowering work, understand the context of client's life and how their current coping was adaptive, incorporate collaboration and problem-solving that includes system and supports and work toward goals and change.
 - » **Connect:** Focus on relationships, particularly for clients who are pushing help away; ensure cohesion and shared mission and values; find out what happened, not what is wrong; work collaboratively; encourage care coordination and family engagement; and focus on accountability and responsibility, not shame and blame.
 - » **Redirect:** Encourage skill-building and competence, teach strategies to cope with stressors and increase wellness, view setbacks or relapses as learning opportunities and include strength-based education and training for staff.
 - » **Cultural affirmation:** Provide welcoming care that is kind, friendly, hopeful and open-minded; and that is also culturally affirming, understanding the relevance of culture of origin and culture of choice to individuals. Culture includes race, ethnicity, language, and sexuality, as well as the full range of individual/family/community affiliations (e.g., veterans' organizations, 12 Step participation) and spiritual/religious practices.
 - » Culturally affirming care recognizes the impact of:
 - Micro-aggressions that may have contributed to unintended traumatization that precipitated the crisis, including experiences in past or current crises and routine behavioral health service delivery.
 - Overt racism.
 - Historical racism and the legacy of inherited privileges for some groups in the community.
 - » Culturally affirming care requires practitioners to:
 - Be inclusive and humble.
 - Check assumptions to examine, explore and understand assumptions about people who present in crisis before they lead to pathologizing or valuing certain behaviors over others.
 - Appreciate diversity. No two individuals are the same, even if their outward presentations are similar.
 - Train and appreciate the uncomfortable, particularly the discomfort of working with people who are in crisis and where the solution may not be easy or obvious, before seeking the comfortable.
 - » **Intentional tracking of race/primary language/housing status** and other markers of limited financial access to food/housing/transportation/employment.
 - Monitor for and address differential treatment of certain groups in the community - for instance, differential involvement of law enforcement or incarceration for community members of color.
 - Once differences are identified, work with other providers to address those biases and measure the impact of those changes.

EXPLORATION OF OPEN DIALOGUE AS AN EMERGING BEST PRACTICE

Part of the continuum of services in an ideal crisis system includes opportunities for staff to learn how to utilize the collaborative network-based approach to psychiatric care. Open Dialogue was established in Finland in the 1980s for people with new onset psychosis. It involves providing immediate help including a treatment meeting with the individual, family, significant members of social network and professionals within 24 hours of a call to a crisis service. Open Dialogue employs listening and communication rather than relying specifically on hospitalization and medication as the initial intervention. Other key principles include gaining a social perspective, embracing uncertainty and creating a dialogue to create a shared understanding of the problem.

Open Dialogue has spread throughout much of Scandinavia and other European Nations and is currently utilized in various sites in the US. Although evidence of effectiveness is still emerging and a recent review suggested that the research support for this practice is significantly limited, there are many positive anecdotal reports from practitioners that reinforce Open Dialogue as a structured approach to a more in-depth implementation of the welcoming, trauma-informed, hopeful, relational approach that was described in the previous section. For this reason, training front-line crisis responders in the use of Open Dialogue is an opportunity to introduce an approach that reinforces the positive culture of practice for the crisis system as a whole.

Measurable criteria for Open Dialogue in the ideal crisis system: The accountable entity ensures that front-line crisis practitioners like those in the crisis center have training in Open Dialogue and opportunities to practice Open Dialogue interventions as teams.

PROVIDER ENGAGEMENT OF FAMILIES AND OTHER NATURAL, COMMUNITY AND PROFESSIONAL SUPPORTS

A comprehensive behavioral health crisis system with a complete continuum of services including ongoing family engagement with the definition of family expanded to include all significant members of the client's natural support system is essential to any community. Families and collaterals, including current service providers, are the people who know the consumer best and will be the first to recognize both subtle progress and early signs of deterioration, making them best-suited to partner with crisis evaluation, intervention and follow-up. Further collaboration among family, consumers and providers helps to facilitate optimal recovery.

Unfortunately, many crisis systems do not provide crisis provider staff with practice guidelines, competencies and supervision for how to effectively engage families and other collaterals. Crisis providers are often over-trained to say "no" to communication with collaterals and under-trained to say "yes." While families are typically the first to realize that a problem is developing, they may have limited knowledge about diagnosis, treatments, the behavior and the behavioral health system.

Consequently, they may not engage with the crisis system in what we might consider the most appropriate way, so they can be criticized and pushed away.

The same thing may happen to collateral behavioral health providers and other informants. They ask the crisis system for help too soon and they are criticized for "dumping." They wait too long and they are criticized for waiting. All crisis staff need to be educated with practice guidelines for family and collateral engagement, have opportunities for supervised practice and know how and when to ask for help rather than saying "no." Active engagement efforts and continued education are vital. Providers have an obligation to address needs of the family and collaterals to an equal extent as those of the client and practice in this area will reinforce the positive benefit.

We should think broadly about how we define engagement of team members and include anyone who provides treatment, services and social supports to a person.

Measurable Criteria for an Ideal System

The accountable entity ensures development of clinical practice guidelines for family and collateral engagement and requires all contracted crisis providers to implement those guidelines and competencies through training, supervision, human resource policies and quality improvement activities. Specific content includes:

- **All staff are trained to regard all families and collaterals as priority customers in crisis situations.** Staff demonstrate competency in routine engagement of all available collaterals and know how to gather information even when the client limits disclosure. Disposition is never complete without full participation of collaterals and provision for their ongoing needs. Families should also receive ongoing supports following an acute crisis. This should include availability of:
 - » Invitation to be part of treatment interventions, problem-solving and disposition planning.
 - » Psychoeducation from the treatment team, including answering family questions, as well as connection with community resources including the National Alliance on Mental Illness (NAMI).
 - » Consistent positive regard in all Interactions with all collaterals.
- **Staff receive training around the importance of strength-based approach to family and collateral involvement** and can communicate importance of family and collateral involvement to all involved.
- **Staff are expected to continually revisit initial denials of consent** to emphasize the importance of family and collateral participation in discharge planning.
- **Staff are trained to not discharge clients with risky behavior or ideation** back to families or housing providers without obtaining information from them on their perception of risk and their ability to have a safety plan.
- **All crisis staff are trained in how family and collateral involvement are viewed as necessary services** that can be documented and, where appropriate, reimbursed.
- **Staff are trained to provide proactive engagement efforts** that directly involve family members in treatment decisions as allowed by the consumer.
- **Staff have skills and access to resources for helping families remain engaged in care following the crisis,** as well as helping families link to ongoing services. Staff have skills for providing continuing support to behavioral health providers and other human service providers who are working with a challenging or risky client.
- **Training provided by families.** Families, who are often advocates participating in the community crisis collaborative, participate in both training families how to access the crisis system and training staff how to respond to families in crisis. Ideally, dialogue between families and staff is part of routine training.
- **Continuing improvement of response to families and collaterals.** Staff have opportunities to connect with collateral providers outside of crisis situations to engage in constructive dialogue about how to be more responsive as well as how the referents can receive a more helpful response.



IN THE STORY OF MR. Y: Mr. Y's family was not involved at the time of his initial crisis. This likely resulted in the loss of information which would have been important to Mr. Y's care. It also caused unnecessary worry and stress for his family and natural support system.

INFORMATION SHARING WITH FAMILY AND OTHER NATURAL, COMMUNITY AND PROFESSIONAL SUPPORTS

Successful crisis assessment and intervention requires involvement of collateral informants, particularly family members and close friends, in the crisis assessment and intervention process. Many crisis providers believe, incorrectly, that their ability to engage those collaterals is prevented by the Health Insurance Portability and Accountability Act (HIPAA) or state confidentiality regulations in the absence of a specific release by the client. For this reason, it is important for an ideal crisis system to provide clear guidelines to crisis providers about how to maximize involvement of family members and collaterals in the crisis intervention process.



Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring that ensures the dissemination and implementation clinical practice guidelines for information sharing and collaboration with family members and other collaterals during the crisis episode. This includes:

- **Permission for necessary communication during crisis.** All confidentiality regulations permit communication with collaterals without release when such communication is necessary for assessment and intervention in a potentially harmful crisis or life-threatening emergency, whether that emergency is for a medical event (e.g., syncopal episode, seizure) or for a behavioral event (e.g., acute psychosis, suicidal threat or behavior, violent threat or behavior). This understanding must be communicated to all crisis providers with the expectation that communication with collaterals is a rule, not an exception in such situations, and that absence of communication would be an adverse quality metric.
- **Permission not required between providers in a treatment relationship with the patient.** Individuals have the right to request restrictions on how a HIPAA-covered entity will use and disclose personal health information (PHI) about them for treatment. A covered entity is not required to agree to an individual's request for restriction but is bound by any restrictions to which it agrees. (45 CFR 164.522[a]). When undertaken on behalf of a single consumer, treatment activities may include case management, care coordination and outreach programs.
- **Permission to receive information.** Even in the absence of a life-threatening emergency, crisis providers can facilitate the receipt of information from collaterals, even without permission to disclose information to collaterals. This information is often vital in the crisis assessment and disposition.
- **Expectation to involve collaterals in disposition planning.** Successful crisis resolution and disposition will rarely, if ever, involve the client being discharged to return home after a significant crisis without involving the people the person lives with in evaluating and participating in the discharge plan. If the client's crisis has been visible to those they live with, such communication is essential to success. Complaints about discharges home without communication or about lack of communication to collaterals in general, are useful quality metrics for system and provider performance monitoring. This point of view remains a crucial component of the crisis network's values – discharge is meant to facilitate crisis intervention and successful discharge is part of the work.
- **Practice-specific training and role playing.** It is necessary for crisis program staff, supervisor and manager training to include role play and rehearsal of specific scenarios for how to conduct information sharing appropriately, as well as when and how to refuse to share information. In addition, such role plays should include delineation of situations when it is expected that front-line staff will contact their supervisors or administrators-on-call for assistance with the situation.

- **HIPAA and confidentiality regulations and training.** It is necessary for the crisis system to ensure that systemwide and provider-specific confidentiality regulations and mandatory confidentiality trainings include specific instructions about when it is permissible to share information with collaterals, as well as when it is not. Such training should provide guidance for how to share information appropriately, in accordance with the standards described in this section.
- **42 CFR Part 2 SUD treatment confidentiality exemption for medical emergencies.** The confidentiality requirements specific to substance use disorder (SUD) treatment do not apply in the case of a medical emergency. “Patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient’s prior informed consent cannot be obtained.” (42 CFR § 2.51) Most standard trainings only cover what is not allowable and fails to provide proper guidance and direction to crisis providers.

USING CRISIS PLANS AND ADVANCE DIRECTIVES

Crisis plans and psychiatric advance directives (PADs) are a simple and effective way to respect an individual’s dignity and autonomy and mitigate the severity of future crises. These plans may range in complexity from a formal legal document (e.g., advanced directive) to a handwritten wallet card. The common feature is that they capture the individual’s preferences and plans so they can be articulated at a later time when the person may be unable to communicate effectively or think rationally. A crisis plan can also include reminders of interventions or techniques that the individual can use to help manage their crisis and ask for help earlier.

The most compressive crisis plans are created during a period of wellness and kept on hand in case of a crisis. One of the best-known crisis planning tools is a Wellness Recovery Action Plan (WRAP). Developed by Mary Ellen Copeland of the Copeland Center for Wellness and Recovery, WRAP is a prevention and wellness self-management program taught in a multi-session group setting led by a trained facilitator. By the end of the program, participants have created their own crisis plan that includes items such as what interventions and medications they prefer and even designates a temporary proxy decision-maker. In many states, this plan can be converted to a legal document – a PAD. Information about the individual state statues governing PADs is available at the National Resource Center on Psychiatric Advance Directives (nrc-pad.org). Advocacy organizations such as NAMI often host local WRAP classes.

Creation of a crisis plan can itself be an effective intervention for preventing future crisis. The Stanley- Brown Safety Planning Intervention (suicidesafetyplan.com) is a quick and simple intervention in which a clinician or peer works with an individual to complete a 6-item worksheet that results in a plan the person can follow if they think a crisis is emerging. Elements include helpful coping strategies, helpful people or agencies to contact and strategies for making the environment safe. There is even a smartphone app so that the individual can refer to the plan when needed.

If a person arrives to a crisis facility without a pre-existing safety plan, then clinical or peer staff can work with the individual to create a focused crisis plan for use during their stay, or to prevent or mitigate future crises. Such a plan can help prevent the crisis from escalating to the point of restrictive interventions such as involuntary medication, seclusion, or restraint. A crisis plan might include information such as preference for specific types of staff (such as female) due to past trauma or that agitation can be prevented by allowing a child, or adult patient with developmental disabilities, to keep his or her favorite stuffed animal.

Advanced directives and Wellness Recovery Action Plans allow people to remain empowered even in a crisis or emergency.

Measurable Criteria for the Use of Crisis Plans and PADs

The accountable entity ensures that all crisis providers have policies and procedures regarding the development and utilization of PADs and crisis plans, as follows:

- **Every individual in crisis is asked if they have a PAD or crisis plan.**
 - » Asking about the existence of crisis plans and PADs is part of the crisis program's intake process.
 - » Crisis plans and PADs are kept in the medical record, just as non-psychiatric advance directives are.
- **The crisis plan is incorporated into crisis care and discharge planning.**
 - » During the crisis intervention process, existing PADs and crisis plans are always reviewed with the individual and involved collaterals and adjusted as needed.
 - » If an individual is unable to access their own plan, there are procedures for the individual's community providers and other collaterals to share the PAD or crisis plan with the crisis providers.
 - » Where technology permits, PADs and crisis plans are shared among providers through electronic health record or information exchange protocols.
 - » When the individual does not already have a PAD or crisis plan, the opportunity is provided to develop such a plan as part of the crisis intervention process during follow-up, since these are best developed during moments of relative wellness.
 - » The individual and involved collaterals that are part of the individual's support system receive copies of the new or updated crisis plan.
- **Crisis plans are used in crisis facilities in order to minimize the use of seclusion and restraint.**
 - » All crisis programs have protocols and procedures to identify individual preferences for de-escalation and document them appropriately in the record.
 - » It is expected that individual preferences will inform de-escalation planning during the crisis episode in order to prevent or minimize the use of seclusion, restraint or medication over objection.

BASIC CORE COMPETENCIES FOR FIRST RESPONDER AND CALL CENTER STAFF

Even in an ideal crisis system, the primary responder to a mental health crisis will often be a law enforcement officer or other first responder. It is critical that uniform practice standards are applied for law enforcement officers, first responders and 911 call-takers. First responders need to know how to de-escalate crisis situations and, when appropriate, how to divert individuals with mental illnesses away from the criminal justice system or emergency medical system and into behavioral health crisis intervention.

A behavioral health crisis system should include law enforcement officers as first responders only when necessary and eliminate the need for law enforcement to be the routine first responder for situations that can be addressed safely by clinicians. In fact, having law enforcement respond can sometimes escalate the situation.

The first important practice guideline for first responders in an ideal system is to have a clear set of instructions for directing the vast majority of behavioral health crises to behavioral health crisis providers. While police officers with Crisis Intervention Team (CIT) training have done and continue to do a remarkable job dealing with individuals with mental illnesses, routinely using law enforcement officers as default first responders is not the ideal model. In an ideal system of care, behavioral health professionals would become the default first responders for the bulk of mental health crises, with CIT-trained law enforcement officers serving as backup for high-risk situations as needed.

Unless law enforcement involvement is critically important, a mental health crisis should be treated like a primary health emergency and medical (i.e., behavioral health) personnel should be the first responder to a mental health emergency. To do otherwise reinforces stigma by sending a message that an individual in mental health distress requires a law enforcement response. Additionally, a law enforcement response often requires that the individual be handcuffed for transportation to a crisis center, which is both embarrassing and traumatizing. These encounters make it more difficult and less likely for an individual with a mental health disorder to seek treatment and makes it harder to trace the trigger of the crisis and intervene – as the law enforcement intervention typically becomes another trigger.

The second important practice guideline for first responders involves transportation. When appropriate, transportation for an involuntary examination should be by a behavioral health professional in a civilian vehicle or ambulance – not a marked police vehicle.

Finally, whether law enforcement officers are serving in a primary responder role or a backup role to a mental health professional, they need to be appropriately trained in best practice response techniques. Communities should adopt the CIT training model developed in Memphis, Tennessee. Known as the Memphis Model, the purpose of CIT training is to set a standard of excellence for law enforcement officers with respect to treatment of individuals with mental illnesses. CIT officers perform regular duty assignment as patrol officers and are also trained to respond to calls involving mental health crises. Officers receive 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, trauma, the role of the family in the care of a person with mental illness, mental health and substance abuse laws and local resources for those in crisis. There are core elements of CIT training that should be included as best practice guidelines for first responders in an ideal system.

Training for 911 call-takers/dispatchers is also an essential part of an ideal and effective response to individuals in a mental health crisis. “The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event and the appropriate questions to ask in order to ascertain information from the call that will help the responding CIT Officer. Dispatchers should receive training courses (a minimum of 8-16 hours) in CIT and additional advanced in-service training.”(University of Memphis School of Urban Affairs and Public Policy, 2007)

With regard to the amount and extent of training, CIT International recommends that CIT officers serve in general patrol duties until called on to respond to mental health related calls and should not be part of a special unit that only responds to mental health calls. CIT officers should volunteer for the training and be selected based on maturity and experience in order to be eligible to become a CIT officer. They discourage training in the pre-service police academy and CIT training for the entire police force. CIT is a specialist model and should not be a generalist model where CIT training is mandated for all officers. Police officers who have not received specialized CIT training should receive the Mental Health First Aid (MHFA) for Public Safety 8-hour training course.

Measurable Criteria for an Ideal System

The comprehensive crisis system defined in this report recommends an accountable entity ensures that all first responders are trained in policies, procedures and practice guidelines related to the following material. Not all first responders need to receive 40 hours of CIT training, depending on their role and the frequency with which they encounter people experiencing behavioral health emergencies, but they do need at least eight hours of training and instruction about where to get immediate consultation in the field when needed.

- **All first responders need to know how to triage a behavioral health emergency situation with the assumption that behavioral health crisis responders will be brought in unless there is indication of a medical emergency or an immediate risk of violence.** Procedures for connecting rapidly with behavioral health crisis responders are clearly delineated and the role of the first responder in maintaining safety in the situation until the behavioral health first responders arrive is communicated.
- **All first responders need guidelines for safe and non-stigmatizing transport of individuals who need to be moved to a behavioral health crisis center or other behavioral health facility.** Marked police vehicles, handcuffs, and other criminal justice devices should be avoided for routine transportation. Other modes of transportation and safe procedures for transportation without involving police should be identified.
- **All first responders, in addition to 911 call dispatchers, should receive basic or introductory training in CIT Core Elements and MHFA for Public Safety.** CIT Officers and others whose first responder role frequently involves behavioral health emergencies should receive the full 40 hours of training in all CIT elements. CIT-trained officers should further have access to the core elements of expansion training, particularly if they are in a supervisory or team leader role.

Table 4: It Core Elements

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation and Networking
3. Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

Sustaining Elements

7. Evaluation and Research
8. In-service Training
9. Recognition and Honors
10. Outreach: Developing CIT in Other Communities

BASIC CORE COMPETENCIES FOR ALL BEHAVIORAL HEALTH CRISIS STAFF

Crisis staff of all disciplines and backgrounds should be competent in the basics of crisis engagement, assessment and intervention. Although staff may have extensive clinical experience in other settings, they may need training in adapting their skills to the unique features of crisis work. No one should assume competency without assessment, practice and supervision.

Measurable Criteria for an Ideal System

The accountable entity establishes and monitors the core competency requirements for all crisis providers, as follows:

- **Training and competency development plan:** Crisis organizations should have an annually-reviewed training and competency plan in place that:
 - » Defines the core competencies needed to provide reliable and high-quality care for each clinical discipline at each level of care within the program.
 - » Ensures that staff receive needed training and competency verification during orientation, which can be achieved by a combination of training, shadowing, observation and demonstration.
 - » Ensures that staff receive ongoing refresher training and competency verification.
 - » Ensures supervisory staff have the same knowledge as line staff and use that knowledge to impact and evaluate performance.
 - » Provides a mechanism for ongoing clinical review and supervision.
 - » Includes basic competencies related to engagement, assessment and intervention, including:
 - **Engagement:** According to NAMI, engagement is the “strengths-based process through which individuals with mental health conditions form a healing connection with people that support their recovery and wellness within the context of family, culture and community.” It is a critical first step to developing a therapeutic relationship with individuals in crisis. Initial interactions can be challenging when the individual cannot or does not seek services voluntarily or when they are under the influence of substances or experiencing severe psychiatric symptoms. Staff should receive training on engagement that includes:
 - Understanding of the prevalence and impact of trauma in general and specifically with engagement.
 - Recovery principles and person-first language.
 - Strategies for communicating with individuals with psychiatric or substance- related symptoms including active listening, validation and reflection.
 - The concepts of “meeting the person where they’re at” and harm-reduction.
 - Recognizing that those with historical intrapersonal engagement may not easily establish trust (a self-protective strategy during trauma exposure that may be a hindrance now) and, as such, may be harder to engage. Strategies that allow for mutual exchange of information and support while slowly establishing trust are helpful here.



IN THE STORY OF MR. Y: He was not engaged, he was arrested.

- **Assessment in the crisis setting must be thorough enough to inform decision- making and focused enough to work within a fast-paced setting in which only limited information may be available.**

Assessments should comply with state and federal regulations and include the following:

- **Need for emergent intervention.** Determine if the person has acute medical or psychiatric needs that need immediate intervention (e.g., injury, unstable vital signs, severe agitation or psychosis, substance intoxication/withdrawal). For non-emergent medical needs, what is needed in the moment to help the person maintain comfort and stability during the behavioral health crisis intervention process (e.g., medications, medical equipment like insulin or needles, monitoring)?
- **Immediate initiation of information gathering.** Assessment should not be delayed because the individual in crisis is too agitated/psychotic/intoxicated. In these cases, collect as much information as possible from collateral sources and chart review, along with an assessment of the individual's mental status and find out why a more detailed assessment cannot be performed at this time. Attempts at reassessment should occur after appropriate intervention. Focus all assessments on addressing the most acute issues.
- **Co-occurring substance use.** How have substances contributed to the crisis presentation? Was there a past recent period of sobriety? If so, what helped the person's success and how can that be applied now? Are there signs and symptoms of acute substance intoxication and withdrawal?
- **Co-occurring cognitive impairment.** Does the person have evidence of cognitive impairment? Is it longstanding, as intellectual and developmental disabilities (I/DD), or recent? For recent impairment, what is the best way to restore cognitive functioning? For persistent impairment, what is the best way to assess cognitive baseline and engage the person in accordance with their cognitive capacity? How will this impairment impact the crisis intervention and the follow-up to deal with this crisis and, if possible, future crises.
- **Why now.** A narrative of the progression of the crisis with focus on identifying the most recent pre-crisis baseline and then determining the sequence of events that led to what precipitated the person to seek (or be brought to) services now.
- **Risk assessment.** As discussed in detail elsewhere, an assessment of the risk of harm to self or others, including mental status exam, an inventory of static and dynamic risk and protective factors and access to firearms and other lethal means.
- **Level of current engagement.** What is the individual's most important request at the moment? How does this relate to their hopeful recovery goals? To what extent and for what issues is the person willing to receive help and what kind of help? If the person is unwilling to accept help, do they meet criteria for involuntary intervention? In all instances, what is the best way to engage the person in a collaborative plan?
- **Prior engagement with the behavioral health system.** What has been tried? What worked and what didn't? Why? Who is responsible for this individual's care? Are there system/administrative barriers that need to be addressed? Was there a crisis intervention/prevention plan? Was the individual able to utilize this plan?
- **Community stressors and supports.** Are there psychosocial factors (e.g., housing, transportation) that are contributing to the crisis? Are there supports that can be leveraged to help the person be successful after discharge?
- **Collateral information.** Whenever possible, within the limits of client choice and privacy regulations, collect information from one or more collateral sources (e.g., family member, case manager) to gain a more complete picture.
- **Level of care assessment.** All staff should have training in utilizing standard level of care assessment tools (e.g., Level of Care Utilization System [LOCUS and CALOCUS]) to make structured level of care determinations and to communicate in a common language to other crisis providers.

- **Intervention.** Crisis intervention must be timely and match the person’s needs as identified in the assessment. Core competency for crisis intervention includes the following:
- **Emergent interventions.** The ability to provide emergency interventions to address medical emergencies. It is not expected that all services be available in the crisis setting, but staff should be trained to recognize medical emergencies and protocols should be in place to ensure that emergency care is available. For example, a free-standing crisis center should require all staff to be certified in basic life support and have protocols for rapid transfer to an emergency room (ER).
- **Treatment of acute agitation.** Acute agitation is a behavioral emergency and should be treated as such according to psychiatric practice guidelines such as those published by the American Association of Emergency Psychiatry. The first line intervention is verbal de-escalation, followed by appropriate pharmacotherapy. If a psychiatrist or other psychiatric care provider is not on-site 24/7, staff should be trained to recognize a behavioral emergency and protocols should be in place to ensure rapid intervention and transfer, if necessary.
 - **Treatment of intoxication/withdrawal.** Interventions for acute intoxication, mild to moderate withdrawal and initiation of medication-assisted treatment (MAT) should be available and all staff trained within the scope of their professional license (if any), skills and supervisory access in provision of these interventions.
 - **Safety planning.** The ability to assist the person in developing their own safety plan, such as the Stanley-Brown Safety Plan (which has an accompanying mobile app) or Applied Suicide Intervention Skills Training. Safety planning should also address the patient’s access to firearms and safety interventions such as weapons removal, trigger locks and so on.
 - **Motivational interviewing.** This provides a useful framework for engaging with people about mental health issues, substance use and other behavioral changes. It is also an effective evidence-based practice that increases the likelihood of increased engagement in follow-up care, as well as reduced substance use and decreased subsequent ER visits, even after a brief intervention.
 - **Crisis resolution and connection to community resources.** A key component of effective crisis intervention is helping an individual identify a strategy to respond to current stressors, identify steps that will help restore previous baseline status, engage with ongoing supports and build a solid follow-up-plan. This requires competency in crisis resolution planning, as well as knowledge of community resources and how to access them. The specific training may vary by role in the treatment team. For example, financial eligibility specialists may need competency in local Medicaid enrollment protocols and federal programs such as Supplemental Security Income/ Social Security Disability Insurance Outreach, Access and Recovery, while social workers may need competency in navigating the local mental health system, housing resources, etc.

In assisting a person in crisis in the community, first use verbal de-escalation, then offer appropriate medications, then - if indicated - arrange transportation to a crisis center.



SCREENING AND INTERVENTION TO PROMOTE SAFETY

NO FORCE FIRST: MAXIMIZING TRUST AND COLLABORATION, MINIMIZING SECLUSION AND RESTRAINT

Much has been written about the “dark side” of the history of psychiatry, including what is now considered the overuse of coercive practices such as indiscriminate use of seclusion and restraint. Today, most agree that these methods should only be used as a last resort to mitigate imminent risk of harm to self or other after attempts at other less-restrictive interventions have been exhausted. This philosophy has been codified into the standards of regulatory agencies such as the Centers for Medicare and Medicaid Services and the Joint Commission.

At the other end of the spectrum, some crisis programs have declared an absolute prohibition of the use of seclusion and restraint. While this is appropriate for programs serving a lower acuity population, from a systems perspective, it is important to note that a prohibition on the use of seclusion/restraint in effect becomes a prohibition on the acceptance of acute patients who may require seclusion/restraint.

While an individual program may adhere to its no-restraint values, the accountable entity must take a larger view. Without a full crisis continuum, patients refused by such programs are actually more likely to be restrained, as they are taken to an ER, where they are restrained (sometimes on a gurney in a hallway) because the ER has minimal ability to attempt less restrictive interventions; taken to jail, where they are restrained, often without access to any medical/psychiatric treatment for many hours or days; or not taken anywhere and continue to decompensate in the community. A full crisis continuum must include specialized programs with the ability to provide care for the highest acuity individuals with the space, staffing and training so restraints can be used minimally and frequently be prevented entirely for those who would have been restrained in an ER or jail setting.

The operating philosophy for the whole crisis continuum, as well as for the crisis center that can accept clients who are very acute and agitated, can be labelled “no force first.” This means that policies, procedures and practices at every level of detail engage the person first, including peer support, and use every possible alternative intervention to promote safety without using restraint or involuntary seclusion, but maintaining capacity to keep everyone safe by using those strategies when necessary.



These programs must have training and processes in place to prevent the use of seclusion/restraint whenever possible, apply seclusion/restraint in the safest and briefest manner possible and employ a quality improvement process for continuous review and improvement of seclusion/restraint processes (e.g., frequency of use, application of best practices, appropriate documentation). The use of security staff to assist in behavioral management should be avoided. Although there are no current benchmarks for restraint use in acute crisis settings, some programs have demonstrated an ability to accept the most acute patients directly from the field without the use of security staff, while achieving seclusion/restraint rates 70% below the Joint Commission's national average for inpatient units (Baugh, 2019).

- **There is a comprehensive crisis continuum comprised of programs capable of safely managing a continuum of acuity, including programs capable of serving the highest acuity individuals, that:**
 - » Do not have exclusionary criteria based on behavioral acuity (i.e., do not refuse patients based on level of agitation or risk of violent behavior).
 - » Are adequately staffed with personnel highly trained in the use of de-escalation and behavioral management techniques.
 - » Have the physical layout to facilitate de-escalation and safe behavioral management (e.g., calming environment, open space to allow higher tolerance of coping behaviors such as pacing, space to allow individuals to voluntarily separate themselves from the stimulation of the milieu, lack of objects that can be used as weapons).
 - » Minimize the use of security to assist in behavioral management.
 - » Have the capability to use seclusion/restraint as a last resort.
- **The accountable entity has a quality assurance/performance improvement plan that includes oversight of use of seclusion and restraint.** This plan should include:
 - » Required reporting from contracted entities on:
 - Prevalence of use of seclusion and restraints.
 - Prevalence of use of security to assist in behavioral management.
 - Safety incidents (e.g., client and staff injuries) sustained during the use of seclusion or restraint.
 - Compliance with staff training on de-escalation and behavioral management techniques.
 - » At the accountable entity level, the use of seclusion/restraint is tracked, trended and discussed to identify program-specific and system-wide opportunities for improvement, including:
 - Investigation of complaints or quality of care concerns.
 - Random audits to ensure consistency between reported data and actual practice.
 - » At the program level, seclusion/restraints are tracked, trended and discussed to identify improvement opportunities, including:
 - Trends based on day of week, shift, staffing levels and individual staff.
 - If video is available, systematic review of every incident.
 - Review of individuals restrained multiple times (e.g., twice in 12 hours).
 - Involvement of front-line staff, including peers, in quality improvement processes to reduce the use of seclusion/restraint such as pacing, space to allow individuals to voluntarily separate themselves from the stimulation of the milieu, lack of objects that can be used as weapons, etc.
 - » Minimize the use of security to assist in behavioral management.
 - » Have the capability to use seclusion/restraint as a last resort.

SUICIDE RISK SCREENING AND INTERVENTION

Suicide is the 10th leading cause of death in the United States. The Centers for Disease Control and Prevention reported that almost 45,000 people died by suicide in 2016, surpassing the number of deaths by motor vehicle accidents. The emergency department and crisis settings are important opportunities for intervention and treatment for patients at risk for suicide. These patients must first be identified so that adequate treatment and follow-up care can be arranged. The ideal crisis system initiates effective suicide screening, assessment and prevention efforts for all patients within its care.

The ability to screen, assess and treat suicide risk is a hallmark of a robust behavioral health crisis center. Several state and local systems have initiated Zero Suicide initiatives. There are best practice tools for suicide screening, as well as for follow-up intervention. Suicide risk must be distinguished from risk of self-harm by people who use self-harm as a tool for relief from painful emotions, rather than as an effort to commit suicide; both types of risk are important to assess but require different intervention strategies. Risk assessment extends beyond asking required questions to having enough familiarity with the screening process and specific screening tools to enable an accurate assessment of risk. Further, intervention requires careful assessment of severity and immediacy of risk, including level of lethality of the method, willingness and ability to ask for help that is realistically available and ability to help with suicidality beyond use of the ER, availability of collateral supports and development of a highly structured safety plan with continuing support provided. Contracting for safety, when a person is asked to agree either verbally or in writing that they will not engage in self-harm, is never regarded as a suitable outcome to a suicide risk intervention. To achieve this end, robust training and education is available for suicide screening and assessment.



The National Suicide Prevention Lifeline (NSPL) has developed specific practice guidelines and training materials for suicide screening and intervention, recognizing that people working within the full spectrum of crisis services - including police, emergency medical technicians, nurses, social workers and physicians - should become skilled at employing the language of suicide screening and assessment (see www.suicidepreventionlifeline.org). These suicide prevention standards are required for certification as a Suicide Prevention Lifeline call center. Currently, however, there are only a few more than 180 centers certified in the United States to meet these standards.

Measurable Criteria for an Ideal Crisis System

The accountable entity ensures that all crisis providers adhere to best practice standards for screening, assessment and intervention for suicide, self-harm and violence for all ages. The following criteria are indicators of adherence to those standards:

Suicide and Self-harm

- All crisis call centers and crisis centers should adhere to the best practice standards developed by the NSPL and obtain certification as NSPL centers.
- All crisis call centers and crisis centers should have structured policies, procedures and protocols for suicide and self-harm assessment, including access to 24/7 consultation and supervision.

- In all crisis settings, all patients entering a crisis setting should be screened for suicide, just as all patients have their vital signs checked.
- Evidence-based tools for suicide risk screening, such as the Columbia Suicide Severity Rating Scale or SAFE-T, are recommended and can be adapted based on the crisis setting. Training and evaluation/monitoring of use is valuable.
- Expression of suicide risk while using substances should always be taken seriously, as substance use contributes to suicide risk rather than diminishes it. If the person no longer endorses suicide when intoxication subsides, it still requires comprehensive assessment, including level of risk while the person was intoxicated and method of lethality, as the person with severe risk may leave the crisis center, use substances again and complete suicide.
- Screening and assessment of suicide risk is only as effective as the screener.
 - » Establishing a quick therapeutic alliance and utilizing motivational interviewing skills are central to eliciting sensitive information.
 - » Every setting should implement a process where a positive suicide screen leads to a more in-depth assessment of suicide risk in a safe setting.
 - » After positive screening, suicide assessment is done or supervised by a trained behavioral health clinician.
- Suicide assessment and intervention always involves gathering information from important collaterals, even if the suicidal person states, “I wasn’t serious,” and refuses to give permission. Suicide threat is a life-threatening emergency and warrants serious attention to complete assessment.
- Suicide assessment procedures and responses must be distinguished from self-harm risk assessment and response. Individuals who engage routinely in self-harm, like cutting, as a means of relief but who do not have suicide intent have a different level of risk than those who are suicidal. Involuntary admission of individuals to prevent cutting behavior, while occasionally indicated, is often more traumatizing than helpful, and may not be as beneficial as engaging the individual in targeted interventions such as dialectical behavioral therapy.
- Following a suicide assessment, a process establishing a comprehensive follow-up formal safety plan for the person who presented with suicidality should be developed; this follow-up plan may include outreach calls and/or mobile team visits.
- Contracting for safety is neither a valid or useful outcome of suicide or self-harm assessment and intervention.



IN THE STORY OF MR. Y: Mr. Y’s risks of self-harm would certainly have increased, given the traumatic way in which his behavioral health crisis was addressed and the delays in his receiving care.

Screen for suicide first: A positive screen requires a full suicide assessment reviewed by a trained behavioral health clinician.

VIOLENCE RISK SCREENING AND INTERVENTION; THREAT ASSESSMENT

Screening, assessment and intervention for risk of violence (e.g., homicide, assault, damage to property) in an immediate behavioral health crisis requires the same attention to detail and the same level of structured process as assessment of suicide and self-harm. There are assessment tools for violence (MacArthur Community Violence Risk Assessment tool, Intimate Partner violence assessment tools, Broset Violence Checklist and Violence Risk Screening), but no widely used screening tools for violence assessment as there are for suicide assessments, nor the level of detailed practice guidelines that have been provided by the NSPL. However, best practice crisis centers can adapt the principles encompassed by suicide assessment tools and intervention strategies to assess violence and create similar expectations of requiring input from collaterals, particularly the family members who might be targets of violence if the person returns home, and developing thorough and adequately supported safety plans. As with suicide contracting, an agreement not to engage in violent actions without an adequate safety plan is never an appropriate outcome of a violence assessment.

Threat assessment: Threat assessment refers to the important process of evaluating an individual who might represent a significant threat of harm to the general public. While it is, fortunately, still an uncommon occurrence, the disturbing frequency of mass shootings requires all crisis systems to maintain awareness of this risk and be able to engage in a comprehensive evaluation of any individual who might be demonstrating risk of committing acts of mass violence (e.g., through a threat communicated in person, online, through social media). Because threats of mass violence are infrequent, most crisis centers do not develop substantial expertise in formal threat assessment. Increasingly, however, major metropolitan areas are developing threat assessment capabilities and these threat assessment resources can be made available to other smaller communities in the region for assistance on a case-by-case basis. For example, the Miami-Dade Police Department developed a Threat Management Section (TMS) in 2018 following the Parkland shootings to identify and intervene in cases involving individuals with serious mental illnesses that have been assessed to have a high level of threat to public safety. The TMS is a multidisciplinary team of law enforcement officers and mental health professionals trained to assess and recommend management strategies for people of concern and threats of violence. They also assist with monitoring individuals identified as high utilizers of public systems of care including law enforcement, criminal justice and public health.

Measurable Criteria for an Ideal Crisis System

The accountable entity ensures that all crisis providers adhere to best practice standards for violence for all ages and have access to expert support for threat assessment. The following criteria are indicators of adherence to those standards.

Violence

- All crisis call centers and crisis centers should have structured policies, procedures and protocols for violence assessment, including access to 24/7 consultation and supervision.
- In all crisis settings, all patients should be screened for risk of violence in the same manner as all patients have their vital signs checked.
- Screening and assessment of violence risk is only as effective as the screener.
 - » Establishing a quick therapeutic alliance and utilizing motivational interviewing skills are central to eliciting sensitive information.
 - » Every setting should implement a process where a positive screen leads to a more in- depth assessment of risk in a safe setting.
 - » After positive screening, violence assessment is done or supervised by a trained behavioral health clinician.
- Violence assessment and intervention always involves gathering information from important collaterals, particularly those who might be targets of the violence, even if the person states, “I wasn’t serious,” and refuses to give permission. Threat of violence is a serious emergency and warrants serious attention to complete the assessment.

- Following violence assessment, a process establishing a comprehensive formal follow-up safety plan for the person who presented with violent tendencies or intentions should be developed. The follow-up plan may include outreach calls and/or mobile team visits.
- Contracting for safety is not a valid outcome of violence assessment and intervention.

Threat Assessment

- There is a tertiary care threat management section or similar entity that is available to all crisis centers in the state or the region.
- Individuals who make threats to harm large numbers of people should always be taken seriously. These individuals are unlikely to ask for help directly and the fact that the crisis system is aware of their threats is sufficient reason to consider the risk to be substantial, even if the person denies that they are serious. Interventions should maintain safety without exacerbating the level of risk, which is why it is important to seek expert guidance.
- Each crisis center has policies, procedures and protocols for all staff to know how to identify potential threats, contact appropriate supervisors and obtain expert guidance from the threat management experts in the process of assessment and intervention.



IN THE STORY OF MR. Y: Mr. Y's perceived risk for violence was one of the things that led to his arrest. In an ideal crisis system, this risk could have been managed far more effectively.

MEDICAL SCREENING AND TRIAGE

Medical triage: The immediate review of medical presentations of individuals with a behavioral health crisis to determine whether emergency medical screening and evaluation are required. Medical screening is a formal term utilized by physicians to evaluate any individual presenting in an emergency room or urgent care setting to determine whether that individual has a medical condition that requires emergency evaluation or intervention (e.g., myocardial infarction, fracture) or inpatient medical care, as well as to determine to the extent that is possible within the confines of the ER setting the status of and recommendations for any identified medical conditions that require continuing intervention but do not require emergency intervention or hospitalization.

Medical clearance: A term that does not have a formal definition in the field of emergency medicine, but is commonly used in the behavioral health field that implies that the individual has received medical triage and medical screening and has been deemed to not require emergency medical intervention or hospitalization and is able to be referred to the behavioral health crisis center or other behavioral health setting for continuing emergency behavioral health care. Informally, medical clearance also implies evaluation for underlying medical conditions that may cause or exacerbate the patient's psychiatric symptoms and to the process of identifying conditions that may require further or ongoing treatment or may affect treatment decisions and medication choices. Medical clearance may also involve consideration of the medical requirements of accepting facilities, such as presence of indwelling Foley catheters, intravenous antibiotics or wound care.

In accordance with American College of Emergency Physicians (ACEP) guidelines, medical screening cannot guarantee that all contributing medical conditions have been identified, nor provide definitive recommendations for ongoing medical care. Successful medical screening only implies that the individual does not need emergency medical care and they would be able to return home if not for the presence of a psychiatric condition that needs immediate attention.


Many medical conditions can present with psychiatric symptoms and some patients with known psychiatric illness may have underlying medical conditions. Having clear understanding about how medical emergency settings, crisis centers and psychiatric facilities can engage in evaluation of medical conditions that may cause or exacerbate psychiatric symptoms or that might lead to medical treatment requirements at subsequent accepting facilities is an important part of crisis system care.

The ideal crisis system needs an organized way to make sure everyone can receive what they need in the proper setting as expeditiously as possible and all the participants in the system (ER staff, inpatient unit staff, crisis center staff) have a common set of guidelines for what constitutes medical screening and medical clearance so individual patients don't get stuck in the middle of unnecessary battles about what level of medical testing is needed before the person can move from one setting to the next. Clear communication that is understood by all staff is necessary.

In short, individuals should be able to receive needed medical treatment while their psychiatric concerns are addressed and vice versa. The ideal system allows for appropriate integration of behavioral health support into emergency medical and medical inpatient settings, appropriate levels of medical support in behavioral health crisis and inpatient settings and continued collaboration and communication between medical and psychiatric professionals throughout.

Fortunately, the American Association of Emergency Psychiatrists (AAEP) and the ACEP have articulated practice guidelines about the appropriate practice of medical screening in emergency rooms and how emergency rooms can partner effectively with behavioral health crisis facilities to best meet individual needs and facilitate client flow. Unfortunately, very few crisis settings currently have adopted these guidelines, and as a consequence, many systems have needless barriers to effective client flow, resulting at times in unnecessary medical testing in the ER with long wait times, or with under-attention to medical issues in behavioral health clients by frustrated and busy emergency physicians, along with a general lack of partnership and collaboration to create the best outcomes.

For that reason, ideal crisis systems need to attend to the development of specific practice guidelines for medical screening, clearance and collaboration/integration to ensure optimal results.



There are four steps to medical assessments: medical triage, medical screening, medical clearance and integrated/collaborative medical care.

Measurable Standards for an Ideal Crisis System

The accountable entity works with crisis providers and the community collaboration, including representatives of emergency rooms and inpatient units to adapt and adopt ACEP/AAEM medical screening practice guidelines for utilization as common practice within the community crisis system, as follows:

- There is an established quality improvement committee or similar collaborative structure whereby medical and psychiatric providers meet regularly to establish and continually improve medical screening procedures and review instances of poor outcomes or treatment barriers and delays.
- **For behavioral health crisis settings:** All individuals presenting to the crisis center should receive initial medical triage to determine need for more formal medical screening. Not all individuals should be required to go to an emergency room for medical screening prior to being seen in the crisis center - only those whose triage indicates a reasonable need for an emergency medical evaluation. In the crisis center, individuals who require medical screening but do not require immediate emergency medical evaluation can receive screening provided by integrating collaborative medical providers on-site or by psychiatry, psychiatric nursing or physician assistant providers in consultation with medical providers.
- **For emergency medical settings:** Per the ACEP/AAEP guidelines previously cited, medical screening examinations of psychiatric patients need to be focused and based upon signs and symptoms; routine laboratory studies for all behavioral health patients are not indicated. It should be assumed that crisis centers, crisis residential programs and psychiatric inpatient facilities are able to manage and engage in ongoing evaluation of the majority of acute or chronic medical conditions that do not require emergency medical intervention, medical/surgical inpatient care or nursing home-level of total care.
 - » If an individual in crisis requires inpatient admission, especially to a facility with limited medical services, medical clearance may involve inclusion of basic laboratory studies, including drug screens, as a courtesy without delaying admission pending results.
 - » The studies required for inpatient admission need to be determined by each psychiatric facility in conjunction with the local medical providers and crisis providers.
- Medical screening and medical clearance should occur in conjunction with psychiatric evaluation and need not delay access to the appropriate level of psychiatric care.
- Routine communication between emergency physicians and behavioral health crisis physicians or nurse practitioners and physician assistants should be an expectation.
- Providers should have easy access to medical records from other medical facilities and pharmacies in the area.
- For patients with alcohol intoxication, psychiatric assessment should be based on cognitive abilities rather than specific blood alcohol level. For assessment of need for withdrawal management, scales such as the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) can help determine level of care required.
- A subset of conditions, such as those listed here, may be agreed upon to require more in-depth medical evaluation with clear agreement on what, if any, evaluations need to be done in the emergency setting and what can be carried out after transfer to a behavioral health crisis facility. For example, if someone with new-onset psychosis needs a CAT scan, it is useful to delineate when that would be done as an emergency procedure or when that would be done, as would be the case in most instances, as part of an ongoing work-up following admission to a behavioral health crisis facility. For ambiguous situations, expectation of direct physician to physician communication 24/7 as needed is recommended.
 - » New-onset psychosis.
 - » A 20-point change in blood pressure from baseline.
 - » Blood glucose < 60 or > 350 in patients with diabetes.
 - » Altered sensorium.
 - » Impending delirium tremens.
 - » HIV with new onset medical complaint.

- All behavioral health crisis programs should have clinical/medical leadership that is knowledgeable about common organic etiologies of psychiatric complaints and able to determine how to evaluate for these etiologies as clinically indicated.
- Behavioral health crisis providers will continue to monitor clients for changes in health status, access ongoing medical consultation as needed and maintain collaboration with continuing medical providers for clients who remain in a crisis facility for a period of time.
- In order to eliminate gaps in the continuum, it is helpful when options such as a combined medical/psychiatric unit or beds are available for disposition of individuals with primary acute behavioral health concerns and significant unstable medical needs. In the event that such a unit is unavailable, crisis providers need to know how to implement and fund appropriate clinical protocols on a case-by-case basis, so such individuals receive psychiatric inpatient care with added medical/nursing support or appropriate medical inpatient care with added psychiatric and behavioral health crisis management. For example, the mobile crisis team might engage in daily visits to the medical inpatient unit working in collaboration with a psychiatric consultant. All mobile crisis team staff need to have clinical practice guidelines and protocols for how to provide and document that service.
- All these clinical practice protocols must be incorporated into the policies and procedures of crisis providers and be monitored both individually for success and poor outcomes and in the aggregate for quality improvement and performance incentives.

The State of Michigan has made considerable progress toward establishing statewide consensus guidelines for medical screening accepted by both emergency departments and psychiatric inpatient facilities.

To develop a common language to guide emergency rooms and inpatient psych units regarding parameters for medical screening/clearance, Michigan stakeholders (Michigan Department of Health and Human Services, Michigan Health and Hospital Association) have collaborated to develop MAPAG- SMART protocol, which has been piloted for ultimate state wide adoption.

“Michigan’s Appropriateness for Psychiatric Admission Guide (MAPAG) – SMART is a consensus-based guideline to standardize the medical assessment of individuals determined to be in need (or potential need) of inpatient psychiatric hospitalization. MAPAG incorporates the SMART clinical criteria for patient assessment allowing for a consistent process for screening for acute medical conditions which may impact psychiatric hospitalization. MAPAG consists of a 4-part process intended to facilitate patient admission/transfer, improve communication between clinicians and reduce costs associated with unnecessary diagnostic testing. Following completion of the MAPAG assessment, patients will be classified into one of three categories (see Attachment 1): GREEN (medically appropriate for psychiatric admission without need for further diagnostic testing), YELLOW (medically appropriate for psychiatric admission after further diagnostic testing and/or clinical explanation of medical condition), and RED (admission to a psychiatric unit contraindicated until medical conditions are resolved). “

SUD SCREENING AND TRIAGE

Crisis services in an ideal system regularly welcome and engage individuals who may be actively using substances, some of whom may be obviously acutely intoxicated, and others who may not. SUD screening and triage involves both detection of substance use and screening and identification of risk.

Detection of substance use: There is a need for routine screening for detection of substance use and substance use disorders to gather information from both the client and collaterals as part of the routine crisis assessment. All assessments must be with the framework that identification of co-occurring substance use is welcomed, that individuals receive a positive response for choosing to share their substance use and that identification of current or past substance use is associated with further integrated assessment for substance use disorder as well as for the person's stage of change regarding each substance. More detail on integrated crisis assessment and intervention for individuals with co-occurring mental health and SUD is presented in [“Practice Guidelines: Integrated Interventions”](#) and [“Crisis Continuum for People with Co-occurring Conditions.”](#)

For crisis programs that provide services to a higher acuity population and have more medical capability (e.g., secure crisis centers, psychiatric emergency services, 23-hour observation beds), urine screening for substances can be a valuable tool, particularly when the individual's clinical presentation is uncertain, confusing or inconsistent with the history provided. However, urine screening should never be experienced as punitive or threatening in the crisis situation, but should always be presented as a helpful way to understand what might be affecting the person in the present and to facilitate disclosure of substance use that may be difficult to share. In addition, people in crisis may have used substances without being certain of what they used. Approaching urine screening in such situations as a routine feature of the clinical assessment for anyone whose history is not well known can be valuable and less stigmatizing.

By contrast, in settings where urine screening is not readily available, requiring urine screens may create unnecessary barriers to care. Even in crisis centers where urine screening may be more routine, it is usually not necessary to wait for the results of the urine screen, which in some cases may take several hours, to plan appropriate disposition. The results of the screen can be transmitted to the follow-up program once the results are obtained, even if the client has been discharged. Routine urine screening may miss certain substances, including fentanyl, and are not quantitative. For that reason, urine screening is only a tool and should complement rather than substitute welcoming engagement and careful history-taking.

Detection and triage of substance use risk: While a significant majority of individuals using substances do not present an immediate or emergent medical or behavioral risk, there is an important minority who do. For this reason, all crisis services need to have organized protocols for SUD screening and triage to ensure that those who are at higher risk are appropriately monitored, receive any needed interventions as soon as possible and, if necessary, are referred to a setting with greater medical capability to respond to their risk.

There are three components of risk to include in SUD screening and triage guidelines:

- Risk from intoxication.
- Risk from overdose.
- Risk from withdrawal.

Risk from intoxication: Guidelines for triage, both before referral to the program and at the time of program entry, should include identification of the degree to which the individual's intoxication can be managed safely in the program setting and the immediate implementation of interventions that promote safe management. For example, if an individual is experiencing alcohol intoxication, are they able to safely negotiate the physical environment with limited assistance? Are they able to lie down and remain safe with staff support and encouragement? Or are they so intoxicated that they are likely to fall and hurt themselves, requiring either more staff support or a more secure environment? Similarly, if an individual is experiencing methamphetamine intoxication, are they able to be engaged in a calm manner to receive assistance to manage their agitation or are they in danger of quickly escalating to violence? The more welcoming the staff, the more likely it is that individuals who are intoxicated will calm down quickly. But at the same time, there need to be protocols to guide both the initial engagement and intervention and the rapid recognition of those few who present elevated risk so that they can be moved to a safer location.

Risk from overdose: All crisis settings must recognize the risk of overdose, including unexpected overdose, whether on opioids or through use of combinations of substances that have dangerous interaction. Frequently, the client may not be aware of what they have taken. All staff need to know how to observe for signs of overdose and be trained to administer naloxone. If a client shows diminishing consciousness, all staff should be alert to the potential of overdose and have rapid protocols for arranging transfer to an emergency room.

Risk from withdrawal: Withdrawal from substances can produce syndromes that vary significantly in severity. As noted in other sections of this document, crisis settings should have the capability to manage mild to moderate withdrawal, commensurate with their available medical or nursing capability. However, more complex and severe withdrawal syndromes must be identified and transferred as quickly as possible. For this reason, all crisis programs should have simple guidelines for screening for withdrawal risk:

- Current pattern of use and time since last use.
- Previous withdrawal history when experiencing a comparable pattern.
- Previous history of seizures, delirium tremens or other severe withdrawal syndromes.
- Previous response to withdrawal management.
- Regular interval assessment of potential withdrawal using standard scales such as the CIWA and the Clinical Opiate Withdrawal Scale.

These guidelines should be used for triage purposes and should trigger observation and intervention as a first step in most instances with facilitation of rapid transfer if the person's withdrawal seems to be worsening. Clearly, those with more complex medical conditions and/or history of more severe withdrawal syndromes who have required high levels of medical intervention previously are better triaged to places that provide that level of care.

Measurable Standard for an Ideal Crisis System

The accountable entity works with crisis providers and the community collaboration, including representatives of emergency rooms and inpatient units to adopt ACEP/AAEM shared SUD practice guidelines for utilization as common practice within the community crisis system, as follows:

- **Oversight:** There is an established quality improvement committee or similar collaborative structure where providers meet regularly to establish and continually improve SUD screening procedures and review instances of poor outcomes or treatment barriers and delays.
- **Detection:** All providers have procedures for welcoming screening and detection of substance use without creating barriers to care for those who screen positive. Urine screening can be utilized as needed for assessment in settings where laboratory capability is available, but is not used punitively or as a barrier to appropriate disposition.
- **Intoxication risk:** All providers have procedures for welcoming individuals who are acutely intoxicated, assessing risk and maintaining safety. Individuals who need to be referred to a safer environment are appropriately transferred without implementation of arbitrary rules or protocols that limit access for people who are intoxicated but not at risk.
- **Overdose risk:** Naloxone is available to all providers in the crisis system. All providers have procedures for identifying overdose and intervening with naloxone or medical transfer. Each instance of overdose is tracked as a quality indicator for continuous improvement.
- **Withdrawal risk:** All crisis providers have protocols for withdrawal risk screening and have the capacity to use withdrawal tools and provide withdrawal management interventions commensurate with their medical and nursing capability. Transfers to ERs for withdrawal management risk are monitored to ensure that they occur when needed but are not overused.

APPLICATION OF CIVIL COMMITMENT AND ASSISTED OUTPATIENT TREATMENT (AOT)

Crisis systems and crisis programs are regularly required to make determinations of the need for civil commitment and, in states where assisted outpatient treatment/mandated outpatient commitment (AOT/MOC) is available, of the need for emergency intervention under the terms of the AOT order. The role of civil commitment and AOT/MOC laws is to provide clinically-driven civil strategies, rather than criminal, for providing safety and treatment of individuals who, by virtue of their mental illness, are at immediate risk of harm to self or others and/or unable to provide for their own self-care in most states. Although such laws vary from state to state, all such laws attempt to balance individual liberty and interest with the protection of the individual and others.

Crisis systems and programs need to develop consistent clinical practice standards that permit consistent application of these laws throughout the system, rather than leaving the interpretation of these laws to individual clinical discretion. The operating philosophy needs to be, “Change tragedy before treatment to one that allows treatment before tragedy.”

Crisis systems that are reluctant to apply civil commitment until violence occurs may inadvertently lead to more individuals engaging in harmful acts, clinically deteriorating to the point of severe harm and/or arrest. Crisis systems that are too quick to commit when the person may be successfully engaged and supported in the community may inadvertently interfere with recovery-oriented treatment and/or encourage unnecessary and unhelpful hospitalizations. In no instance should clients and families be turned away because the crisis program states, “He is not committable. Until he hurts someone there is nothing we can do.” Delayed time to treatment can cause increased risk for morbidity and mortality.

Measurable Criteria for an Ideal Crisis System

- **Competency-based training:** All crisis system staff receive specific training and demonstrate competency in knowledge and application of the local and state laws regarding emergency civil commitment, emergency treatment over objection and outpatient commitment.
- **Treatment before tragedy guidelines:** The crisis system provides clinical practice guidelines for how to respond to individuals who are at risk to ensure that treatment is provided before tragedy, while rights are protected. These guidelines include instructions on how to maximize engagement of client and family in appropriately intensive collaborative interventions to address highly risky situations and provide guidance for proactive use of civil commitment or invocation of outpatient commitment rules for clients on AOT/MOC in risky situations when no other alternative can effectively mitigate the risk of harm.
- **Promotion of client engagement and shared decision-making:** The crisis team has procedures to inform clients of their rights and due process to protect their rights and using shared decision-making, provide clients with sufficient psychoeducation about the beneficial and detrimental consequences of their decision to accept or not accept treatment and services and help empower clients to make truly informed decisions, including in situations where emergency medication over objection may be warranted. All clients should be informed of their right to counsel and have access to legal consultation.
- **Clinical and legal consultation:** All crisis programs have mechanisms for access to clinical and legal consultation 24/7. Crisis clinicians are required to access consultation before disposition or emergency medication over objection in ambiguous situations.

**Mandated treatment
can be delivered in a
recovery-oriented and
empowering manner.**

- **Family and collateral engagement:** Input from family and collaterals is essential for accurate determination of risk. If the family states that the client has engaged in unsafe behavior, this must be taken seriously, even if the client denies such behavior and appears to be in control in the moment. Risk assessment involves determining safety outside the controlled environment of the crisis setting. Further, crisis planning must consider the possibility of safe involvement of family and other social supports to help engage and motivate the client to engage in change.
- **Definition of least restrictive alternative:** The least restrictive means of care that can adequately provide for the safety of the client and community should always be the goal of treatment. Note that putting a client back into the community when he or she is at risk of likely arrest is not less restrictive than hospitalization. Releasing a disorganized psychotic person who is demonstrably unable to provide for his or her own care to the streets is also not less restrictive than hospitalization. At the same time, committing someone for expressing suicidal or self-harm impulses who can and will participate in an effective community-based safety plan is not less restrictive, even though it may have some level of risk.
- **State-specific mandates:** All crisis programs must demonstrate that staff are trained in adherence to state-specific mandates, if any, regarding AOC or MOC. In many states, court ordered MOC uses a lesser requirement that “patients who, as a result of their mental illness, are unlikely to seek or voluntarily adhere to needed treatment” and who have a history of multiple hospitalizations and violence must be “linked to intensive outpatient services, prescribed for extended periods of time, up to 180 days...” In these states, the MOC orders require referral to a higher level of care but do not mandate medication over objection.
- **Medication-assisted treatment:** There is no general mandate for involuntary medication-assisted treatment of substance use disorders. The exception to court ordered medication treatment over objection for mental illness is in the case of an emergency. In a nonemergency, using a recovery-oriented approach to individualized care is the ideal. A recovery-oriented, client-centered crisis program is compelled to focus on engagement and motivational techniques to help clients understand and accept treatment and services. All staff need to have competency to utilize those techniques and document how those techniques were utilized in all situations when clients may be receiving medication involuntarily or by persuasion.



PRACTICE GUIDELINES FOR INTERVENTION AND TREATMENT

PRACTICE GUIDELINES: MULTIDISCIPLINARY TEAMWORK AND CASE SHARING; ROLE OF PEERS

A comprehensive behavioral health crisis system, with a complete continuum of services, provides a continuum of best practice crisis intervention services to meet the needs of the community. In almost all crisis intervention settings, there will be multidisciplinary teams, usually including medical/nursing providers, licensed/certified and unlicensed crisis providers and certified/non-certified peer supporters (see sections on “Multidisciplinary Teams” and “Peer Supports”). Successful crisis response is maximized when the various disciplines are not only present, but work effectively as an interdisciplinary team with collaborative case sharing that minimizes duplication and maximizes the ability of each individual to support other team members and contribute their unique perspective and expertise most effectively.

Measurable Criteria for an Ideal System

The accountable entity is responsible for oversight, contracting and quality monitoring supports crisis providers to develop interdisciplinary teamwork, including maximizing peer support, through creation of clinical practice guidelines and provision of supportive administrative and funding regulations, as follows:

- **Definition and support of interdisciplinary teamwork:** The crisis system defines and reimburses crisis assessment and intervention as an interdisciplinary team process rather than discrete billable events by separate categories of providers. Instructions for completing necessary documentation emphasize the broad capacity of all team members to contribute to most functions, ranging from history gathering, to completing screening forms, to taking vital signs, to providing supportive interventions, to contacting collaterals and referrals, while clarifying the role of specialty providers to operate at the “top of their license” and to sign-off on the work of other team members when indicated.
- Maximizing peer involvement: **The crisis system and each crisis provider incorporate peer support into the** interdisciplinary team and define the role of peers as having particular expertise in provision of hope and engagement of very disengaged or frightened clients. Peer roles are not limited to being support staff or clinician extenders, but as the experts in engagement and delegated to providing outreach (and helping other team members provide outreach in situations their expertise is most needed. Meaningful peer involvement is reinforced in regulations and reimbursement policies and measured as a quality metric. All staff are trained to understand the peer role and to practice developing successful skills in working with, supporting and being supported by peers on the interdisciplinary team.
- **Job descriptions and competencies:** Job descriptions, competencies and performance evaluations include skills in interdisciplinary teamwork in crisis situations. Program managers and supervisors are similarly expected, trained and supported to reinforce successful case collaboration and team functioning.
- **Case sharing:** When managing one or more cases in a crisis center during any shift, supervisors are to maximize the ability of the team members to support each other and share the responsibility for success. It is important that practice guidelines for each discipline reinforce that everyone cross-covers, and no one says, “That’s not my job,” unless it’s specifically something they are not permitted to do by law or regulation (e.g., only nurses or doctors can dispense medication).

PRACTICE GUIDELINES: NONPHARMACOLOGIC CRISIS INTERVENTIONS

The capacity for the multi-disciplinary team in any program or service within the crisis system to provide an organized set of nonpharmacologic crisis interventions is a core element of best practice crisis response. Crisis services often default to prioritizing medication interventions and disposition planning without attending adequately to the importance of ensuring the entire team has a coherent approach to responding directly to the crisis, using non-pharmacologic best practices for de-escalation, crisis resolution and ongoing crisis planning. There is a small but important subpopulation of individuals with serious mental illnesses, including psychosis, who are committed to managing their lives without using psychotropic medications, either at all or consistently. When these individuals present in crisis, it is important to have a set of guidelines for staff to follow to engage with and help them resolve their crises appropriately without medication, unless medication is needed for immediate safety concerns.

Many of the elements of nonpharmacologic crisis intervention are addressed in other sections of this report. Examples include basic welcoming and engagement, identification of person-centered hopeful goals, trauma-informed care, de-escalation with no force first, crisis assessment and intervention, collaboration with families, collaterals, community resources, safety planning and crisis planning. It is helpful to provide a coherent framework so that all staff understand that their job is not just to wait for the medications to work, but have an organized set of practice guidelines and skills for using nonpharmacologic interventions to help clients and families in crisis.

Measurable Standards for an Ideal Crisis System

The accountable entity works with crisis providers and community collaborators including service recipients (and any organized clinical quality committees) to adopt, adapt and implement nonpharmacologic practice guidelines:

- **Develop and monitor adherence to written guidelines for the following situations:**
 - » Nonpharmacologic de-escalation (see [“No Force First: Maximizing Trust and Collaboration, Minimizing Seclusion and Restraint”](#)).
 - » Value-based service provision: Welcoming, hopeful, trauma-informed, cultural humility, anti-racist, recovery and resiliency-oriented (see Section on [Universal Framework: Welcoming, Hopeful, Safe, Trauma-informed and Culturally-affirming](#))
 - » Crisis assessment: See section on [“Basic Core Competencies for Behavioral Health Crisis Staff.”](#)
 - » Crisis Intervention: Identification of goals and priorities, delineation of previous stable baseline and assistance with specific steps to resolve problems and return to previous baseline.
 - » Engagement of family and other supports in crisis intervention and crisis resolution.
 - » Engagement of community resources by current and new providers in crisis resolution, outreach and engagement during the crisis and continuity of care.
 - » Implementation of crisis plans and safety plans (see sections on “Crisis Planning”, “Suicide Screening and Intervention”, and “Violence Screening and Intervention”).
 - » Specific guidelines for engagement and collaboration with individuals who experience psychotic symptoms but choose not to use medications as part of their ongoing self-management.

PRACTICE GUIDELINES: PSYCHOTROPIC MEDICATIONS

An important element of delivery of crisis services is appropriate psychopharmacologic intervention for both mental health and SUD conditions. There are numerous articles written about pharmacologic management of behavioral health crises. The purpose of this section is not to reiterate or summarize these articles, but to ensure that crisis systems 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. The following criteria can be utilized to insure proper psychotropic management of behavioral health crises.

Measurable Standards for an Ideal Crisis System

The accountable entity works with crisis providers and community collaborators, including a medical quality committee established for adoption, review and continuous improvement of medical practice guidelines, to adopt, adapt and implement psychopharmacologic practice guidelines, including but not limited to guidelines based on those promulgated by the AAEM, as follows:

- **Develop written guidelines for the following situations:**
 - » Management of agitation in the medical or psychiatric crisis setting (Stonewell, 2012).
 - » Administration of involuntary medication with provision to maximize client engagement and minimize the use of chemical restraint or medication over-objection and ensure that underuse of medication does not lead to client or staff injury or need for physical restraint.
 - » Initiation of continuing medication for psychiatric disorders in the crisis setting, including attention to available community formulary restrictions, provision of adequate amounts of medication to bridge to next appointment, provision for gap refills if needed and encouragement of long-acting injectables for individuals who are willing, in order to minimize relapse.
 - » Initiation of medication-assisted treatment for SUD in the crisis setting, including oral naltrexone and acamprosate or long-acting naltrexone for alcohol use disorder (AUD) and buprenorphine or naltrexone for opioid use disorder (OUD).
- **Develop protocols for psychiatric care provider education on evidence base for pharmacologic management of behavioral health crises in the behavioral health crisis setting and for monitoring adherence to the above practice guidelines, including continuous improvement and review of exceptions.**
 - » Yearly training and review of the practice guidelines for crisis prescribing by all psychiatric care providers in the crisis continuum.
 - » Independent peer review of one record/ month for all psychiatric care providers to insure appropriate use of psychotropics.
- **Ensure 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.
- **Emphasize implementation of shared decision-making, including collaboration between psychiatric care providers and peers to help individuals make better medication decisions in the crisis setting.** When possible, and as clinically indicated, ensure the individual in crisis receives the medications they report are now successful for them or have been in the past via their preferred route (oral vs. injectable), while working with them to make better choices (e.g., avoiding initiating ongoing use of benzodiazepines, encouraging transition to long-acting injectables for individuals with adherence difficulties).
- **Establish formulary guidelines for which medications are available in crisis centers and how to access medications for individuals from collaborating pharmacies.** Develop mechanisms to pay for medications in urgent situations for individuals who are uninsured or who do not have their insurance information with them.

- **Ensure access to naloxone and training in its administration for first responders and behavioral health crisis personnel.**
- **Establish procedures for clozapine administration via utilization of risk evaluation and mitigation strategy in all relevant crisis settings.** Consider establishing protocols for administration of ketamine for acute suicidality as ketamine preparations become more readily available.
- **Establish protocols and procedures for continuation of methadone for individuals in behavioral health crisis who are on methadone maintenance.**
- **Establish protocols for routine initiation of withdrawal management for commonly encountered substances.**
- **Establish guidelines regarding crisis management of individuals who are on benzodiazepines.** Administration of acute benzodiazepines may be very effective in a behavioral health crisis. Administration of benzodiazepines is often part of alcohol withdrawal management and initiation of discontinuation of benzodiazepines is not recommended during an acute behavioral health crisis and for some individuals, discontinuation should not be recommended at all. Management of individuals who are inappropriately requesting continuing benzodiazepine prescriptions requires careful response to promote engagement over time to help those who are high risk for poor outcomes make better medication decisions.
- **Establish guidelines for promoting engagement and appropriate ongoing evaluation of individuals who demand access to controlled substances in the behavioral health crisis setting.** These individuals are a high-risk poor outcome group that should be considered a high priority for continuing engagement and thorough evaluation. Establishing protocols for facilitating more comprehensive evaluation, information from collaterals, daily contact and so on can transform a conflictual situation into a productive alliance.
- **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.
- **Create procedures for follow-up checks** to ensure individuals in crisis have accessed medications (e.g., automated via pharmacy to provider, phone call checks).
- **Assure health care providers systematically assess for medication adherence using both clinical interview and prescription fill data.**

PRACTICE GUIDELINES: INTEGRATED INTERVENTIONS

A comprehensive behavioral health crisis system, with a complete continuum of services, is an essential element of safety-net health and human services for any community. It is critical that all elements of the system demonstrate the most effective engagement and clinical practice protocols for individuals who may be at particularly high risk and/or demonstrate behaviors or conditions that may be viewed as challenging or difficult, such as individuals with active substance use and/or active SUD. This has become an even more concerning issue because of the opioid epidemic. Rather than encountering barriers to access and unwelcoming attitudes, these individuals must be identified as priorities for crisis response who require best possible engagement in care to prevent increased morbidity and mortality.

Measurable Criteria for an Ideal System

- **Practice guidelines for SUD:** The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and an accountable provider responsible for provision of direct services and/or coordination of all service elements that incorporate the following clinical practice guidelines and expectations into contracting, with associated quality indicators and metrics of success (Minkoff, 2019):
 - » **Welcoming:** Individuals and families with active substance use or co-occurring mental health and SUD of any kind are welcomed for crisis services and are a priority population for engagement and care.
 - » **No access barriers based on SUD levels:** Under no circumstances shall any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with a substance use disorder based on requiring alcohol level to be below a certain number or that a urine screen must be completed and cleared prior to initiation of services. If a person is too intoxicated to communicate coherently, the assessment begins with welcoming engagement, contact of collaterals and obtaining history. Direct assessment begins as soon as the person can begin to communicate clearly. Disposition is made as soon as possible and it is not routinely necessary for the person to be sober before the next step response is determined.
 - » **Managing intoxication and withdrawal:** All crisis providers shall have policies and protocols to manage individuals who may be intoxicated in a welcoming and safe manner and provide support for withdrawal management commensurate with the level of medical care they do or do not offer. Note that the vast majority of people who are intoxicated do not require a medical intervention in order to safely become sober. The determination of level of medical detox is based on assessment of history and risk factors. All but the most severe detoxes can be managed in non-hospital settings.
 - » **Co-occurring capability:** All crisis providers and programs are co-occurring programs and have a formal commitment to co-occurring capability, engage in regular self- assessment using established tools (COMPASS-EZ, Dual Diagnosis Capability in Addiction Treatment/ Dual Diagnosis Capability in Mental Health Treatment [DDCAT/DDCMHT]) and demonstrate regular quality improvement (QI) planning and activity to improve continuously over time.
 - » **Integrated assessment:** All crisis providers can perform an integrated assessment of a person in crisis who has both mental health and substance use issues based on obtaining a careful longitudinal history, reviewing periods of recent sobriety or minimal use and contacting collaterals. In most instances, persistent mental illness is identified by history. Diagnosis of a substance-induced mental health disorder requires that the mental health symptoms clear up completely within 30 days after substance use is discontinued and considered a diagnosis of course, not cause, utilized cautiously in the crisis setting. Training and supervision are crucial here and often begin with recognition of underlying attitudes which may impede learning and care.

We must treat the whole person; this includes addressing mental health AND substance use disorders.

- » **Individualized disposition:** Determination of crisis response for individuals with active SUD, including those with co-occurring mental health issues, should be based on the individual's crisis presentation and request for help, and should not involve referral for abstinence-expected services (e.g., detox program, addiction treatment program) if that is not consistent with what the individual wants. Individuals who present with mental health needs (e.g., suicidality, psychosis) are more at risk if there is co-occurring SUD present and should not have their request minimized because of the presence of SUD. Consider commitment if the person presents with impulses to harm while intoxicated and there is no collateral confirmation of safety once if person changes their mind once sober.
- » **Engagement of individuals who are challenging:** Individuals with SUD, including those who present with frequent intoxication, requesting a place to stay or stating they are suicidal to get a bed, should be treated as a high-risk group who need to be engaged. The crisis system should have a clearly demonstrated mechanism for providing crisis follow up for such individuals for up to 90 days, including the use of intramuscular naltrexone, to help those individuals become more in control and engage in some level of community-based services, even if they continue to use substances.
- » **Engagement of individuals with opioid use disorder:** Individuals who present with unmanaged pain, requests for opioids, escalation of opioid doses or other indications of potentially risky or lethal opioid use and/or OUD are considered a priority for engagement and not simply labelled as "med-seekers" and extruded from service. Emergency medical providers routinely seek crisis consultation for such individuals and the outcome is to engage them in continuing service, including initially with the crisis provider, to help them best manage ongoing pain and/or OUD and/or co-occurring mental health and trauma issues, while minimizing risk of overdose.
- » **MAT initiation and induction:** The crisis system must have routine capacity to induct individuals into medication assisted treatment for AUD and OUD (with or without co- occurring mental illness), including buprenorphine induction, initiation of naltrexone (as for jail discharges who are at risk) and rapid connection to same day or next day methadone initiation.
- » **Collaboration with SUD providers:** For individuals who need and want referral to abstinence-based addiction services for any SUD or COD, the crisis system maintains strong partnerships with the continuum of SUD service providers, including provision of proactive consultation and welcoming offers of instant crisis response for clients who become hard to manage safely.
- » **These guidelines are monitored for quality improvement and performance incentives.**

PRACTICE GUIDELINES: CO-OCCURRING MEDICAL CONDITIONS

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community. It is critical that all elements of the system demonstrate the most effective engagement and clinical practice protocols for individuals of any age who suffer from co-occurring medical conditions and physical disabilities. Medical screening and triage functions may identify individuals who require acute and emergency medical intervention, but the majority of individuals with common medical conditions and physical disabilities will not require emergency medical intervention and will be routinely served in all components of the behavioral health crisis system.

Measurable Criteria for an Ideal System

Practice guidelines for co-occurring medical conditions and physical disabilities: The comprehensive crisis system defined in this report recommends an accountable entity responsible for oversight, contracting and quality monitoring and accountable providers responsible for provision of direct services and/or coordination of all service elements that incorporate the following clinical practice guidelines and expectations into contracting with associated quality indicators and metrics of success:

- **Welcoming:** Individuals and families in behavioral health crisis with physical disabilities of any kind (e.g., vision impairment, hearing impairment, mobility impairment), and/or co-occurring medical conditions that do not require medical hospitalization, emergency intervention or 24-hour skilled nursing intervention for total care are proactively and specifically welcomed for help in all settings and programs in the crisis continuum.
- **No access barriers based on physical disability:** All programs in the crisis continuum have specific provisions and policies for engaging and serving individuals with visual, hearing and mobility impairments and challenges. This includes access to communication aids and American Sign Language interpreters for people with hearing impairment and wheelchair accessibility for environments where services are provided. Under no circumstances shall any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with a physical disability.
- **No access barriers based on medical co-morbidity:** All programs in the crisis continuum -- particularly residential programs -- have specific provisions and policies for engaging and serving individuals with common medical conditions that are routinely managed on an ambulatory basis. This includes provision for self-administration of medications such as insulin, individuals who require routine oxygen supplementation and so on. Specific written procedures guide staff in the process of admitting such individuals and working collaboratively with the individual, collaterals, medical providers and crisis system leader to facilitate access to needed services and medications that the person would normally access at home. Under no circumstances should any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with routine medical conditions, unless management of these conditions requires a level of nursing care that the provider cannot offer, in which case the person must be accommodated at the appropriate setting in the crisis system with more nursing capacity, either on-site or through visiting nurse services.
- **Availability of medications:** All crisis providers must have policies and protocols to work with individuals who have medical needs to obtain the medications they need to address their conditions. This includes a protocol to assist the client in obtaining their existing medication supply, temporary medications from their pharmacy and obtaining interval prescriptions. The crisis coordinator and crisis system leadership must create system policies that facilitate access to those support services so no one is prevented from accessing the behavioral health crisis care that is appropriate to their needs simply because they cannot obtain continued access to medications for medical conditions.

We must treat the whole person; this includes working with individuals in behavioral health crisis who have co-occurring medical conditions and/or physical disabilities.

- **Access to medical services, including primary care, specialty care, laboratory and physical therapy:** All crisis providers of residential programs must have policies, procedures and protocols to facilitate connection to medical providers through direct transport or telehealth, laboratory services through on-site blood draw or transport or other supportive therapies that may be medically indicated.
- **Collaboration and consultation:** All crisis providers shall have the capacity to coordinate care with medical providers and to collaborate as needed to be able to provide the individual and family clear information about how to address both behavioral health needs and ongoing medical needs in an integrated manner.
- **Wellness management support:** All crisis providers, including peers, must have capacity and competency to work with individuals in crisis to help them make good decisions about management of their health and wellness (weight, tobacco use) - as well as continuing medical conditions and physical challenges - in the process of addressing their immediate and ongoing behavioral health needs.
- **These guidelines are monitored for quality improvement and performance incentives.**



POPULATION-SPECIFIC CLINICAL BEST PRACTICES

PRACTICE GUIDELINES: WORKING WITH YOUTH AND FAMILIES

The ideal crisis system must be able to respond to individuals of all ages in crisis, their families and caregivers. In some settings, there may be capacity to develop a specialized continuum of crisis services for children and adolescents, but in most systems, they will be served to some extent by generic crisis staff. In either case, all the crisis practice guidelines described in this section need to be adapted for the specific needs of youth.

Measurable Criteria for an Ideal System

The accountable entity works with crisis providers and community collaborators to develop and implement clinical practice guidelines and competencies for all staff who might be providing services to youth. These can be integrated into existing competencies and guidelines (e.g., a section on psychotropic medications for youth incorporated into the overall guidelines on psychotropic medication) or developed as freestanding guidelines (e.g., a comprehensive set of crisis practice guidelines for youth that includes all the elements of crisis guidelines for adults, as appropriate). The content of these guidelines relates to the adaptation of all the usual crisis protocols to accommodate the following areas of knowledge and skill for crisis providers:

- **Clinical competencies: knowledge and skills**
 - » Engagement of youth with use of play as an engagement tool.
 - » Engagement of youth and families in a culturally sensitive manner without re-traumatizing or blaming youth and families for the crisis.
 - » Matching engagement and intervention to age and development of child/youth.
 - » Assessment, including psychiatric and medical diagnosis and attention to social issues with greatest impact for youth (e.g., child welfare and juvenile justice involvement).
 - » Developmental milestones, including language development.
 - » Distinguishing symptoms of mental illness from imaginary play.
 - » Collaboration with family and caregivers because crisis for the child is usually crisis for the family.
 - » Coordination with community resources, including, but not limited to:
 - Early intervention programs, schools, including pre-schools and colleges.
 - Teams, clubs and other peer groups or organizations.
 - Medical pediatric teams.
 - Protective services for children, juvenile justice services.
 - Age-specific non-pharmacologic interventions and age-specific medication sensitivities and dosing.
 - Balance of privacy and individual focus with need for family/community input.
 - » Age specific rights and limitations.

- **Resources:** All staff should have access to written resources (handy tools) to help with the unique needs of children. For example:
 - » Developmental milestones, language and cognitive development.
 - » Unique impact and related intervention for youth exposed to community and interpersonal violence/trauma.
 - » Protective service referral processes and criteria.
 - » Access to home-based crisis resources.
 - » Cultural variations in youth experience, including immigrant communities.
- **Consultation:** Pediatric specialists should be available remotely and with near-time direct access for the following functions:
 - » **Clinical functions:** Complex diagnostic assessment and intervention.
 - » **Complex multisystem involvement, involving resource coordination:**
 - Use of “safe havens” and other domestic violence crisis services with a family focus.
 - Child protection services available for crisis diversion when the child is not safe at home.
 - Protocols for case consultation and alternative planning for individuals who have failed to link with community resources and repeat visits to the crisis center.
 - Protocols for using community crisis resources outside the behavioral health system, including protective services and more normative resources. Some communities have respite services for families with youth who are difficult to parent or hard to treat. These services are ideally used before the crisis point; however, they should be considered at the point of crisis if not already in use.
 - Protocols for coordination with juvenile justice.
 - Engagement and coordination with schools and special education services.
- **Continuous improvement:** Regular QI planning actively leads to improvement of quick disposition, caregiver satisfaction and adverse events, including episodes of challenging behaviors/violence.
- **Practice guidelines:** Clinical practice protocols specific to this population are incorporated into the policies and procedures of crisis providers and monitored both individually for both success and poor outcomes and in the aggregate for the purpose of quality improvement and performance incentives.

PRACTICE GUIDELINES: WORKING WITH OLDER ADULTS AND CAREGIVERS

The ideal crisis system must be able to respond to individuals of all ages in crisis and to their families and caregivers. In some settings, there may be capacity to develop a specialized continuum of crisis services for older adults who are medically frail, dependent or suffering from dementia, but in most systems, those individuals will be served to some extent by generic crisis staff. All the crisis practice guidelines described in this section need to be adapted for the specific needs of older adults.

Measurable Criteria for an Ideal System

The accountable entity works with crisis providers and community collaborators to develop and implement clinical practice guidelines and competencies for all staff who might be providing services to older adults. These can be either integrated into existing competencies and guidelines (e.g., a section on psychotropic medications for elders incorporated into the overall guidelines on psychotropic medication) or developed as freestanding guidelines (e.g., a comprehensive set of crisis practice guidelines for older adults that includes all the elements of crisis guidelines for adults, as appropriate). The content of these guidelines relates to the adaptation of all the usual crisis protocols to accommodate the following areas of knowledge and skill for crisis providers:

- **Clinical competencies: knowledge and skills**
 - » Engagement of older adults in a culturally sensitive manner without re-traumatizing or blaming older adults and their families for the crisis.
 - » Assessment, including psychiatric and medical diagnosis and attention to social issues with greatest impact for older adults (e.g., elder protective services).
 - Difference between ordinary forgetting and dementia.
 - Medical differential for delirium.
 - Distinguishing symptoms of mental illness from confabulation.
 - » Collaboration with family and caregivers.
 - » Coordination with community resources including, but not limited to:
 - Senior centers, assisted living and nursing homes.
 - Teams, clubs and other peer groups or organizations.
 - Medical geriatric teams.
 - Protective services for elders/disabled.
 - Age-specific non-pharmacologic interventions and age-specific medication sensitivities and dosing.
 - Balance of privacy and individual focus with need for family/community input.
 - » Age-specific rights and limitations.
- **Resources:** All staff should have access to written resources (handy tools) to help with the unique needs of older adults, for example:
 - » Unique impact and related intervention for older adults who are exposed to community and interpersonal violence/trauma.
 - » Protective service referral processes and criteria.
 - » Access to home-based crisis resources.
 - » Cultural variations in older adult experience, including immigrant communities.
- **Consultation:** Geriatric specialists should be available remotely and with near-time direct access for the following functions:

- » **Clinical functions:** Complex diagnostic assessment and intervention.
- » **Complex multisystem involvement, involving resource coordination:**
 - Availability of domestic violence crisis services with a family focus.
 - Adult protection services when the older adult is not safe at home.
 - Protocols for case consultation and alternative planning for individuals who have failed linkage with community resources and repeat visits to crisis centers.
 - Protocols for using community crisis resources outside the behavioral health system, including protective services and more normative resources. Some communities have respite services for families who are caring for elderly parents. Ideally, services are used before the crisis point; however, if not already in use they should be considered at the point of crisis.
 - Protocols and coordination with elder home services, including visiting nurses.
- **Continuous improvement:** Regular QI planning actively leads to improvement of quick disposition, caregiver satisfaction and adverse events, including episodes of challenging behaviors or violence.
- **Practice guidelines:** Clinical practice protocols specific to this population are incorporated into the policies and procedures of crisis providers and monitored both individually for both success and poor outcomes and in the aggregate for the purpose of quality improvement and performance incentives.

PRACTICE GUIDELINES: WORKING WITH PEOPLE LIVING WITH COGNITIVE DISABILITIES AND CAREGIVERS

The prevalence of mental health comorbidities in patients with cognitive disabilities, including I/DD, ASD and ABI/TBI requires a behavioral health crisis system capable of caring for the needs of patients presenting in behavioral health crisis with those special needs.

It has been reported that the prevalence of mental health comorbidities in patients with intellectual disabilities ranges from 32 to 40% (Aggarwal, 2013), challenging behaviors such as self-injury, self-stimulatory behaviors and aggression are common in these patients and 12 to 46% of patients with intellectual disabilities are prescribed psychotropic medications. The ideal behavioral health crisis system should be able to accommodate the needs of patients with intellectual disabilities who may present for care. This involves providing accurate assessment, diagnosis and referral to appropriate next steps in their care. Because of challenges these patients may have in communicating their needs to staff, involving current caregivers and knowing appropriate cognitive disability support resources in the community is important.

Measurable Criteria for an Ideal System

The accountable entity works with crisis providers and community collaborators, including representatives from the I/DD and brain injury service system and providers, to establish criteria for how the behavioral health crisis system responds to individuals with cognitive disabilities in crisis and practice guidelines for crisis staff who are working with these individuals throughout the crisis continuum. Important competencies include:

- **Welcoming:** All individuals with cognitive disabilities and their caregivers should be welcomed for crisis services. Under no circumstances should any provider of crisis services have a formal or informal policy that creates barriers to access for individuals with cognitive disabilities.

It is important to remember that people who have cognitive impairment may need a different approach to care and treatment.

- **Engagement of guardians and caregivers:** The importance of guardians and caregivers for these individuals will be acknowledged by early recognition of guardianship paperwork or surrogate decision-makers, if the individual lacks capacity/competency to make medical decisions, and by an absence of barriers to the engagement of guardians or caregivers with the treatment team.
- **Accommodation of functional levels:** The facilities of the crisis center should be able to accommodate individuals of varying IQs and functioning levels, including any medical equipment these patients may require, such as feeding tubes.
- **Basic staff training:** Staff will have basic training in working with individuals with cognitive disabilities in crisis, have knowledge in assessment and diagnosis of mental illness in the population and access to specialty consultation, when indicated.
- **Crisis assessment training:** Staff will be able to perform an integrated assessment of an individual with cognitive disabilities who is in crisis.
- **Clinical competencies: knowledge and skills**
 - » Engagement of individuals with cognitive disabilities in a culturally sensitive manner without re-traumatizing or blaming families and caregivers for the crisis.
 - » Assessment, including psychiatric and medical diagnosis and attention to social issues with greatest impact for individuals with cognitive disabilities.
 - Alternative presentations of common mental illnesses.
 - High risk of current or past trauma affecting behavior.
 - Sensitivity to apparently small changes in environment or supports.
 - Distinguishing symptoms of mental illness from impact of trauma and cognitive/emotional dysregulation.
 - Awareness of risk and impact of fetal alcohol syndrome and alcohol/drug-related neurodevelopmental disabilities and related syndromes.
 - » Collaboration with family and caregivers, including professional caregivers for individuals in supported living environments and group homes.
 - » Coordination with community resources including, but not limited to:
 - Special education, supported employment centers and support organizations for individuals with cognitive disabilities.
 - Veterans organizations for individuals with combat-related brain injury.
 - Specialty medical services for cognitively disabled.
 - Protective services for people with disabilities.
 - Cognitively adapted nonpharmacologic interventions and medication sensitivities and dosing.
 - Balance of privacy and individual focus with need for family/community input.
 - » Age-specific rights and limitations.
- **Resources:** All staff should have access to written resources (handy tools) to help with the unique needs of individuals with cognitive disabilities. For example:
 - » Adaptive strategies for individuals with various types of cognitive disability.
 - » Protective service referral processes and criteria.
 - » Access to home-based crisis resources.
 - » Information about access to I/DD and brain injury services in the community, including coordination of services for individuals with overlapping needs.

- **Consultation:** Cognitive disability specialists should be available remotely and with near-time direct access for the following functions:
 - » **Clinical functions:** Complex diagnostic assessment and intervention.
 - » **Complex multisystem involvement involving resource coordination:**
 - Coordination of services with the I/DD and brain injury service systems.
 - Adult protection services when the disabled person is not safe at home.
 - Protocols for case consultation and alternative planning for individuals who have failed linkage with community resources and repeat visits to crisis center.
 - Protocols for using community crisis resources outside the behavioral health system, such as respite services.
 - Protocols and coordination with home services, including visiting nurses.
- **Availability of Services:** IQ and functioning level along with challenging behaviors associated with cognitive impairment will not be a barrier to an appropriate, safe disposition, as there will be disposition options available for patients of all IQ and functioning levels and with various medical needs.
- **Continuous improvement:** Regular QI planning actively leads to improvement of quick disposition, caregiver satisfaction and reduced adverse events including episodes of challenging behaviors or violence.
- **Practice guidelines:** Clinical practice protocols specific to this population are incorporated into the policies and procedures of crisis providers and monitored both individually for success and poor outcomes and in the aggregate for quality improvement and performance incentives.



COLLABORATION, COORDINATION AND CONTINUITY OF CARE

TIMEFRAMES/WORKFLOW WITHIN THE CRISIS CONTINUUM

It is critical that crisis services provide immediate care to those who need it most. To achieve this goal, established methods for measuring and improving throughput should be employed.

Quality improvement methods (including, but not limited to “Lean”) are well-suited for maximizing workflow processes and quality improvement in crisis services. Lean is an organizational philosophy developed to translate the successes of the Toyota Production System to auto manufacturing in the United States and has since been adapted to a wide variety of industries, including health care. An important focus of Lean is waste reduction, which is defined as anything that is non-value added to the customer, such as time spent waiting. This naturally appeals to fast-paced health care settings, and many emergency departments have implemented Lean methods.

These organizational processes and procedures must be translated into practice guidelines and core competencies for all staff. Given the rapid flow of activities in the crisis intervention process and the need for staff to work effectively as an interdisciplinary team, it is important to include instructions for what is done (e.g., engagement, assessment, intervention), who does it and how quickly. The more specificity provided for staff, including specificity for how to deal with the need for flexibility in changing circumstances, the more likely the overall crisis intervention process will flow smoothly at maximum efficiency.

Measurable Criteria for an Ideal System

The accountable entity, in collaboration with crisis providers and community collaborators, establishes guidelines and quality improvement processes for workflow and throughput in all levels of the crisis system (see [“Accountability and Finance”](#)) and ensures that each crisis provider translates these guidelines into clinical practice instructions for staff that are continually monitored and incorporated into human resource policies and supervision. Specific competencies should include:

- **Triage protocols:** Clear triage protocols and triage timelines to determine who needs help most urgently.
- **Clinical flow metrics:** Objective timeliness and goals for clinical flow metrics that are established, measured and reported, such as time from referral to admission, time from entering the door to assessment, length of stay, etc. (See Balfour et al., 2016, for a description of application of quality improvement methods to clinical flow metrics in a crisis center).
- **Definition of overlapping staff roles and teamwork:** Well-defined staff roles and responsibilities so all staff know how and when to cross cover and ensure all required tasks are completed without duplicate work.
- **Documentation facilitation:** Documentation templates designed to reduce redundancy to prevent both inefficient use of staff time and client frustration.
- **Continuous improvement of flow:** Ongoing quality improvement methods employed to continuously reduce waste and improve throughput via the following:
 - » Empowering the whole team in identification of bottlenecks and barriers to service flow.
 - » Engaging direct-care staff in developing solutions to identified problems.
 - » Sharing performance data with staff to assess performance and identify targets for continuous improvement.

POST-CRISIS CONTINUITY OF CARE/CRITICAL TIME INTERVENTION

An individual's crisis needs do not abruptly end at the end of the acute crisis assessment and intervention. On the contrary, the transition from crisis care to outpatient treatment as usual care is a critical time during which the individual is at high risk for recurring crisis and/or readmission. Individuals in crisis frequently no longer need hospitalization or crisis residential services, but still be unable to engage in routine outpatient services, especially when there was no previous engagement with those services prior to the crisis. Extended crisis intervention and stabilization may be needed for individuals and their families prior to successful transition to continuing community care. It is important for the crisis continuum to include services that provide continued stabilization and warm handoff to community-based care and for staff to have basic competencies in providing continuing home-based and office-based crisis intervention, including such best practices as critical time intervention and wraparound services for families.

Measurable criteria for an ideal system

The accountable entity ensures that staff have training and competency in clinical practice guidelines for ensuring continuity of crisis intervention, including:

- **Continuity:** Engagement in continuing relationships with individuals and families prior to and during the transition from acute crisis, residential or inpatient services and throughout the process of connecting with continuing care services, rather than practicing on the assumption that the crisis program's involvement ends when a referral appointment for outpatient services has been made. Peer bridgers are particularly useful in this role, but all staff can share responsibility for successful transitions.
- **Transition support:** Provision of care and support to people transitioning out of crisis (e.g., peer support, case management, psychiatric follow-up) until the client is successfully transitioned to community-based outpatient care.
- **Critical time intervention:** Utilization of evidence-based protocols such as critical time intervention throughout the crisis transition period, which may range from two weeks to two or three months.
- **Home-based Services:** Provision of more intensive and home-based services multiple times per week for individuals and families who may need that level of care during the post-crisis transition period.
- **Assistance with administrative barriers:** Assistance through the crisis transition in addressing social and administrative barriers to continuing care (e.g., troubleshooting problems filling prescriptions, help with benefits, housing, transportation).
- **Warm handoff procedures:** Specific care coordination and warm handoff procedures for success in receiving both behavioral health and primary health continuity of care.
- **Follow-up calls:** Reminder and follow-up phone calls to ensure that clients make it to their follow-up appointments, as well as follow-up calls to receiving providers to make sure that successful transitions occur.

PRE- AND POST-CRISIS PLANNING WITH COMMUNITY PROVIDERS

A comprehensive behavioral health crisis system with a complete continuum of services provides a range of best practice crisis intervention services to meet the needs of the community. In such a system, crisis is recognized as more than a single encounter with psychiatric emergency services. Individuals and families in crisis commonly experience early signs of emerging crisis before there may be a need for an emergency encounter and pre-crisis planning and response in these situations may mitigate the need for more expensive and emergent crisis response. Individuals and families in crisis commonly require continuing crisis services over time, whether or not they have an emergency intervention, hospitalization or admission to a crisis residential program. Provision for best practice post-crisis intervention services mitigates the likelihood of recurrence of the emergent situation. For both pre- and post-crisis intervention, crisis systems work in partnership with community behavioral health providers to develop a seamless continuum of services from pre-crisis through crisis to post-crisis.

Measurable Criteria for an Ideal System:

- The accountable entity responsible for oversight, contracting and quality monitoring implements the following clinical practice guidelines for pre- and post-crisis collaboration with community behavioral health providers:
 - » **Collaboration with community providers:** The crisis system components are expected to collaborate with community behavioral health providers in the community. Regular meetings are organized by the crisis coordinator in the community to ensure this occurs. Both crisis system providers and community providers are accountable for metrics and indicators regarding the following pre- and post-crisis practices.
 - » **Pre-crisis planning:** Community behavioral health providers routinely develop and document meaningful crisis plans in partnership with individuals and families in service. These crisis plans identify early warning signs of impending crisis and identify recommended strategies for early response by both the community provider and the crisis system. Crisis plans can be accessed by the crisis system when clients present in an emergency and can be used for collaborative planning between the crisis provider, community provider and individual/family to respond to the crisis most effectively.
 - » **Alerts:** There is an established mechanism for clients at risk who are in a pre-crisis situation to alert the crisis system. The crisis system has procedures for working proactively and collaboratively with the community provider to develop an effective early response to the crisis and to identify the best possible response should the crisis proceed to warrant emergency intervention.
 - » **Post-crisis planning:** In the same way that the crisis system responds proactively to community providers, community providers respond to the crisis system. Community providers have mechanisms and incentives for providing rapid follow-up appointments, including outreach when indicated, for individuals or families transitioning from crisis services of any type, including hospitalization. Crisis providers and community providers are held accountable for QI performance metrics related to this.
 - » **Critical time intervention:** Both crisis providers and community providers, including assertive community treatment (ACT) teams, have capacity to provide intensive crisis intervention services, such as evidence based critical time intervention. Procedures are established that clearly delineate the responsibility for providing these services. Usually, the crisis service will provide continuing intervention for individuals that are not yet engaged with a community provider for ongoing care and will provide that service until engagement occurs. Community providers will in turn usually deliver intensive crisis intervention for existing clients.

**Remember
that there is pre-
crisis planning, crisis
management and post-
crisis recovery. We need
to provide continuity
across all stages of
crisis.**

COORDINATION OF CARE WITH COMMUNITY SYSTEMS

Individuals and families in behavioral health crisis frequently are involved with human service systems in the community outside the behavioral health system. Crisis assessment, intervention and resolution require close coordination and collaboration with these partner systems. For this reason, all crisis providers and programs need to articulate clear clinical practice guidelines and competencies for staff to coordinate care with each partner system and the specific programs and providers within those systems with whom they will likely come in contact on shared cases.

Measurable Criteria for an Ideal System

- The accountable entity responsible for oversight, contracting and quality monitoring expects all contracted crisis providers to document and implement the following clinical practice guidelines for program and staff collaboration with community human service systems through training, supervision and human resource evaluation (Collaborative human service systems include the following: law enforcement, criminal justice [including specialty courts, probation and parole], housing/homeless services, child protection, elder protection, aging/disability, school systems, visiting nurses, intellectual/developmental disability, brain injury services, nursing homes, rehabilitation centers and other long-term care, social services [e.g., benefits, refugee services], veteran's services, office of conservator/public guardianship, domestic violence and vocational rehabilitation):
 - » **Communication with community human service systems and providers:** All programs and staff have expectations for identifying and documenting any involved human service systems and providers during the crisis assessment and documenting efforts to obtain releases of information to contact them. All programs and staff are trained to be aware of indications where communication with a collaborating provider may be permissible without a release because of the nature of the emergency situation (e.g., a person is brought in from a homeless shelter with an acute psychosis and is unable to provide necessary history that might explain what contributed to the acute psychosis). There are established timelines and guidelines for contacting those collaterals, documenting information provided and continuing to attempt to get any withheld releases during the crisis episode, when necessary.
 - » **Collaboration with community human service systems and providers:** All crisis providers and their staff have guidelines for treating collaborative community systems as partners and priority customers in the community. During the crisis, it is important to understand the needs of the involved system as well as the client/family and to develop a plan that is supportive to all parties to the extent possible. Staff have guidelines for how to access assistance from supervisors when there is a potential dispute with collaborating systems at any time. Crisis intervention and dispositions acknowledge the need for continuing support to the involved system and make provisions for continued consultation and access to ongoing help when indicated.
 - » **Guidelines for mandated reporting:** Crisis staff need specific training, instructions and guidelines (with the assistance of supervisors) for how to address situations where there may be a requirement for mandated reporting.
 - » **Guidelines for specific challenges:** It is common in crisis situations for clients to present in crises that involve behaviors or circumstances that may get them in trouble with other involved systems (e.g., probation, child welfare, housing) because they have violated rules or expectations. All staff and programs have guidelines, including recommended communications and scripts when needed, for how to maximize coordination of care without jeopardizing the client's status and for attempting to find positive ways for the client to communicate what happened in order to develop a plan that will provide additional support rather than punishment.
 - » **Post-crisis coordination:** The crisis system providers and staff have guidelines for continuing coordination with involved systems after the crisis, including proactive outreach and engagement, follow-up calls and debriefing meetings to help prevent recurrence of the crisis. For partner systems that have a particularly challenging client, there are mechanisms for setting up one or more continuing care case conferences to help the partner system address troubling behaviors and to facilitate early access to assistance.

EPILOGUE

A comprehensive behavioral health crisis system with a complete continuum of services is an essential element of safety-net health and human services for any community; the same as is true for police, fire and emergency medical services. This report has outlined the measurable criteria for design and implementation of an ideal behavioral health crisis system for any community. These criteria can be used by states, counties, managed care organizations and other accountable entities to evaluate their current crisis systems, determine opportunities for improvement and steadily make progress toward creating the type of behavioral health crisis system that would best serve their communities.

But an ideal crisis system means much more than adhering to a list of criteria. An ideal crisis system is most meaningful when we consider what difference it can make in the experiences and outcomes of real people in need, as well as the difference it can make in how community resources are utilized. Let us consider the experience of [Mr. Y](#), the young man with mental illness who was eating bananas in the convenience store without paying for them, whose tragic experience of arrest and incarceration was described in the introductory section of this report.

What would have been different for Mr. Y if he had been fortunate enough to live in a community with an ideal crisis system such as the one described here?

Let us consider what might have happened differently, step-by-step, from the moment that the store owner called 911. For the moment, we will not consider all the ways a community with an ideal crisis system might have intervened earlier when he was picked up for vagrancy or during other previous encounters with law enforcement, emergency rooms or homeless services.

In an ideal crisis system, the 911 call center immediately triages the call for whether the issue involves someone with a mental health crisis and determining that this is the case. If there is no immediate risk of violence, the dispatcher notifies the CIT-trained officers to go to the scene while also contacting the mobile crisis team. When the officers arrive, they immediately notice how terrified – and hungry – the young man is acting and they behave in ways to help him not feel further threatened. This is further supported by the mobile crisis team workers.

Mr. Y tells the officers that he has no place to live and he eats bananas because other foods are “dangerous” and possibly “poisonous,” but bananas are protected by the peel. The officers take time to persuade the young man that they do not want to arrest him but would like the crisis workers to help him find a place to stay temporarily where he can find some people to help him and food that is safe for him. They let him know that they appreciate how hard it has been for him in the street and they want him to have a chance to get back on his feet.

After some time, Mr. Y agrees to voluntarily have the mobile crisis team bring him to the crisis center. The store owner is told that the crisis center can pay for the bananas if he wants, but he says that he is happy that the young man is getting help. At the crisis center, he is brought into the Living Room area, where he is met by a peer counselor, who introduces him to the rest of the team and gets him a banana to eat. The peer explains that he also used to be homeless and scared, but eventually he found people he could trust to help him, he got some good medical treatment to get healthy and now he is working to help others. Mr. Y is intrigued, but still skeptical. The peer works with him to let him know what other safe foods they might be able to find in addition to bananas and eventually puts together a decent meal.

The whole team is very welcoming and hopeful to Mr. Y, and accepting of the fact that he has been using marijuana to help himself relax on the street. Mr. Y is appreciative of the fact that no one seems to be trying to force him to do anything and he is grateful for their efforts to find him safe food and not challenge him on his fears of being poisoned or the fact that he is in possession of marijuana. They help him get acclimated to the crisis center and start to find out more of his story, as well as inquiring about whether he has any family who might be worried about him.

After a while, Mr. Y lets them know how to contact his grandmother. They find out the following story from her:

His grandmother was greatly relieved to hear about Mr. Y from the crisis center. She reported that even while living on the streets he usually came to her home about twice a week to ask for money and eat a banana or other food that he believed was safe that day. She explained that she was terrified he had been killed on the streets and had been calling local hospitals and even the morgue to try to locate him. She revealed that he had been raised primarily by her in what she described as a “good Christian home” and explained that his mother had “problems of her own,” had been diagnosed with schizophrenia, (although his grandmother thought it was probably laziness) and had “run off” by the time Mr. Y was four or five years old, not to be heard from again.

His grandmother reported that Mr. Y was a nice boy who was helpful to her and gave her no trouble as a small child. She said he had been treated for asthma since he was a child but was otherwise healthy. However, he had learning and behavioral problems in his elementary school years and repeated the 4th and 7th grades. Reading was particularly difficult for him, and he would “act up” in class. By the 9th grade, he was missing a lot of school, but was never in “special classes.”

His grandmother noted he was “hanging out with a bad crowd” and suspected he might be using drugs. She believed he started using marijuana regularly at that time and continued to do so whenever he had access to it, stating, “I know how that nasty stuff smells.” He dropped out of school in the 11th grade. He was employed for several years in an uncle’s car wash business and initially did well, moving into a small apartment which he shared with someone his uncle knew. However, his attendance and his behavior there had been erratic over the previous year or so, and finally his uncle had to let him go.

He tried to get other jobs – at fast food restaurants and Walmart – but was never successful. His roommate kicked him out for not paying the rent and he could no longer stay with his grandmother as she had moved into a senior apartment. She said that Mr. Y. was “not himself” and that although he had never been aggressive towards her, he was not taking care of himself, declined to shower or wash his clothes and would sometimes “talk out of his head” when he visited her. He stayed at the shelter until he had used up his 45 day per year maximum and had been out on the streets since. At the shelter, he was withdrawn and seemed to be mumbling to himself at times. He had been living on the street for only a few weeks prior to the incident at the convenience store.

The grandmother spoke to Mr. Y on the phone and told him she was very happy that he was somewhere safe and said that if he stayed there a few days and got some help, she would come visit and bring him some money. He seemed pleased with that.

After the crisis center, with help from the peer worker, performed a medical screening and a brief psychiatric examination, it was determined that Mr. Y was suffering from a psychotic illness but had no acute medical needs. He was currently clearly paranoid and attending to voices but was not agitated as long he was not challenged and he seemed to be feeling safer in the crisis center.

Mr. Y was offered the opportunity to stay in the crisis stabilization unit at the crisis center for a few days until next steps for him could be figured out. With the support of the peer, he agreed. He was offered medication in the crisis center but was too frightened to accept it. The peer suggested he think about it while he was in the crisis unit and shared his own experiences with finding medication helpful. Mr. Y agreed to think about it.

After two days of support and food in the crisis stabilization unit, Mr. Y began to accept small doses of medication. He was very nervous at first, but found that he felt less frightened and was able to eat more foods. He was transitioned to a crisis residential program where he met new staff, including peers, who continued to help him feel welcome and safe.

The crisis residential program was able to link Mr. Y with community services through its relationship with emergency housing programs in the community. They involved his grandmother in ongoing service planning as well, and her input helped him to trust the process. Further, the crisis collaborative in the community built a strong relationship with housing and homeless services because the mobile crisis team provided outreach on request to all the housing programs and, in turn, housing services could arrange emergency placement in shelter plus care for individuals coming out of crisis. Under the guidance of the crisis coordinator for the whole community, the crisis residential unit was able to coordinate and prioritize Mr. Y for attachment to a mobile intensive crisis intervention team that could work with him for several months to support him in his temporary housing and eventually transition him to ACT services.

Mr. Y was encouraged not to use marijuana, but he only agreed not to use it inside the shelter plus care location and the crisis team continued to work with him on how to make better decisions about marijuana use in service of his recovery goals. Mr. Y was also able to accept a medical examination and had medication prescribed for his asthma.

After a period of weeks in the crisis continuum, Mr. Y was much less psychotic, but still quite ill, and developed a level of trust with an array of community providers. He had a temporary place to live with community support, reconnected with his grandmother and he had NOT been arrested and had NOT been hospitalized.

More importantly, he had hope. He said to his team: "I am beginning to trust you people. Maybe someday I can help other people just like you do."

This is the value of the ideal crisis system!

We hope your community finds these materials useful in improving behavioral health crisis services so individuals and families in crisis with serious behavioral health conditions can more easily receive the help they need - and deserve - wherever, whenever and for however long they need it.

RECOMMENDATIONS FOR ACTION

USING THIS REPORT TO IMPROVE COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEMS: 10 STEPS

This report provides a wealth of detailed information, but the information is only worthwhile to the extent that it provides a roadmap to change. **The intention of this report is to provide guidance for action both at the community level and at the system leadership and advocacy level.** For this reason, we include specific recommendations for action steps that can be taken, using this report to advance the development of ideal behavioral health crisis systems at the state and local level. In addition, we are providing a Behavioral Health Crisis System Report Card that incorporates the essential elements and measurable indicators in this report and can be used to evaluate the current baseline in any community and measure progress over time (see [Appendix for the Report Card](#)).

We recommend that communities and systems do not hesitate to ask for help (e.g., consultation and technical assistance) at any step, in order to facilitate progress. The journey toward developing ideal crisis systems will be a new venture for most communities, and even where the community – or state system – may identify other systems to emulate, outside facilitation may be needed to help the community or state come to consensus on the best path to follow.

10 Steps For Communities

In order to make this information optimally accessible and useful for communities that wish to improve their behavioral health crisis system, the following 10 steps are a recommended approach:

- 1. Identify and convene community partners:** Identify community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within your community and develop a voluntary ad-hoc group for initial discussions. Remember to engage stakeholders and funding partners that represent the whole community, not just those who are indigent or funded by Medicaid. Behavioral health crisis systems are an essential community service for everyone.
- 2. Read and process relevant sections of the report:** Share the report with your stakeholders and ask them all to read the [Introduction](#). Then, have the stakeholders identify aspects of the report most relevant to them over a few sessions and have them present sections of the report to the group as a whole.
- 3. Develop a local vision:** Have the stakeholders develop an initial vision for an ideal behavioral health crisis system in your community. Do not be discouraged if you are far from that goal right now. Every community with an improved behavioral health crisis system had to start at the beginning and make progress over time.
- 4. Disseminate the vision:** Write down this vision with some initial action steps and actively share it with others.
- 5. Accountable entity:** Identify one or more entities that may serve as the accountable entity within your community. It could be county leadership, city leadership, a managed care organization or an existing community collaborative addressing jail diversion or suicide prevention.
- 6. Planning and implementation team:** Identify a team of people to meet regularly on an ongoing basis to begin to plan the ideal behavioral health crisis system. This could be a new group under the accountable entity or a component of an existing collaboration. Do not hesitate to seek consultation or outside facilitation if needed at this step or any other step along the way.

7. **Baseline self-assessment:** Using the measurable criteria in the report, rating each item from 1-5, have the planning team rate the current status of your behavioral health crisis system. No matter what you find, give yourselves a round of applause. See the [Report Card](#) in the Appendix to help you organize this step. Use the Report Card as well to track your progress over time.
8. **Early wins:** Identify 3-5 improvement opportunities that the team can address early on, within available capacity and resources. Develop and implement a collaborative plan to begin to make progress in small steps on each item. Give yourselves another round of applause for making progress.
9. **Data and financing:** At the same time, members of the planning team begin to gather clinical and cost data on current system performance and identify potential local, state and federal funding opportunities. Do not worry that your initial data are not perfect or that you do not find all the funding you will eventually need. Every community makes progress in steps, with slow improvement of data and using initial seed funds to attract further funding as the vision of the crisis system takes shape.
10. **Comprehensive plan:** Keep meeting and working together. Over a period of time, using the data you have gathered with consultation (if needed), use this report for guidance to develop a comprehensive, collaborative plan for the design of an ideal behavioral health crisis system for your community. Identify a step-by-step approach for multiple partners to begin to work together to make progress over a period of years.

10 Steps For System Leaders And Advocates

What can system leaders at the state and regional/county level do that can facilitate the development of ideal community behavioral health crisis systems? What can advocacy organizations do to encourage state leaders, legislators, funders and policymakers to support progress at all levels? This report provides detailed guidance for how to address these issues at many levels. Here are 10 steps that can help focus and prioritize these efforts:

1. **Establish, articulate and communicate a systemwide vision of ideal behavioral health crisis systems for all:** The core of this vision is that behavioral health crisis systems are an essential community service that should be designed to be at least on par with the responsiveness of emergency and urgent medical care: Every person gets the right response every time. Incorporate core values in the vision: welcoming, hopeful, trauma-informed, recovery-affirming, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.
2. **Develop an implementation plan:** As part of the vision, articulate a 10-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress. Remember that implementing universal 911 response systems took a decade or more.
3. **Disseminate this report as a guiding document:** Highlight the essential elements of the system and encourage the development of a system wide conversation to adopt the vision. Essential elements that might be highlighted for purposes of conversation include local accountability (accountable entities), all-payer financing, system performance metrics, crisis continuum (call center, mobile crisis, urgent care, crisis center, various types of crisis residential programs, intensive community crisis intervention), response to all ages and population groups, clinical/medical leadership, peer support and best practices for crisis intervention.
4. **Perform baseline self-assessment:** Encourage communities to come together to perform a systemwide baseline assessment of the current behavioral health crisis system, using the enclosed Report Card. Use the report card to track progress across the system over the course of the 10-year plan.
5. **Identify performance metrics:** Using this report, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.
6. **Award planning and implementation grants:** Develop a process to award community crisis collaboratives grants, possibly matching grants, for planning and implementation. This can begin with a few pilot communities and slowly be disseminated to the whole system. Continually measure progress in all communities across the system, rewarding small steps forward over time.

7. **Create a framework for identifying and empowering accountable entities:** Identify mechanisms for regional and local accountability for crisis system performance. These could be based on regional intermediary system structures and/or on existing templates for delineating community accountability for EMS.
8. **Require all-funder participation:** All private and public behavioral health funders should be required to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.
9. **Require coverage of, and adequate rates for all elements of the crisis continuum:** Identify clear definitions of the various components and services in the behavioral health crisis continuum and require that Medicaid and other funders reimburse for those services (e.g., urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention) at rates that at least cover costs. Note that medical urgent care and emergency services do not operate at a loss; neither should commensurate behavioral health crisis services.
10. **Incorporate best practice standards into system regulations:** This report provides guidance for those regulations, addressing items such as no force first, advance directives, medical screening, integrated response to individuals with co-occurring mental health/SUD and behavioral health/IDD, and so on.

CONCLUSION

This report provides a detailed description of the essential elements, measurable indicators and clinical best practices for an ideal behavioral health crisis system. The goal is to create a vision and blueprint for progress for states, counties and communities across the nation to move from our current state, where high quality behavioral health crisis services and systems are characterized mostly by their absence, to an aspirational vision for where we should be as a nation.

Keeping the end in mind, it is helpful here to restate the vision.

THE VISION

- An excellent behavioral health crisis system is an essential community service, just like police, fire and emergency medical services. As such, every community should expect a highly effective behavioral health crisis response system to meet the needs of its population, just as is expected for the other essential community services.
- A behavioral health crisis system is more than a single crisis program. It is an organized set of structures, processes and services that are in place to meet all types of urgent and emergent behavioral health crisis needs in a defined population or community, effectively and efficiently.
- While no system will ever likely reach the ideal, the aspirational goal is, “Every person receives the right service in the right place, every time.”

Using This Report To Improve Community Behavioral Health Crisis Systems: 10 Steps

The intent of this report is to provide guidance for action both at the community level and at the system leadership and advocacy level. It includes specific recommendations for action steps that can be taken to advance the development of ideal behavioral health crisis systems at the state and local level. The Behavioral Health Crisis System Report Card in the Appendix incorporates the essential elements and measurable indicators in this report and can be used to evaluate the current baseline in any community and measure progress over time. We recommend further that communities - and systems - do not hesitate to ask for help (e.g., consultation, technical assistance) at any step, in order to facilitate progress. The journey toward developing ideal crisis systems will be a new venture for most communities and outside facilitation may be needed to help the community or state come to consensus on the best path to reach their goals.

10 Steps For Communities

In order to make this information optimally accessible and useful for communities that wish to improve their behavioral health crisis system, the following 10 steps are a recommended approach:

- 1. Identify and convene community partners:** Identify community stakeholders and potential partners who are interested in, or have a stake in, behavioral health crisis services within your community and develop a voluntary ad-hoc group for initial discussions. Remember to engage stakeholders and funding partners that represent the whole community, not just those who are indigent or funded by Medicaid. Behavioral health crisis systems are an essential community service for everyone.
- 2. Read and process relevant sections of the report:** Share this report with those stakeholders and ask them to read the Executive Summary and the Introduction. Have the stakeholders identify aspects of the report most relevant to them over a few sessions and have them present sections of the report to the group as a whole.
- 3. Develop a local vision:** Have the stakeholders develop an initial vision for an ideal behavioral health crisis system in your community. Do not be discouraged if you are far from that goal right now. Every community with an improved behavioral health crisis system had to start at the beginning and make progress over time.
- 4. Disseminate the vision:** Write down this vision with some initial action steps and actively share it with others.
- 5. Accountable entity:** Identify one or more entities that may serve as the accountable entity within your community. It could be county leadership, city leadership, a managed care organization or an existing community collaborative addressing jail diversion or suicide prevention.
- 6. Planning and implementation team:** Identify a team of people to meet regularly on an ongoing basis to begin to plan the ideal behavioral health crisis system. This could be a new group under the accountable entity or a component of an existing collaboration. Do not hesitate to seek consultation or outside facilitation if needed at this step or any point along the way.
- 7. Baseline self-assessment:** Using the measurable criteria in the report, rating each item from 1-5, have the planning team rate the current status of your behavioral health crisis system. No matter what you find, give yourselves a round of applause. See the [Report Card](#) in the Appendix to help organize this step. Use the Report Card as well to track your progress over time.
- 8. Early wins:** Identify three to five improvement opportunities that the team can address early on, within available capacity and resources. Develop and implement a collaborative plan to begin to make progress in small steps on each item. Give yourselves another round of applause for making progress.
- 9. Data and financing:** At the same time, members of the planning team begin to gather clinical and cost data on current system performance and identify potential local, state and federal funding opportunities. Do not worry that your initial data are not perfect or if you do not find all the funding you will eventually need. Every community makes progress in steps with slow improvement in data using initial seed funds to attract further funding as the vision of the crisis system takes shape.
- 10. Comprehensive plan:** Keep meeting and working together. Over a period of time, using the data you have gathered, with consultation if needed, use this report for guidance to develop a comprehensive, collaborative plan for the design of an ideal behavioral health crisis system for your community. Identify a step-by-step approach so multiple partners can begin to work together to make progress over a period of years.

10 Steps For System Leaders And Advocates

What can system leaders at the state and regional/county level do to facilitate development of ideal community behavioral health crisis systems? What can advocacy organizations do to encourage state leaders, legislators, funders and policymakers to support progress at all levels? This report provides detailed guidance for how to address these issues at many levels. Here are 10 steps that can help to focus and prioritize these efforts:

- 1. Establish, articulate and communicate a systemwide vision of ideal behavioral health crisis systems for all:** The core of this vision is that behavioral health crisis systems are an essential community service that should be at least on par with the responsiveness of emergency and urgent medical care - every person gets the right response every time. Incorporate core values in the vision: welcoming, hopeful, trauma-informed, recovery-oriented, integrated and designed with the goal of eliminating disparities in response for those who are most vulnerable and marginalized.
- 2. Develop an implementation plan:** As part of the vision, articulate a 10-year plan for working collaboratively with all system intermediaries, funders and communities to make step-by-step progress toward achieving universal progress. Remember that implementing universal 911 response systems took a decade or more.
- 3. Disseminate this report as a guiding document:** Highlight the essential elements of the system and encourage development of a system-wide conversation to adopt the vision. Essential elements that might be highlighted for purposes of conversation include local accountability (accountable entities), all-payer financing, system performance metrics, crisis continuum (e.g., call center, mobile crisis, urgent care, crisis center, various types of crisis residential programs, intensive community crisis intervention), response to all ages and population groups, clinical/medical leadership, peer support and best practices for crisis intervention.
- 4. Perform baseline self-assessment:** Encourage communities to come together to perform a systemwide baseline assessment of the current behavioral health crisis system, using the Report Card to track progress across the system over the course of the 10-year plan.
- 5. Identify performance metrics:** Using this report, convene system stakeholders to identify the most important quality metrics for behavioral health crisis system performance that all system intermediaries should be accountable to achieve.
- 6. Award planning and implementation grants:** Develop a process to award community crisis collaboratives grants (possibly matching grants) for planning and implementation. This can begin with a few pilot communities, then slowly disseminated to the whole system. Continually measure progress in all communities across the system, rewarding small steps forward over time.
- 7. Create a framework for identifying and empowering accountable entities:** Identify mechanisms for regional and local accountability for crisis system performance. These could be based on regional intermediary system structures and/or on existing templates for delineating community accountability for EMS.
- 8. Require all-funder participation:** Require all private and public behavioral health funders to contribute appropriately to the funding of the community behavioral health crisis system that serves the people covered by or affected by their funding. This includes all types of insurance plans.
- 9. Require coverage of and adequate rates for all elements of the crisis continuum:** Identify clear definitions of the various components and services in the behavioral health crisis continuum and require that Medicaid and other funders reimburse for those services (e.g. urgent care centers, crisis centers, residential crisis services, mobile crisis, intensive community crisis intervention) at rates that at least cover costs. Medical urgent care and emergency services do not operate at a loss; neither should commensurate behavioral health crisis services.
- 10. Incorporate best practice standards into system regulations:** This report provides guidance for regulations that address items such as no force first, advance directives, medical screening, integrated response to individuals with co-occurring mental health/substance use disorder and behavioral health/intellectual and developmental disabilities and so on.



ACHIEVING THE VISION

For communities across the U.S. to transition from minimal behavioral health crisis services toward an ideal behavioral health crisis system, a blueprint for doing so must be available. This report is an effort to provide that blueprint. It enumerates all aspects of an ideal behavioral health crisis system with measurable performance criteria that communities can use to assess their progress in an ongoing manner through a continuous quality improvement process.

The report provides specific action steps, a Report Card, concrete guidance for communities to use to evaluate their current behavioral health crisis capacity and a strategy toward implementing structures, services and processes that moves towards an ideal crisis system.

For communities that believe this is a daunting task, be heartened by the fact that once upon a time the U.S. did not have a universal 911 and EMS system. It took 10 years or more to build it, but now we take it for granted. Individuals and families in behavioral health crisis deserve no less. The time to make progress is now, and the tools for making progress are in your hands.

Thank you for your interest.

APPENDIX:

Table 5: Examples of Progress:

1. Stories of progress from current crisis systems: Pima County (Tucson), Arizona; Johnson County (Iowa City), Iowa
2. State legislation defining a crisis system: Iowa
3. National efforts to increase resources and expectations for community crisis systems
4. International models: The example of Trieste
5. High Level Collaboration to Establish a Crisis Continuum for Adults Healthy Minds Policy Initiative - Tulsa, Oklahoma
6. Expansion of Access to Mobile Crisis Teams in New York State

The Tucson Model: A Collaborative Approach to Behavioral Health Crisis and Public Safety: Margaret Balfour, MD

Pima County, Arizona, has developed a robust crisis system over the past 20 years, beginning with CIT training for law enforcement in 2001. The evolution of the crisis system has been a collaboration between many diverse stakeholders, with the County and Regional Behavioral Health Authority acting as the primary convener.

With a population of just over one million, Pima County is one of the oldest continually inhabited counties in the U.S., and one of the largest at 9,187 square miles. About half of the population resides in Tucson, with the remainder living in small towns, Native nations and rural areas. The population is 51.2% White non-Hispanic, 37.8% Hispanic, 4.4% Native American, 4.3% Black and 3.3% Asian.

While it was the last state to implement Medicaid, Arizona was the first to finance Medicaid via a statewide managed care waiver. The state is divided into geographical service areas, and a Regional Behavioral Health Authority (RBHA) is selected via a competitive bid process to fund and oversee a variety of behavioral health services, including crisis services. The RBHA receives funding via Medicaid, the Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, and other state and county funds, and it uses this braided funding stream to contract with various provider agencies to deliver crisis services to anyone in need. By serving as a single point of accountability, the RBHA is able to ensure that its subcontracted providers function as a coordinated system aligned toward the common goal of achieving stabilization in the least-restrictive setting that can safely meet the individual's needs. In this model, clinical and financial incentives are closely aligned, as the least restrictive levels of care also tend to be less costly. The RBHA during much of the early development of the crisis system was Community Partnership of Southern Arizona (CPSA), a non-profit owned by multiple service providers. In 2015, the RBHA contract was awarded to Cenpatco Integrated Care, now known as Arizona Complete Health, a subsidiary of Centene Corporation.

Pima County also plays an important role as a leader and convener. As the operator of the jail and a primary funder of the safety net hospital emergency department, the County has long had an interest in improving care for individuals with behavioral health needs. The County created a dedicated Behavioral Health Department in 2010 to oversee its role in civil commitment evaluations and jail programs. As part of the MacArthur Foundation Safety + Justice Challenge, Pima County has developed data sharing agreements which it uses to identify opportunities for community-based alternatives to incarceration and collaborates closely with the RBHA, law enforcement and various service providers on a variety of self and grant funded programs.

By the mid-2000s, Pima County was serviced by a growing crisis system comprised of a crisis line, crisis mobile teams and a walk-in crisis clinic. An increasing awareness of the prevalence of mental illness in the Pima County jail, compounded by a series of tragic events related to untreated mental illness, created the momentum needed to mobilize the resources needed for a crisis center to service the needs of law enforcement and the community. Leaders from Pima County and CPSA (the RBHA at the time) collaborated on a bond to build a crisis center to serve as an alternative to arrest and emergency department use. The bond was passed in 2006, and the facility was completed in 2011. A few months prior to the Crisis Response Center (CRC) opening, Jared Lee Loughner opened fire at a community forum held by U.S. Representative Gabrielle Giffords, killing six and wounding 14. This prompted leaders at the Pima County Sheriff's Department and the Tucson Police Department to develop approaches that went beyond CIT. Both agencies created dedicated Mental Health Support Teams that seek to prevent crisis by identifying individuals at risk and connecting them to mental health services. Law enforcement and mental health collaborations have continued to grow, resulting in multiple specialty and co-responder teams and a robust training program for jurisdictions across the entire southern Arizona region.

The CRC is the centerpiece of the crisis system, serving approximately 12,000 adults and 2,200 children annually. In the year following its implementation, the percentage of Pima County Jail inmates with serious mental illness decreased by half, and the number of behavioral health visits to the adjacent emergency department decreased from 750 per month to 150. The facility is owned by Pima County, licensed to Banner-University of Arizona Medical Center and managed by Connections Health Solutions, a private behavioral health provider. Services are primarily funded by the RBHA.

Services for adults and children are provided in separate areas of the facility and include 24/7 walk-in urgent care and 23-hour observation for 34 adults and 10 youth. Most patients arrive directly from the field via law enforcement, with the remainder arriving via transfer from outside EDs, mobile crisis teams or walk-in. Reasons for presentation include danger to self/other, acute agitation, psychosis, intoxication and withdrawal. In an ED, these patients would board waiting for an inpatient bed, whereas at the CRC, 60-70% return back to the community without the need for hospitalization via rapid assessment, early intervention and proactive discharge planning. Care is provided by an interdisciplinary team of psychiatric providers, social workers, nurses, behavioral health technicians and peers. The open design allows for continuous visualization to ensure safety and provides the opportunity for interpersonal interaction in a therapeutic milieu. For those who need it, a 15-bed adult short-term inpatient unit provides 3-5 days of continued stabilization.

Law enforcement uses the CRC as their central behavioral health receiving facility, dropping off both voluntary and involuntary patients via a secure gated sally port with a < 10-minute turnaround time for adults and 20 minutes for children. There are no exclusionary criteria for behavioral acuity, and officers are never turned away. Highly agitated or violent patients are cared for without the use of security by trained behavioral health technicians, with seclusion/restraint rates often lower than the national average for inpatient psychiatric facilities.

The CRC is part of a unique campus that has received national recognition for both its architectural design and multi-agency collaborative clinical model. In addition to the crisis services described above, the CRC houses the crisis call center for southern Arizona, which serves an "air traffic control" function, dispatching over a dozen mobile crisis teams throughout Pima County. A covered breezeway connects the CRC to the Banner emergency department and 66-bed inpatient psychiatric hospital, which contains a courtroom that is used for civil commitment hearings and some criminal matters. The CRC also contains space for co-located community partners, such as behavioral health clinics that can immediately enroll patients, and a peer run program that provides post-crisis wraparound services.

The governance and financing structure in southern Arizona has supported the continued development and oversight of the crisis system. The result is a robust continuum of crisis services, operated by a wide variety of provider agencies. A culture of "no wrong door" means that agencies work together to create a system in which anyone in crisis can get their needs met wherever they present. Regular stakeholder meetings, convened by the RBHA and the County, allow for ongoing analysis of data trends, problem solving, and continuous improvement of the system.

A community case study: Building a crisis center from the ground up. Johnson County (Iowa City), Iowa
Michael Flaum, MD

Iowa City is a university town in eastern Iowa. Home to the largest of Iowa's three state universities (the University of Iowa), it has a population of roughly 100-175K depending upon how you count (i.e., students account for 30K, surrounding towns another 30-40K). The University is the major employer, including one of largest university hospitals in the country - the University of Iowa Hospitals and Clinics (UIHC).

It is a generally a service-rich area relative to most of the rest of the state, and that is true of behavioral health services. UIHC has over 75 psychiatric inpatient beds across five units (all of which are locked). It also has a relatively large department of psychiatry, accounting for a sizable proportion of the overall number of psychiatrists in the state (Iowa ranks in the bottom five states nationally in terms of psychiatrists per capita).

The most common "front door" for accessing anything other than routine psychiatric services has been the UIHC emergency room. It is a top-tier ER that we are lucky to have in our community. But for behavioral health resources, it leaves much to be desired. Up until recently, it had essentially no dedicated behavioral health staff or resources, other than two "psych rooms" where patients presenting with behavioral health complaints would wait to see the "psych on-call." That person, as is the case in many academic medical centers, is usually a junior psychiatry resident. And that person's job has traditionally been one of triage - i.e., to make the following a dichotomous decision: Does this person need admission? If yes, (and if there is a bed available) they are admitted, and then it is up to the inpatient team to determine what is going on and what to do about it. If yes, and there is no bed available, then a system is in place to find a bed somewhere else in the state and transfer them there (with transport provided by law enforcement). If the client does not want to be admitted, there is a very low bar for a 48-hour emergency hold - the resident simply calls the magistrate on call, indicates why they feel the person may be a danger, and that is usually all it takes. Not surprisingly, given the resident's junior status and relative lack of experience, they tend to err on the side of caution, and so tend to admit if there is any real question. And typically, if the person could go back to where they came from without the situation that brought them in likely to escalate, then they probably wouldn't have come to the ER in the first place. So, it is not surprising that our rate of admission had been on the order of 60% or more for all those who presented to the ER with a behavioral health chief complaint.

What happens when two out of every three people who present to a busy emergency room with a behavioral complaint get admitted? You run out of inpatient beds pretty quickly, so patients tend to sit waiting for beds in the emergency room, untreated, and mostly unattended to other than by a police or security officer sitting outside the room. The two "psych rooms" are always full, and others with similar complaints end up occupying more and more of the other beds in the ED, typically accounting for the longest lengths of stay in the ED, and slowing down ED throughput dramatically. Some 300 general patients per month were discovered leaving the UIHC ED before being seen because of waiting times (i.e., sitting in the waiting area, as all the ED beds were full) - this is not limited to behavioral health patients, but all patients. And of those behavioral health patients who are admitted to inpatient psychiatric units, many are discharged shortly after arriving. An analysis of all psychiatric admissions (~ 2010) found that the modal length of stay across all psychiatric units was two days, followed next by one day (length of stay is often presented as an average, but in this case, we are looking at the most common lengths of stay). Those data strongly suggest that these were avoidable admissions. Indeed, a common scenario is that a person comes in at night, exhausted after a difficult day - often involving alcohol or substance use, and they have "hit the wall." After getting some sleep, the next morning things seem different and they are no longer anywhere near the level of crisis they had been in just a day before. But in our system, many of these patients had already been admitted, or worse, they are still sitting in the ER, waiting to be transported to an inpatient facility on the other side of the state - on a temporary legal hold, vowing never again to make the mistake of seeking help. Because this scenario occurs all around the state, i.e., an over-reliance on inpatient hospitalization, it is not at all uncommon for there to be no inpatient beds anywhere in the state, necessitating patients spending long periods of time, up to several days in the ED. We had essentially no treatment services in the ED, so patients would be waiting for their "treatment" to begin once they found their way to an inpatient unit.

Iowa has a long history of local control for its mental health services. Indeed, up until a recent legislative change, each of Iowa's 99 counties had its own funding streams, and many decisions about services were made at the county level. In the county in which Iowa City is located - Johnson County - a "System of Care" (SOC) group had been established in the early 2000s at the suggestion of a consultant who had been brought in to advise about how our community could improve behavioral health services. This proved to be a critical step in much of what would happen since. The group consisted of representatives from a variety of agencies and entities that share a common population - including each of the hospitals (in addition to UIHC, there is a VA hospital and one small private hospital), the primary substance use service provider, the local homeless shelter (which provides a variety of housing services), multiple law enforcement agencies (county sheriff and the police of several surrounding municipalities as well as University police), community support service providers, family and consumer advocacy groups and others. The group met monthly. All those who came did so voluntarily on their own time and expense. The group was organized by a staff member from the county (who later went on to become our jail alternatives person).

Initially, the major benefit of the SOC group was to familiarize ourselves with one another, putting names with faces, getting each other's cell phone numbers, etc., i.e., establishing relationships between people who worked at these various agencies. That proved to be tremendously valuable, especially when working with our highest utilizers of services, many of whom were well known to most of these agencies - and would go from one to the next without any coherent plan or communication between them. Early on, many of us in the SOC group found ourselves doing informal "case conferences" before and after the meeting, and because there was initially some understandable discomfort in discussing personal health information, we soon engaged colleagues from the law school to help us come up with processes to share information in a manner that was consistent with all of the various regulations that govern such disclosure. This specific project alone was extremely useful, within and across the various systems, resulting in a manual and curriculum for information sharing, and a "release of information" form that specifically allowed for sharing across various institutions and agencies.

Through the years, the SOC group continued to meet monthly and pursued a variety of projects, most of which had the common denominator of breaking down silos of services and increasing coordination. Examples included establishing a jail diversion program using a boundary spanner model, behavioral health training for law enforcement and other first responders, and enhanced supported housing for those who were chronically homeless in the context of severe mental illness. We also conducted a detailed financial analysis of all costs associated with a small group of extremely high utilizers of services.

Efforts to enhance our crisis system remained a high priority - both at the local and state levels. One part of this initiative was aimed at improving services within the UIHC emergency department. In 2019, after several years of planning, the UIHC department of psychiatry established a psychiatric arm of the emergency room (which they called a "crisis stabilization unit"), and that has substantially improved some of the problems in the ER described above. However, it is still hospital-based and still results in a relatively high rate of inpatient admission and a predominantly "medical model" response to crisis.

The SOC group wanted an alternative to the two choices that existed for people in behavioral health crisis: hospital or jail. We wanted a third choice. We investigated various models around the county, with subgroups of our SOC team visiting many sites including San Antonio, Arizona (Phoenix and Tucson), Kansas, and Miami. We quickly learned that when you see a crisis center, you've seen only one; each of those we visited felt very different from one another.

We liked the idea of having an actual physical space - rather than a "virtual" crisis system - envisioning a campus of sorts, where various health and human service providers would come together, so clients could go to one central place. But we also knew that creating such a campus would be an expensive undertaking, with no obvious sources of funding. We recognized that building grassroots support for this among the community was going to be necessary if it was ever going to happen.

Thus began a multi-year series of meetings, discussions, focus groups, etc., with city councils of all the local municipalities, school boards, university officials, advocacy groups, county boards of supervisors, (not only in our county but in

surrounding counties), law enforcement leadership, legislators and candidates running for any local office - basically anyone whose agenda we could get on - to talk about why this project was important, and why it might matter to them. That process also allowed us not only to educate and build enthusiasm for the project, but to elicit from the community what kinds of services they perceived to be lacking. We found that most people we spoke with had some personal experience, either themselves, with a family member or a friend who has had some sort of behavioral health crisis, and struggled to find timely help. Awareness of the problem was there - they just needed to understand some of the reasons behind it and learn that there were other models that could serve the community better.

Ultimately, through this process we recognized and prioritized the need for several different kinds of services: We wanted: 1) a place for people in behavioral health crisis to be quickly and efficiently evaluated, and in which needed treatment could begin immediately; 2) a safe place for people who were intoxicated to “sleep it off” prior to such an evaluation; 3) ready access to full medical detox if needed (our community was under-capacity for detox, resulting in many admissions to medical inpatient hospital beds); and 4) some capacity to provide a safe place for a subgroup of clients who utilized the services mentioned above, but who might need a few extra days to figure out next steps.

Finally, our community was in need of a low barrier shelter, i.e., a place for people homeless people who were still using alcohol or other substances to be able to safely spend the night, especially during the winter months.

We referred to the model as an “access center”, i.e., a place where people could come to access a variety of services in one place - that would be easy to navigate, welcoming and integrated. We underscored the potential for decreased utilization of costly and inefficient services like hospital emergency rooms, inpatient units and jails (our community had repeatedly voted down a series of bonds to expand our county jail, which was chronically over capacity.).

Eventually, the questions evolved from “What is an access center?,” to questions like “How big does it need to be?,” “How much will it cost, and how will it be financed?,” “Where will it be located?,” “Who will it serve, and when are we going to build it?”

And by 2018, we had financial commitments from the county and each of the municipalities within the county, as well as some funding from surrounding counties that together were nearing the expected capital costs. Somehow, we had cobbled together more than 7 million dollars for these capital expenses.

A staffing model and ongoing cost estimates was developed based on expected third-party payer reimbursement. Much time has been spent with the various payors in an effort to gain their support and optimize funding streams for each of the services. That effort was complicated by the fact that Iowa’s Medicaid system for behavioral health is divided among multiple managed care organizations (MCOs), and those entities change over time. Among the current MCOs, all appear to be supportive, and details for reimbursement of each of the services have been worked out, but it will likely be an ongoing challenge to ensure that reimbursement is reasonably commensurate with services provided.

An ideal site was located and purchase, near to the existing homeless shelter and substance use provider agency, all the hurdles around zoning and NIMBY (Not in My Back Yard) issues were cleared, architects, contractors, etc. were engaged, and the building is set to open in January 2021.

About 75% of the building will be used for the access center with the remainder used for the winter shelter. The access center will have capacity for up to 40 clients at a time, to be used flexibly across four types of services:

1. **Evaluation and treatment:** A 23-hour crisis observation, in which a full assessment is done and treatment is initiated; expected length of stay (LOS) of approximately one day.
2. **Sobering:** A safe place for those who are acutely intoxicated to be cared for, followed by an evaluation when sober as needed; expected average LOS of up to 12 hours.
3. **Medical detox:** For those in need of full detoxification services; expected average LOS of up to several days.
4. **Crisis stabilization:** For those who need more time before returning to community; expected LOS of up to five days.

The land and building are owned by the county. The county contracted with a local mental managing entity. The managing entity will subcontract the provision of some services with other provider agencies in the community. Specifically, the substance abuse provider agency will provide the sobering and detox services, and the agency that currently provides mobile crisis services will do the initial triage evaluations. A fairly extensive set of outcomes have been developed, with expected reporting requirements and performance targets specified in the contract. These will be reviewed on a regular basis by a community-based oversight board.

Embedded within the oversight and outcome measures is the expectation that all services are performed in a welcoming and engaging, trauma-informed and culturally-sensitive manner.

It has certainly been a journey, spanning more than a decade of effort thus far (at the time of this writing we are still a few months away from opening our doors). Our goals were and remain ambitious, including a change in the expectations of the community that high quality behavioral health crisis services should be available to every member of our community, just like the fire department or ambulance services.

Finally, while the efforts described above were all directed at improving crisis behavioral health services for one community, the impact of this work has already expanded well beyond our local borders. Apparently, word got around the state about our efforts, and people began talking about “access centers” as if it were a known type of entity and a missing part of the service array. Much to our surprise, in a 2018 “State of the State” address, our governor talked about the “need to expand access centers.” This was followed by legislation that year that mandated a minimum of access centers around the state. As is often the case, this was an unfunded mandate, leaving it to the local regions to figure out how to finance them. Had we been consulted, many of us would probably have suggested working things out in one site before replicating it elsewhere, but before we knew it, criteria for the components of an access center were incorporated into state administrative code. The first of these actually opened in the southern part of the state in late 2019, and at least two others besides the one in Johnson County are expected to open within the next year.

We chose to call our access center the “Guidelink Center,” following suggestions from a host of focus groups conducted by a marketing firm we hired. The Guidelink Center is scheduled to open in spring 2021.

EXCERPTS FROM IOWA LEGISLATION ESTABLISHING CRISIS ACCESS CENTERS (CRISIS HUBS) AND DEFINING A CONTINUUM OF CRISIS SERVICES AS CORE SERVICES.

Another section of the legislation required a minimum of six access centers statewide, and yet another section defined the component services that an access center was expected to include. In addition, the legislation defines a comprehensive array of crisis services for any region, with the intent that each of the 16 Mental Health and Disability Services (MHDS) regions (a division of Iowa’s Department of Human Services and the model for creating locally controlled multi-county regional accountability for behavioral health and disability services), with or without a crisis access center, would be responsible to work with the state, Medicaid MCOs and providers to establish a continuum of crisis services.

House Filing 2456 (2018) – Iowa State Legislature 331.397 Regional core services.

For the purposes of this section, unless the context otherwise requires, “domain” means a set of similar services that can be provided depending upon a person’s service needs.

Subsection 2. a. (1) A region shall work with service providers to ensure that services in the required core service domains in subsections 4 and 5 are available to residents of the region, regardless of potential payment source for the services.

(2) Subject to the available appropriations, the director of human services shall ensure the initial core service domains listed in subsection subsections 4 and 5 are covered services for the medical assistance program under chapter 249A to the greatest extent allowable under federal regulations. The medical assistance program shall reimburse Medicaid enrolled providers for Medicaid covered services under subsections 4 and 5 when the services are medically necessary, the Medicaid enrolled provider submits an appropriate claim for such 25 services and no other third-party payer is responsible for reimbursement of such services.

Subsection 5

5a. Provided that federal matching funds are available under the Iowa health and wellness plan pursuant to chapter 249N, the following intensive mental health services in strategic locations throughout the state shall be provided within the following core service domains:

1. Access centers that are located in crisis residential and subacute residential settings with 16 beds or fewer that provide immediate, short-term assessments for persons with serious mental illness or substance use disorders who do not need inpatient psychiatric hospital treatment, but who do need significant amounts of supports and services not available in the persons' homes or communities.
2. Assertive community treatment services.
3. Comprehensive facility and community-based crisis services, including all of the following:
 - a. Mobile response.
 - b. 23-hour crisis observation and holding.
 - c. Crisis stabilization community-based services.
 - d. Crisis stabilization residential services.
4. Subacute services provided in facility and community-based settings.
5. Intensive residential service homes for persons with severe and persistent mental illness in scattered site community-based residential settings that provide intensive services and that operate twenty-four hours a day.

5 b. The department shall accept arrangements between multiple regions sharing intensive mental health services under this subsection 5.

Subsection 6. A region shall ensure that access is available to providers of core services that demonstrate competencies necessary for all of the following:

- a. Serving persons with co-occurring conditions.
- b. Providing evidence-based services.
- c. Providing trauma-informed care that recognizes the presence of trauma symptoms in persons receiving services.

The Certified Community Behavioral Health Clinic Model: Leveraging Federal and State Financing to Expand and Improve Crisis Systems: Joe Parks, MD

Improving access to crisis care is a cornerstone of the Certified Community Behavioral Health Clinic (CCBHC) model, launched as an 8-state Medicaid demonstration in 2017. The model is designed to expand Americans' access to addiction and mental health care by investing in a robust community treatment infrastructure that includes 24/7 crisis care, mobile crisis teams and partnerships with local law enforcement and hospitals.

Results to date show substantial improvement in access to crisis care. More than half of CCBHCs added crisis services where none existed before and all engaged in new partnerships with hospitals and law enforcement to support crisis intervention and coordinate post-crisis care. As a result of improved crisis intervention and ongoing community-based care, CCBHCs have produced significant reductions in hospitalizations, emergency department visits and incarcerations. In light of the program's success, as of mid-2020, Congress has extended the demonstration to two additional states and allocated a total of \$600 million in CCBHC expansion grants over the last three years. Thirty-three states now have at least one CCBHC, but additional federal and state action will be needed to bring the model to every community nationwide.

Required CCBHC crisis services. In contrast to the patchwork of crisis care typically available in other communities, all CCBHCs must provide a standard array of crisis services linked with ongoing outpatient treatment. CCBHCs' crisis management services are available and accessible at all times, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization. CCBHCs must partner with organizations that frequently come in contact with individuals in crisis, such as local emergency departments and local law enforcement agencies, to facilitate crisis intervention, care coordination, discharge and follow-up. Following a crisis, CCBHCs work with the individual on a crisis plan to prevent and de-escalate potential future crisis situations, while ensuring they are linked to comprehensive ongoing community-based treatment. CCBHCs must have an interdisciplinary care team that works together to coordinate the full range of support services needed by individuals in crisis and following a crisis. Staff must be culturally competent and have access to language services depending on the community the CCBHC serves.

CCBHCs are advancing the continuum of care and ensuring sustainable financing. The CCBHC model works because it provides a source of funding sufficient to cover the costs of implementing an advanced crisis system. The CCBHC model ensures:

- **Expanded access to crisis care through an enhanced workforce.** CCBHCs' funding includes the cost of hiring new staff such as nurse care managers, training staff in required competencies such as suicide prevention and naloxone administration and placing staff liaisons in settings like ERs or jails where individuals in crisis commonly present.
- **Timely follow-up and warm handoff from the ER to ongoing, community-based services.** CCBHCs must establish partnerships with hospitals and other providers and ensure services are available to transition patients from an ER or hospital to a community-care setting. Through quality reporting requirements, CCBHCs are accountable for the timeliness of a patient's transition between care settings and ensuring that no patient falls through the cracks.
- **Electronic exchange of health information for care coordination purposes.** CCBHCs' funding includes the cost of purchasing or upgrading electronic systems for real-time electronic information exchange along with data collection, quality reporting and population health approaches to care.
- **Enhanced patient outreach, education and engagement.** CCBHCs' funding supports activities that have traditionally been near-impossible to reimburse, yet play a critical role in crisis intervention, care management and coordination of services.
- **Care where people live, work and play.** CCBHCs may provide services outside the four walls of their clinic, for example, via mobile crisis teams, home visits, telemedicine, outreach workers and emergency- or jail-diversion programs.

International Example of Evolved, Nuanced Community Mental Health Program: World Health Organization Collaborating Centre for Research and Training in Mental Health in Trieste, Italy.

Keris Myrick, PhDc

The community mental health system in Trieste has achieved worldwide recognition for its culture of hope and recovery. This summary is taken from my visit in 2019 to Trieste with other members of the leadership team at the Los Angeles County Department of Mental Health. These notes are an attempt to convey the high points of what I experienced as a visitor and as a person with lived experience. There are clearly unique characteristics of both Italian culture and the Italian delivery system that contribute to the success of this system. Nonetheless, the presence of such a system provides an aspirational vision for what we in the United States might accomplish, if we apply the same values to the way we provide a community of services for people with behavioral health needs.

- **Powerful moments of connection.** This is a community mental health program that lives, breathes, walks and talks moments of connection and welcoming. Mental health services are grounded in strong values, a philosophy that starts with freedom first and is relentless about relationships and trust. The philosophical approach to treatment begins with expecting that each moment with a person is a moment to make a positive connection. No matter how complex the needs of the person, each person is met first as a human being, not as an illness or a problem to be fixed. The focus is on freedom first, helping people remain in the community of their choice, connected to others with meaning and purpose in their lives. There is no restraint, no coercion, no police – just people. People to people, connected in the most human(e) ways.
- **Integrated crisis system.** It is difficult to say or think of the Trieste model as having a separate crisis system. One of the goals of Trieste community mental health is to keep people in the community, even in the midst of crisis, by providing in-home services and providers until the crisis subsides. If this is not possible, a person may be hospitalized in the general hospital via the ER and transferred to the psychiatric unit. There are not locks on any doors. Even in the rare case when a person is adjudicated to care (involuntary care), the doors are never locked and restraints are never used. Patients can come and go as they please – out the door of the unit to get a coffee in the café or outside for some fresh air. They do not need to ask permission or have providers accompany them. Generally, the patient returns to the unit. When they want to walk out and end treatment, providers usually are not far behind and generally can help the person return to the unit for the rest of their stay. The stays are short, and throughout, freedom, autonomy and choice are emphasized through the powerful relationships and trust that the staff develops with each individual.
- **Staffing includes psychiatrists, nurses of varying levels and occupational therapists.** Peers are part of the staff as well, due to Italian laws around any type of non-licensed staff providing services within health services, their work is performed via community behavioral health organizations or external social cooperatives, with a focus of coordinating with the mental health system as a whole. For example, when one patient was ready for discharge, the psychiatrist from one of the four community health centers came to meet with the individual and took them to the community mental health center, which also has four or five bedrooms to accommodate overnight stays until a person is ready to return to their own residence and continue treatment as outpatient at the community mental health center.
- **Salient points on developing behavioral health crises services in the Trieste model of care:**
 - » A strong vision, a well-articulated philosophy and a committed leader who can instill values into operationalized practices and ingrain them via training of providers/staff and who can align practices and training with policy, funding and programs to advance a model that is sustainable over time.
 - » Succession planning that is ingrained in the teaching, training and mentoring of the staff and providers to sustain the culture, practices and growth aligned with the vision of the founder, Franco Basaglia.
 - » Ultimate and unwavering belief that people can thrive and flourish in the community and the belief in the power of and relentless pursuit of positive relationships in the midst of crisis as well as when people are well.

- » Facilitation of meaningful roles and lives in the community concomitant with the development of community support that moves beyond acceptance to participation by all members of the community, resulting in no distinguishable difference between those being served by the mental health system, those working in the mental health system and those who are neither.
- » Involvement as identified by the person receiving services. If desired, family members and other supports participate in any aspects of their care and recovery journey.
- » Embracing “freedom first” as not just a motto, but as foundational to the belief that the human spirit must be free, that when not free it will fight to be free and or will wither.
- » Elimination of use of coercion.
- » Consideration of universal health coverage. This may be one reason the coordination and reimbursement for such services is a bit less complex.
- » Documentation is still done though far less burdensome.
- » Acknowledgement that shifts in the political climate can and do impact the ability to do the work.

5. High Level Collaboration to Establish a Crisis Continuum for Adults: The Healthy Minds Policy Initiative Tulsa, Oklahoma

Over the past seven years, local Tulsa community leaders have developed various components of a comprehensive crisis response system for behavioral health disorders. Along the way, it became clear that having an overarching strategic plan was needed to prioritize critical initiatives and coordinate the resources that support implementation. Out of this recognition, the Tulsa mental health planning project was initiated. It was led by the Tulsa Mental Health Steering Committee, a 17-member committee made up of mental health care professionals, philanthropists and other community leaders. Between 2016-2018, careful strategic planning and consensus building resulted in a report by the Urban Institute. The funder of this work, The Anne and Henry Zarrow Foundation, obtained consultation to help establish an ongoing infrastructure to develop and oversee initiatives to advance the plan. What emerged is the Healthy Minds Policy Initiative (HMPI), a dedicated team of mental health policy experts who work with state and local leadership to build capacity and develop policies to improve mental health services in Tulsa and the state. A key focus for Tulsa has been building on the work of multiple collaborations to further develop existing crisis services in the Tulsa area and identifying strategies to address gaps that limit capacity for effective crisis response for all. Existing services and activities include: a Community Response Team comprised of a paramedic, mental health professional and law enforcement; a sobering center; a mental health crisis call center with mobile crisis response; a Crisis Care Center (CCC) for crisis assessment and treatment; and Project Blue Streets, a convening of local first responders and medical professionals that produced a Tulsa area consensus medical clearance protocol. A recent result of the collaboration is Tulsa’s Family & Children’s Services, a large community mental health center, successfully embedding mental health professionals in the 911 communications center to assist 911 staff with mental health crisis calls. Another initiative, facilitated by HMPI, is enabling the CCC to be an accessible “front door” for law enforcement (Police One Stop) for people in crisis to be supported, assessed and connected to the right level of care. HMPI convened key partners, including local mental health professionals, the state department of mental health and community leaders from the Mayor’s office, Tulsa Police Department, and the judicial system to plan and implement significant enhancements to CCC. Family & Children’s Services operates the CCC and took the lead to implement the enhancements, including increased chair capacity for urgent care observation services, additional staffing for serving more people and those with higher needs, increased short-term crisis residential beds and construction of a dedicated police drop-off entrance. Another significant and complimentary initiative facilitated by HMPI was development of a new program operated by 12&12 (that also operates the Sobering Center) that provides evidence-based treatment and recovery for people with meth addiction. Due to the high incidence of methamphetamine use in the Tulsa area, the CCC often receives people experiencing psychotic symptoms that were due to acute methamphetamine intoxication. The CCC is working closely with 12&12 to coordinate and transfer these individuals for intensive detox and entry into treatment and recovery services.

After years of careful strategic planning, consensus building and implementation planning, local and state mental health professionals and community leaders from the Mayor's office, Tulsa Police Department, universities, philanthropy and non-profits are well-underway to developing a robust and comprehensive crisis response system for behavioral health disorders.

Where is your community on the Roadmap to the Ideal Crisis System?

Note: This report card is meant to accompany: "ROADMAP to the IDEAL CRISIS SYSTEM: ESSENTIAL ELEMENTS, MEASURABLE STANDARDS AND BEST PRACTICES for BEHAVIORAL HEALTH CRISIS RESPONSE" (GAP, 2021).

6. Expansion of Access to Mobile Crisis Teams in New York State

Mobile Crisis Teams were first started in New York State (NYS) in combination with Comprehensive Psychiatric Emergency Programs (CPEP) in 1989 (See CPEP textbox), but have recently been expanded considerably.

Criteria for an in-home/community response by a Mobile Crisis Team

- A person is eligible for a Mobile Crisis Team (MCT) if the person currently meets the NYC/NYS definition for a behavioral health crisis, and the person is unwilling or unable to seek or adhere to behavioral health care on their own or with the aid of a family member, caregiver or friend - or if the person requires short-term supports until behavioral health services are available.
- MCTs can provide mental health engagement, intervention, and follow-up support to help engagement in treatment. Depending on what a person is willing to accept, the teams may offer a range of services, including:
 - Assessment.
 - Crisis intervention.
 - Supportive counseling.
 - Information and referrals, including to community-based mental health services.

A new Crisis Intervention benefit became effective in Medicaid Managed Care in NYC (2015), and for the remainder of NYS (2016). A MCT is part of this larger Crisis Intervention benefit. NYS-approved Mobile Crisis providers bill Medicaid Managed Care Organizations for mobile and telephonic follow-up services.

A MCT consists of:

- A multidisciplinary team that is accessible 24/7, 365 days a year.
- No prior authorization allowed for billing.
- Respond within three hours of the initial contact.
- Initial evaluation and triage.
- Follow-up services may be delivered face-to-face or through telephonic contact and are eligible for reimbursement if provided within 14 days of the qualifying crisis episode. Contacts with collaterals are also billable services.

Billable activities may include:

- Therapeutic communication and interactions.
- Maintaining stabilization following a crisis episode.
- Preventing escalation of behavioral health symptoms.
- Facilitation of engagement in outpatient behavioral health services, care coordination, medical health and/or basic needs related to the original crisis service with the individual receiving services.
- Follow-up with the individual and the individual's family/support network to confirm that enrollment in care coordination, outpatient treatment and/or other community services has occurred or is scheduled.

If a mobile crisis team determines that a person in crisis needs further psychiatric or medical assessment, they can transport that person to a hospital psychiatric emergency room.

Mobile crisis teams may direct police/EMS to take a person to an emergency room against their will only if they have a mental illness (or the appearance of mental illness) and are a danger to themselves or others. This is in accordance with New York State Mental Hygiene Law.

MCT calls are handled centrally, in NYC, through a single point of access program coordinated by NYC Well. There is an online application that can be filled out and submitted by treatment providers or a single phone number, 1-888-NYC-WELL that families, friends, or concerned individuals can call to initiate a MCT consult.

As of February 2021, NYC, through a collaboration between the NYC Fire Department (FDNY) and Health and Hospitals, a team of behavioral health clinicians (MCT) will co-respond with FDNY Emergency Medical Services/Emergency Medical Technicians for 911 calls for people in a behavioral health crisis. Police will only respond if the co-response team believes there is an imminent risk for violence. This pilot is modeled after the CAHOOTS (Crisis Assistance Helping Out On The Streets) program in Oregon.

References:

1. New York State Office of Mental Health 2012 Annual Report to the Governor and Legislature of NYS on Comprehensive Psychiatrist Emergency Programs. https://omh.ny.gov/omhweb/statistics/cpep_annual_report/2012.pdf
2. Crisis Intervention Benefit: Mobile Crisis Component Benefit and Billing Guidance. June 18, 2019. https://omh.ny.gov/omhweb/bho/docs/mobile_crisis_intervention_guidance.pdf
3. NYC Well: Mobile Crisis Referrals. <https://nycwell.cityofnewyork.us/en/providers/mct-referral/>
4. Journal of Emergency Medical Services. <https://www.jems.com/2020/11/10/new-mental-health-teams-to-respond-to-mental-health-crises-in-ny/>

TABLE 6: REPORT CARD

Introduction and Purpose of the Report Card

This instrument is designed to provide a process to assist communities working on enhancing their crisis system to assess their current status on each of the elements of an “ideal crisis system,” and to help prioritize next steps.

Scoring the Report Card

All items are scored on a 1 – 5 scale. The scale reflects a complete continuum ranging from non-existent/not started in our community through fully implemented and functioning well.

Anchors

These may be useful in assigning a score on individual items:

1. Not started and/or not on our radar and/or If interest does exist in moving on this, barriers seen as too overwhelming to make it worthwhile to put any energy into moving forward.
2. At least some awareness of this as a desirable goal within our system, and/or initial efforts to explore implementation, but no actual movement or specific plans yet.
3. Active steps that are beginning the process toward implementation; early stages of implementation.
4. Active steps being taken toward full implementation, but still incomplete, with intent to implement further.
5. Implemented in our system in a manner that is functioning well.

Tips on Scoring and Using This Report Card

Keep in mind this is not an exact science; Not all items will fit neatly with the specific anchors suggested above. In general, **if you find yourself between two scores (which will happen commonly) choose the lower score.** This may prompt you to set the higher score as a short or intermediate term goal.

Also remember that there is neither a “perfect score” for the instrument as a whole or a “right answer” for individual items. The goal is to ensure that stakeholders are aware of each of the specific aspects or ingredients of an ideal crisis system and have a common language and a process by which to discuss and assess where their community is at with regard to each of these. Hopefully, this can be used to assist in goal setting (short-, medium- and long-term) and prioritization.

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in “Ideal Behavioral Health Crisis System.”
Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION I: ACCOUNTABILITY AND FINANCE			
1A	Accountable entity identified and established.		
1.	Behavioral health crisis system coordinator identified.		
1C	Community behavioral health crisis system collaborative meets.		
1D	All services are accountable for system values.		
1E	Multiple payers contribute to financing services and capacity in the continuum.		
1F	Accountable entity coordinates financing.		
1.	Financing is adequate for population need.		
1H	Everyone is eligible, regardless of insurance.		
1I	The crisis continuum meets standards for capacity and geographic access for the population.		
1J	Quality metrics are established and measured for each service and the crisis continuum as a whole.		
1K	Data is collected and used collaboratively for customer oriented continuous improvement.		
1L	Provider contracts include incentives for performance in line with values and metrics.		
1M	System metrics include attention to how clients flow through the continuum timely/successfully.		
1N	The crisis system has data and capability to keep track of client progress through the continuum.		
1O	Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved.		
1P	Consistent level of care determination and utilization management criteria throughout the system.		
1Q	All services in the crisis system function as safety-net support partners for behavioral health system programs.		
1R	Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).		
1S	Standards define how community systems work collaboratively with the behavioral health crisis system.		
Section I Total:		/ 95 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there
4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in “Ideal Behavioral Health Crisis System.”
Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITY AND SERVICES			
2A	Safe, welcoming, values-based services throughout the continuum.		
2B	Services address the continuum of crisis experience from pre-crisis to post-crisis.		
2C	Spaces and security practices are safe, warm, welcoming, therapeutic.		
2D	Families and collaterals are partners/customers.		
2E	First responders are priority customers		
2F	The service continuum responds to all ages		
2G	Continuum of capacity for people with co-occurring needs: mental health/substance use disorder (MH/SUD), behavioral health/intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).		
2H	Cultural/linguistic/immigrant capacity.		
2I	Continuum of services described operationally.		
2J	Capacity for seamless flow and continuity of care.		
2K	Client information sharing thru the continuum.		
2L	Clients are kept track of through the continuum.		
2M	Family/collateral outreach and engagement.		
2N	Outreach/consultation with community providers.		
2O	Telehealth utilized effectively throughout the continuum.		
2P	Crisis hub secure access and urgent care center(s).		
2Q	Crisis call/text/chat center (911/non-911).		
2R	Crisis-trained first responders deployed.		
2S	Available, low barrier, medical screening/triage.		
2T	Mobile crisis for all ages, to homes, schools, etc.		
2U	23-hour observation.		
2V	Residential crisis services: high and low medical.		
2W	Peer respite/Living Rooms.		

2X	Detox and sobering support center capacities.		
2Y	Psychiatrically capable emergency room services.		
2Z	Psychiatric inpatient capacity: all ages, both general units and specialized units.		
2AA	Continuity of crisis intervention: home and office.		
2BB	Emergency and non-emergency transport.		
2CC	Adequately staffed multidisciplinary teams in all settings.		
2DD	Clinical, nursing, medical leadership.		
2EE	Access to specialty consultation.		
2FF	Peer support throughout the continuum.		
	Section II Total:	/ 160 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there
4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in “Ideal Behavioral Health Crisis System.”
Completed means that all indicators are met and are matched to population need.

Community/Region:

Size of Population:

Adult/Child/Both:

Date Completed:

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION III: BASIC CLINICAL PRACTICE			
3A	Crisis system framework for practice improvement and competency development.		
3B	Universal competencies: welcoming, hopeful, safe, trauma-informed, culturally affirming.		
3C	Engaging families and other natural supports.		
3D	Competency in information sharing.		
3E	Using crisis plans and advance directives.		
3F	Basic core competencies for call center staff and first responders.		
3G	Basic core competencies for behavioral health crisis staff.		
3H	No force first: maximizing trust and minimizing restraint.		
3I	Suicide risk screening and intervention.		
3J	Violence risk screening/threat assessment.		
3K	Medical triage and screening.		
3L	Substance use disorder triage and screening.		
3M	Application of civil commitment (inpatient/output).		
3N	Practice guidelines: multidisciplinary crisis teamwork, including role of peers.		
3O	Practice guidelines: non-medical crisis intervention.		
3P	Practice guidelines: crisis psychopharmacology.		
3Q	Practice guidelines: co-occurring substance use disorder/medication-assisted treatment startup.		
3R	Practice guidelines: co-occurring medical illness.		
3S	Practice guidelines for youth/families/guardians.		
3T	Practice guidelines for older adults/caregivers.		
3U	Practice guidelines for cognitive disabilities.		
3V	Workflows within the crisis continuum.		
3W	Post-crisis continuity, critical time intervention.		
3X	Pre-/post-crisis planning with community providers.		
3Y	Coordination of Care with Community Systems		
Section III Total:		/ 125 (total points possible)	
Grand Total:		/ 380 (total points possible)	

GLOSSARY

The glossary is a handy reference for readers on the terminology used in this report for common components of the ideal crisis system. Building upon the previous resources describing the continuum of care for crisis services in the community, we are using language consistent with reports by the SAMHSA, the National Association of State Mental Health Program Directors, the Treatment Advocacy Center, the Meadows Mental Health Policy Institute and the Crisis Services Task Force. The terms and definitions for the various service components are described in more detail in [“Service Components,”](#) but are provided here for easier reference.

Call center or crisis line: A direct-service telephone line that is answered 24/7 by staff that has been trained to work with individuals in urgent and emergent crisis and can connect individuals to needed resources and help support problem-solving and coping skills. Suicide Prevention Lifeline Centers are one example.

Warmline or helpline: A direct service in which trained peers or volunteers provide support via telephone during specified hours of operation. These lines are used for non-emergent situations, such as loneliness, anxiety or need for support, that could potentially worsen to an emergency if not addressed.

Crisis hub or crisis center: Also called crisis access centers, crisis resource centers and psychiatric emergency centers. These centers provide an array of 24/7 behavioral health crisis services in one location, including assessment, treatment, stabilization and referrals to appropriate community resources and follow-up care and often serve as a point of coordination for all the crisis services in the continuum for all age groups and populations.

Crisis telehealth services: A broad term that encompasses the array of technologies used to support clinical, administrative and education services when different parties are in remote locations. These services include wireless and mobile communication, mobile and tablet-based applications, videoconferencing, internet services, streaming capability and electronic access to reference and educational materials, electronic medical records and billing/scheduling services.

Extended (23-hour/48-hour) crisis observation: Provide up to 23 or 48 consecutive hours of direct and usually intensive supervised care in order to help individuals in acute crisis with either unclear or transient situations to have more thorough assessments and potentially resolve the crisis to avoid unnecessary hospitalization. Services provided include 24-hour observation and supervision, assessment and treatment of symptoms and referrals to appropriate community resources.

Inpatient psychiatric care: inpatient hospital-based psychiatric treatment in general hospital or freestanding psychiatric hospital settings, designed for individuals whose acute exacerbation of psychiatric symptoms render them unable to cope safely in the community and are too severe to be managed at a lower level of care. Services provided include a secure setting, 24-hour medical and nursing management, 24-hour observation and supervision, intensive assessment and treatment of symptoms, both individual and group therapeutic services, social services and development of a plan to transition the individual back into the community.

Mobile crisis services: Teams consisting of behavioral health specialists, usually professionals and peers, who can be deployed rapidly to meet an individual experiencing a crisis at their location in the community. These teams perform psychiatric assessments, de-escalate crises, determine next steps in an individual’s treatment and connect the individual in crisis to needed services in the community. Mobile crisis workers may be deployed independently and/or work as co-responder teams with law enforcement, emergency medical services or other first responders.

Peer respite services: Residential crisis services in a home-like environment with substantial peer support as the primary intervention.

Psychiatric care provider: A generic term for all professionals who have the expertise and credentials to prescribe psychotropic medication along with their other professional clinical activities, including medical doctors, doctors of osteopathy, advanced practice registered nurses, nurse practitioners or physician assistants.

Residential crisis services: Provide a few days up to two weeks of 24-hour crisis intervention and monitoring for individuals in acute behavioral health crisis who cannot be served as outpatients but do not require inpatient psychiatric services. Services provided include 24-hour supervision, assessment and treatment of symptoms, individual and group therapeutic services, social services and referrals and handoffs to community resources. Different terms are used, such as crisis stabilization unit, crisis residential unit and crisis respite services, depending on the level of medical/nursing involvement and service intensity. See the text ([link to residential crisis services section](#)) for more detailed delineation of terminology for various types of residential crisis services

Telepsychiatry: Refers specifically to clinical services provided by an off-site psychiatric care provider that allows 24-hour access to medical and psychiatric services without requiring an on-site psychiatric care provider.

REFERENCES

- Eleventh Circuit of Florida. (n.d.). 11th judicial circuit criminal justice mental health project, CIT program. <https://www.jud11.flcourts.org/Criminal-Mental-Health-Project>
- The Institute for Dialogic Practice. (n.d.). The open dialogue approach. <http://www.dialogicpractice.net/open-dialogue/about-open-dialogue/>
- Aggarwal, R., Guanci, N., & Appareddy, V. L. (2013, August). Issues in treating patients with intellectual disabilities. *Psychiatric Times*, 30(8), 9.
- Alam, A., Rachal, J., Tucci, V. T., & Moukaddam, N. (2017). Emergency department medical clearance of patients with psychiatric or behavioral emergencies, part 2: Special psychiatric populations and considerations. *Psychiatric Clinics*, 40(3), 425-433. <https://doi.org/10.1016/j.psc.2017.05.001>
- Allen, M. H., Forster, P., Zealberg, J., & Currier, G. (2002). Report and recommendations regarding psychiatric emergency and crisis services. A review and model program descriptions. APA Task Force on Psychiatric Emergency Services. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/task-force-reports/tfr2002_EmergencyCrisis.pdf
- ACEP Emergency Medicine Practice Committee. (2014). Care of the psychiatric patient in the emergency department—A review of the literature. *American College of Emergency Physicians*. <https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/mental-health-and-substance-abuse/psychiatric-patient-care-in-the-ed-2014.pdf>
- American Psychiatric Association. (2015). Position statement on involuntary outpatient commitment and related programs of assisted outpatient treatment. https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/resource-2015-involuntary-outpatient-commitment.pdf
- Balfour, M. E., Tanner, K., Jurica, P. J., Rhoads, R., & Carson, C. A. (2016). Crisis reliability indicators supporting emergency services (CRISES): a framework for developing performance measures for behavioral health crisis and psychiatric emergency programs. *Community Mental Health Journal*, 52(1), 1-9. <https://doi.org/10.1007/s10597-015-9954-5>
- Balfour M.E., Hahn, S. A., Winsky, J., & Goldman, M. L. (2020). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>
- Baugh, Y., Leslie, J., Altman, C., and Balfour, M. E. (2019, October). Guardians of the galaxy: Mobilizing quality improvement teams to reduce restraint. New Orleans, LA: American Psychiatric Nurses Association Annual Conference.
- Bradley, E. (2002). Guidelines for managing the client with intellectual disability in the emergency room. University of Toronto, Ontario: Centre for Addiction and Mental Health. <https://www.porticonetwork.ca/documents/489955/505369/Guidelines+for+Managing+the+Client+with+Intellectual+Disability+in+the+Emergency+Room/784ed5d2-0711-4783-bec3-3d3e4a2d5f74>
- Centers for Disease Control and Prevention. (2020, July 10). Leading Causes of Death and Injury - PDFs|Injury Center|CDC. <https://www.cdc.gov/injury/wisqars/LeadingCauses.html>
- CIT International Position Statement on CIT as a Specialist/Generalist Model – Not Mandated Training. (n.d.). http://www.citinternational.org/resources/Documents/Position%20Statement%20on%20Generalist_Specialist%20Model.pdf
- CIT International Position Statement on Providing CIT Training in the Pre-Service Academy
- Committee on Quality of Health Care in America, & Institute of Medicine Staff. (2001). Crossing the quality chasm: A new health system for the 21st century. National Academies Press. <https://pubmed.ncbi.nlm.nih.gov/25057539/>
- Criminal Mental Health Project. (n.d.). Eleventh Judicial Circuit of Florida. Retrieved August 30, 2020, from <https://www.jud11.flcourts.org/Criminal-Mental-Health-Project#:~:text=The%20Eleventh%20Judicial%20Circuit%20Criminal,based%20treatment%20and%20support%20services.>

Crisis Services/Mental Health: Mobile Crisis Teams. (n.d.).

<https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page>

Day, S., Hyde, P., Mulkern, V., & O'Brien, J. (2005). A community-based comprehensive psychiatric crisis response service: an informational and instructional monograph. Retrieved November 11, 2020, from <http://www.tacinc.org/media/13106/Crisis%20Manual.pdf>

Dixon, L. B., Dickerson, F., Bellack, A. S., Bennett, M., Dickinson, D., Goldberg, R. W., & Peer, J. (2010). The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements. *Schizophrenia Bulletin*, 36(1), 48-70. <https://doi.org/10.1093/schbul/sbp115>

Donabedian, A. (1988). The quality of care: How can it be assessed? *Jama*, 260(12), 1743-1748. <https://jamanetwork.com/journals/jama/article-abstract/374139>

Dupont, R., Cochran, S. and Pilsbury, S. (2006). Crisis intervention teams: Core elements. <http://www.citinternational.org/resources/Pictures/CoreElements.pdf>

Ebaugh, F. G. (1939). Recommendations for a mental health program in Hawaii. *American Journal of Psychiatry*, 95(4), 873-879. <https://doi.org/10.1176/ajp.95.4.873>

Feiring, E., & Ugstad, K. N. (2014). Interpretations of legal criteria for involuntary psychiatric admission: A qualitative analysis. *BMC Health Services Research*, 14, 500. <http://doi.org/10.1186/s12913-014-0500-x>

Freeman, A. M., Tribe, R. H., Stott, J. C., & Pilling, S. (2018). Open dialogue: A review of the evidence. *Psychiatric Services*, 70(1), 46-59. <https://doi.org/10.1176/appi.ps.201800236>

Glauser, J., Marshall, M., & Shepherd, S. M. (2011). Medical clearance of psychiatric patients. *Emergency Medicine Reports*, 32(23), 273-282. <https://insights.ovid.com/emergency-medicine-reports/egmr/2011/10/240/medical-clearance-psychiatric-patients/1/00131313>

Glick, I. D., Stekoll, A. H., & Hays, S. (2011). The role of the family and improvement in treatment maintenance, adherence, and outcome for schizophrenia. *Journal of Clinical Psychopharmacology*, 31(1), 82-85. <https://doi.org/10.1097/JCP.0b013e31820597fa>

Grimes, L. and Geddes, J. (2015). What helps what harms Maryland: A young adult peer-led quality improvement project. On Our Own Of Maryland's Transitional Age Youth Outreach Project and Taking Flight of Maryland Coalition of Families for Children's Mental Health's Young Adult Advisory Board. https://assets.website-files.com/56251a4dc2878dac656712b2/5c7dd2e210414d7e0e4e88e7_What-Helps-What-Harms-Recommendations-Report-Final-2016.pdf

The Office of the National Coordinator for Health Information Technology. (n.d.). What is telehealth? How is telehealth different from telemedicine? Retrieved November 12, 2020, from: <https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine>

Hermann, R. C., & Palmer, R. H. (2002). Common ground: a framework for selecting core quality measures for mental health and substance abuse care. *Psychiatric Services*, 53(3), 281-287. DOI: 10.1176/appi.ps.53.3.281

Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine and e-Health*, 19(6), 444-454. DOI: 10.1089/tmj.2013.0075. <https://www.liebertpub.com/doi/10.1089/tmj.2013.0075>

Hubley, S., Lynch, S. B., Schneck, C., Thomas, M., & Shore, J. (2016). Review of key telepsychiatry outcomes. *World Journal of Psychiatry*, 6(2), 269. <http://doi.org/10.5498/wjp.v6.i2.269>

Jacobs, D. (2007). The joint commission 2007 patient safety goals on suicide featuring the suicide assessment: Five-step evaluation and triage (SAFE-T). <https://www.sprc.org/sites/default/files/migrate/library/jcsafetygoals.pdf>

LeMelle, S., Arbuckle, M. R., & Ranz, J. M. (2013). Integrating systems-based practice, community psychiatry, and recovery into residency training. *Academic Psychiatry*, 37(1), 35-37. <https://link.springer.com/content/pdf/10.1176/appi.ap.12030057.pdf>

Lloyd-Evans, B., Slade, M., Jagielska, D., & Johnson, S. (2009). Residential alternatives to acute psychiatric hospital admission: Systematic review. *The British Journal of Psychiatry*, 195(2), 109- 117. <https://doi.org/10.1192/bjp.bp.108.058347>

Lukens, T. W., Wolf, S. J., Edlow, J. A., Shahabuddin, S., Allen, M. H., Currier, G. W., & Jagoda, A. S. (2006). Clinical policy: Critical issues in the diagnosis and management of the adult psychiatric patient in the emergency department. *Annals of Emergency Medicine*, 47(1), 79-99. <https://doi.org/10.1016/j.annemergmed.2005.10.002>

- Lunsky, Y., Gracey, C., & Gelfand, S. (2008). Emergency psychiatric services for individuals with intellectual disabilities: Perspectives of hospital staff. *Intellectual and Developmental Disabilities*, 46(6), 446-455. <https://doi.org/10.1352/2008.46:446-455>
- Manaugh, B. (2020, February). Behavioral health crisis and diversion from the criminal justice system: A model for effective community response. Arnold Ventures.
- McFarlane, W. R., Lefley, H. P., & Beels, C. C. (2004). Multifamily groups in the treatment of severe psychiatric disorders. Guilford Publications.
- Meadows Mental Health Policy Institute. (2016, December). Behavioral health crisis services. https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf
- Mee-Lee, D. (Ed.) (2013). ASAM criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions. American Society of Addiction Medicine.
- Miami Beach Police Department/South Florida Behavioral Health Network. (n.d.) Homeless Resource Officer Program. 2018 Power Point Presentation.
- Minkoff K. (2019, January). Substance use disorders in crisis settings: Engagement, assessment, and intervention approaches. *Psychiatric Times*, 26-29.
- Murphy, S. M., Irving, C. B., Adams, C. E., & Waqar, M. (2015). Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, (12). <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001087.pub5.abstract>
- National Council for Behavioral Health. (2020). About MHFA. Mental Health First Aid. <https://www.mentalhealthfirstaid.org/about/>
- National Council for Behavioral Health. (2020). Mental Health First Aid for Public Safety. Mental Health First Aid. <https://www.mentalhealthfirstaid.org/wp-content/uploads/2018/07/Mental-Health-First-Aid-Public-Safety-One-Pager.pdf>
- National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). Crisis now: Transforming services is within our reach. Education Development Center, Inc. <https://riinternational.com/listing/crisis-now/>
- The National Alliance on Mental Illness (NAMI). (2016, December). Public Policy Platform of The National Alliance on Mental Illness. <https://www.nami.org/Advocacy/Policy-Platform>
- NAMI. (n.d.). Who we are. <https://www.nami.org/About-NAMI/Who-We-Are>
- The National Suicide Prevention Lifeline. (n.d.). About the lifeline. <https://suicidepreventionlifeline.org/about/>
- Nordstrom, K., Berlin, J.S., Nash, S. S., Shah, S. B., Schmelzer, N. A., Worley, L. L. M. (2019, July 22). Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *West Journal of Emergency Medicine*. 20(5). 690-650. <https://escholarship.org/uc/item/71z0q1n8>
- On Our Own of Maryland's Transitional Age Youth Outreach Project. (2016). What helps what harms a young adult peer-led quality improvement project. On Our Own of Maryland. <https://onourownmd.org/wp-content/uploads/what-helps-what-harms-maryland-final-report-2016.pdf>
- Ostrow, L., & Fisher, D. (2011). Peer-run crisis respites--A review of the model and opportunities for future developments in research and innovation. <https://www.power2u.org/wp-content/uploads/2017/01/Ostrow-Fisher-PRCR-12.20.2011.pdf>
- Pinals, D. A., Fuller, D. A. (2017, October). Beyond beds: The vital role of a full continuum of psychiatric care. A joint report with the National Association of State Mental Health Program Directors. Treatment Advocacy Center. <https://www.treatmentadvocacycenter.org/beyond-beds>
- Posner, K., Brent, D., Lucas, C., Gould, M., Stanley, B., Brown, G., Fisher, P., Zalazny, J., Burke, A., Oquendo, M., & Mann, J. (2009, January 14). Columbia Suicide-Severity Rating Scale [Rating Scale]. The Columbia Lighthouse Project. https://cssrs.columbia.edu/wp-content/uploads/C-SSRS-Baseline-Screening_AU5.1_eng-USori.pdf
- Ranz, J.M., Weinberg, M., Arbuckle, M.R., et al. (2012). A four factor model of systems-based practices in psychiatry. *Academic Psychiatry*, 36, 473-478. <https://doi.org/10.1176/appi.ap.11030046>

- Ribbers A, et al. (2020). The crisis and transition services (CATS) model: A program to divert youth in mental health crisis from the emergency department. *Psychiatric Services*, 71, 1203-1206;
- Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., & Lehtinen, K. (2006). Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16(2), 214-228. <https://doi.org/10.1080/10503300500268490>
- SAMHSA. (2011, June). Consumer-operated services evidence-based practices (EBP) kit. U.S. Department of Health & Human Services. <https://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633>
- SAMHSA. (2014, June). Crisis services: Effectiveness, cost-effectiveness, and funding strategies. U.S. Department of Health and Human Services. <https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848>
- Stoneman, R. (2008). *Alexander the Great: A life in legend*. Yale University Press.
- Stowell, K.R., Florence, P., Harman, H. J. (2012). Psychiatric evaluation of the agitated patient: Consensus Statement of the American Association for Emergency Psychiatry Project Beta Psychiatric Evaluation Workgroup. *West Journal of Emergency Medicine*, 13, 11-16.
- Swartz, M. S. (2016). Emergency department boarding: Nowhere else to go. *Psychiatric Services*, 67(11), 1163-1163. <https://doi.org/10.1176/appi.ps.671102>
- Swartz, M. S., & Swanson, J. W. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What's in the data? *The Canadian Journal of Psychiatry*, 49(9), 585-591. <https://doi.org/10.1177/070674370404900903>
- Technical Assistance Collaborative, Inc. (2005). *A community-based comprehensive psychiatric crisis response service: An Informational and instructional monograph*. A Community-Based Comprehensive Psychiatric Crisis Response Service - TAC (tacinc.org)
- Trestman, R. L. (2017). Committed: The battle over involuntary psychiatric care. *Journal of the American Academy of Psychiatry and the Law*, 45(4), 513-514. <http://jaapl.org/content/45/4/513>
- Tucci, V. T., Moukaddam, N., Alam, A., & Rachal, J. (2017). Emergency department medical clearance of patients with psychiatric or behavioral emergencies, Part 1. *Psychiatric Clinics*, 40(3), 411-423. <https://doi.org/10.1016/j.psc.2017.04.001>
- Tucci, V., Siever, K., Matorin, A., & Moukaddam, N. (2015). Down the rabbit hole: Emergency department medical clearance of patients with psychiatric or behavioral emergencies. *Emergency Medicine Clinics*, 33(4), 721-737. <https://doi.org/10.1016/j.emc.2015.07.002>
- Text - H.R.2345 - 115th Congress (2017-2018): National Suicide Hotline Improvement Act of 2018. (n.d.). U.S. Library of Congress. <https://www.congress.gov/bill/115th-congress/house-bill/2345/text>
- U.S. Department of Justice, Bureau of Justice Programs. (n.d.). Police-mental health collaboration (PMHC) toolkit. Bureau of Justice Assistance. <https://bia.ojp.gov/program/pmhc>
- Vanderpool D. (2017). Top 10 myths about telepsychiatry. *Innovations in Clinical Neuroscience*, 14(9-10), 13-15.
- Weiss, J. A., Lunskey, Y., Gracey, C., Canrinus, M., & Morris, S. (2009). Emergency psychiatric services for individuals with intellectual disabilities: Caregivers' perspectives. *Journal of Applied Research in Intellectual Disabilities*, 22(4), 354-362. <https://doi.org/10.1111/j.1468-3148.2008.00468.x>
- Williams, E. R., & Shepherd, S. M. (2000). Medical clearance of psychiatric patients. *Emergency Medicine Clinics of North America*, 18(2), 185-198. [https://doi.org/10.1016/S0733-8627\(05\)70117-6](https://doi.org/10.1016/S0733-8627(05)70117-6)
- Wilson, M. P., Pepper, D., Currier, G. W., Holloman Jr, G. H., & Feifel, D. (2012). The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. *Western Journal of Emergency Medicine*, 13(1), 26-34. <https://doi.org/10.5811/westjem.2011.9.6866>
- Zeller, S. (2019, December). Hospital-level psychiatric emergency department models. *Psychiatric Times*, 36(12), 30-31. <https://www.psychiatrytimes.com/view/hospital-level-psychiatric-emergency-department-models>
- The Zero Suicide Institute. (n.d.). About. Education Development Center. <https://zerosuicide.edc.org/about>
- Zun, L. S., Leikin, J. B., Stotland, N. L., Blade, L., & Marks, R. C. (1996). A tool for the emergency medicine evaluation of psychiatric patients. *The American Journal of Emergency Medicine*, 14(3), 329-333. [https://doi.org/10.1016/S0735-6757\(96\)90191-6](https://doi.org/10.1016/S0735-6757(96)90191-6)

ACKNOWLEDGMENTS

The Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry would like to acknowledge the following individuals or organizations for providing thoughtful reviews and comments on an earlier draft of this report

- Travis Atkinson, TBD Solutions
- Beacon Health Options
- Ron Bruno, CIT International, ISMICC
- Council on State Governments
- Thom Craig, Peg's Foundation
- Arthur Evans, American Psychological Association
- George Everly, American Psychological Association
- GAP Publications Committee
- Mary Giliberti, ISMICC, NAMI, Mental Health America
- Matthew Goldman, University of California, San Francisco Department of Psychiatry
- Brian Hepburn, National Association of State MH Program Directors
- Elena Kravitz, Interdepartmental Serious Mental Illness Coordinating Committee
- Roger Peters, Florida MH Institute
- Policy Research Associates
- Heather Rae, Common Ground
- Ruth Simera, Northeast Ohio Medical University
- Patricia Stern, William Josef Foundation

AUTHOR BIOSKETCHES

CURTIS ADAMS, MD: Assistant Professor of Psychiatry at the University of Maryland School of Medicine, is an ACT psychiatrist in Baltimore who currently works in a psychiatric emergency room part-time and supervises another psychiatric emergency room part-time.

SARAH E. BAKER, MD, MA is an Assistant Professor of Psychiatry at the University of Texas Southwestern Medical Center. She serves on both local and state workgroups exploring crisis diversion and other models of care for justice-involved patients.

MARGIE BALFOUR, MD is a psychiatrist and national leader in quality improvement and behavioral health crisis services. She is the Chief of Quality and Clinical Innovation at Connections Health Solutions, which provides 24/7 access to mental health and substance use care throughout Arizona, and is an Associate Professor of Psychiatry at the University of Arizona. Dr. Balfour was named the Doctor of the Year by the National Council for Behavioral Health for her work at the Crisis Response Center in Tucson and received the Tucson Police Department's medal of honor for her efforts to help law enforcement better serve the mentally ill population.

XINLIN CHEN, MD. Columbia University Public Psychiatry Fellow, Part-time Attending Psychiatrist at Gouverneur Clinic, has worked in various aspects of the crisis system in NYC during residency and fellowship.

DIANNA DRAGATSI, MD: Associate Clinical Professor of Psychiatry at Columbia University Medical Center and Attending at Mid-Hudson Forensic Psychiatric Center, was Director of the Psychiatric Emergency Room at New York Presbyterian Hospital, as well as an attending in an emergency room at an upstate New York hospital (Garnet Health). She has published about delivery of behavioral health care in emergency room settings, consulted with the Council of State Governments on crisis services in different states as well taught psychiatric residents about emergency psychiatry and de-escalation practices.

JACQUELINE MAUS FELDMAN, MD, Professor Emerita, Department of Psychiatry and Neurobiology, University of Alabama at Birmingham. Prior Director of Psychiatric Services (Duke), Vice-Chair for Clinical Services (over Psych ER) and Chair, Task Force on Crisis Services (NAMI AL).

MICHAEL FLAUM, MD, President, American Association for Community Psychiatry and Emeritus Professor of Psychiatry at the University of Iowa has focused on a variety of strategies to expand the array of behavioral health services in a manner that optimizes quality and access to care, including the development of crisis services, and has been actively involved in the development of Johnson County (Iowa) Crisis Center.

ANN HACKMAN MD: Division Director Community Psychiatry University of Maryland School of Medicine, Medical Director Programs of Assertive Community Treatment.

STEPHANIE LE MELLE MD, MS, is the Director of Public Psychiatry Education at Columbia Univ Department of Psychiatry/ New York State Psychiatric Institute. She is an Associate Professor of Clinical Psychiatry at Columbia University Medical Center.

Dr Le Melle was a member of the MacArthur Foundation Network on Mandated Outpatient Treatment, a consultant to SAMHSA and to various other national, state and local organizations.

JUDGE STEVE LEIFMAN is an Associate Administrative Judge in the Eleventh Judicial Circuit of Florida, Chair of the Steering Committee on Problem Solving Courts for the Supreme Court of Florida, a Lecturer in Psychiatry at Columbia University Vagelos College of Physicians and Surgeons and a Voluntary Assistant Professor of Psychiatry and Behavioral Sciences at the University of Miami School of Medicine, has worked to improve the crisis response system in Miami-Dade and around the United States to keep people with mental illnesses out of the criminal justice system.

KENNETH MINKOFF, MD: Vice President of ZiaPartners, Inc, in Tucson AZ, Part-Time Asst Professor of Psychiatry at Harvard, has operated numerous MH and SUD crisis services and systems since 1976, and currently provides crisis system consultation in multiple states.

MARK R. MUNETZ, MD is Professor and Chair of Psychiatry, Emeritus, Northeast Ohio Medical University, since 2020 after serving as Chair of Psychiatry from 2007-2019. He is the co-developer of the Sequential Intercept Model, a framework to address the over-representation of people with serious mental illness and co-occurring substance use disorders in the criminal justice system.

KERIS JÄN MYRICK, MBA, MS is Co Director of the Mental Health Strategic Impact Initiative (S2i) with over 15 years of experience in mental health services innovation, transformation and peer workforce development at federal, national and local levels which includes integration of peer workforce in policy program and practice work in crisis systems and the continuum of care

FRED OSHER, M.D., has overseen the development of community urgent care models and the continua of crisis services for individuals with serious mental illnesses while Director of Community Psychiatry at the University of Maryland. More recently he consults on effective law enforcement/behavioral health systems crisis response.

PAULA PANZER, MD has contributed for decades to crisis service provision in New York City as a member of a mobile crisis team and as a CBHO Medical Director and systems leader of services for adults, children and families throughout the city,

JOSEPH PARKS MD is Medical Director and Vice President for Practice Improvement at the National Council for Behavioral Health. He is former Medicaid Director and former DMH Medical Director for the state of Missouri and is also a Distinguished Professor of Science at Missouri Institute for Mental Health, University of Missouri St. Louis.

JOHN SANTOPIETRO, MD, is the Physician-in-Chief of the Behavioral Health Network at Hartford HealthCare as well as Assistant Clinical Professor of Psychiatry, Yale School of Medicine and Assistant Professor of Psychiatry, UCONN School of Medicine.