2022

Crisis Services - Best Practices Summary

Someone to Come and A Place to Go

Prepared for:
Washington State's Crisis Response Improvement Strategy (CRIS) Committee

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Crisis Services - Best Practices Summary Document Purpose

This document has been prepared for Washington State's Crisis Response Improvement Strategy (CRIS) Committee to provide a summary and references of national best practices related to core crisis system services. As defined by Substance Abuse and Mental Health Services Administration's (SAMHSA), core crisis services[i] are often referred to as:

- *Someone to Come* (Crisis Mobile Team Response)
- *A Place to Go* (Crisis Receiving and Stabilization Facilities)

Crisis System Models

Someone to Come and *A Place to Go* are concepts within the context of a crisis services continuum. Over the past several years, there has been a growing consensus regarding what constitutes the core of a crisis services continuum, including crisis call centers, crisis mobile response teams, and crisis receiving and stabilization facilities. Furthermore, there is a growing body of literature that provides consistency in defining these crisis services. [ii iii iv v] This same literature also conveys that these services must not just exist, but truly *provide access for all* at the time needed. Additionally, there is growing consensus on an *expanded view* of a crisis continuum that includes early engagement to avoid crisis as well as post-crisis care to support individuals and families to remain stable in their communities. Figure 1: WellBeing Trust - Crisis Response Continuum of Care illustrates how this expanded concept is envisioned to include prevention

Figure 1: WellBeing Trust - Crisis Response Continuum of Care

and post-crisis care.[vi] Examples of these services include warmlines, transportation, crisis respite, crisis step-down, and peer navigators. [vii viii ix x]

Someone to Come

SAMHSA defines Crisis Mobile Team Response or Someone to Come as "Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner". [xi] SAMHSA further defines the minimum and best practices for these services.

SAMHSA's Minimum Expectations to Operate Mobile Crisis Team Services:

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

SAMHSA's Best Practices to Operate Mobile Crisis Team Services:

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

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

All states are currently working to design, implement and/or enhance mobile crisis services. Following are examples of best practices from other states.

Arizona

For over twenty-five years, Arizona has been providing mobile crisis services to *anyone* in the state who is experiencing a crisis using a *no wrong door* or *no wrong insurance* approach.

Arizona's approach and requirements[xii]:

- The state Medicaid agency, Arizona health Care Cost Containment System (AHCCCS), contracts with a single health plan within a region that requires a comprehensive crisis continuum for all (Medicaid and non-Medicaid) including mobile crisis that responds 24/7/365.
- Oversight and key performance metrics include response times that are within an average of one hour in Maricopa County and within an average of 90 minutes for other areas. Incentives exist for performance below established thresholds.
- Prioritize law enforcement requests for mobile team dispatch with a target response time of 30 minutes or less.

- Work collaboratively with law enforcement/public safety personnel and develop strategies to ensure mobile team response is effective and tailored to specific needs.
- Utilize credentialed peers and/or family support specialists for mobile crisis team response.
- Crisis telephone services are directly linked with mobile crisis teams to dispatch mobile teams and tracking of mobile teams.
- When clinically indicated, mobile crisis or non-emergency medical transportation (NEMT) providers transport an individual to an appropriate facility for further care.
- Braided crisis funding from multiple sources into a single contract per region provides a continuum of crisis services including mobile crisis to facilitate and enhance crisis system collaboration with stakeholders. The braided funding includes Medicaid, the state-allocated funding for crisis services, federal block grants, and some county funding.
- Use of advanced technology that[xiii]:
  - Dispatches mobile crisis teams
  - Has integrated tools that support sending and receiving clinical information to/from call centers and mobile crisis
  - Uses tablets to easily capture data and make "time stamps" for dispatch travel and arrival times to track response times
  - Uses GPS capabilities to identify where teams are and connect them with individuals in need (like Uber and Lyft type technology)
  - Utilizes dashboards to monitor the current activity of the call center and mobile crisis services

Ohio

The Ohio Department of Medicaid and Department of Mental Health and Addiction Services (MRSS) have established a robust approach to providing mobile crisis for ***any young person under the age of 21*** who is experiencing significant behavioral or emotional distress and their families (birth, kinship, foster, guardian, and adoptive). The program is called the ***Mobile Response Stabilization Services (MRSS)*** and is connected with the advancement of *Wraparound Ohio* that emphasizes community supports that "wrap around" a young person and their family with the needed services.

The MRSS program uses advanced tools that have been developed by the state and stakeholders.

Mobile Response and Stabilization Services Practice Standards[xiv] outline:

- Overview, objects, and context within Systems of Care
- MRSS service components that include screening/triage, mobile response, and stabilization
- Parameters of operations such as service availability, service location, family engagement, use of telehealth
  - Service length includes screening, triage, and mobile response which can last up to 72 hours and the stabilization can last up to six weeks
- MRSS staffing standards such as team composition, supervisors, peer supporters, consultation, staffing levels, staff competencies
- Administration and oversight include topics such as provider certification, fidelity (within 12 months of beginning operations a provider must participate in a fidelity review to ensure fidelity to the model), data management, and Ohio Center for Excellence

The Mobile Response and Stabilization Service Tool Kit and Resource Guide[xv] has extensive protocols, techniques, and tools for each of the three core services of MRSS, including:

- Triage checklist to guide the individual who receives and processes telephone calls
- Triage levels (see Figure 2: MRSS Triage Response Levels)
- Mobile response tasks include an open mindset for uncovering needs, activities for when they arrive at the place where the young person and/or family are, engagement and assessment including on-site triage to assess the level of risk and needs, intervention techniques (with a focus on young people), functional mapping (assets of the young person and their family),and identifying *underlying needs.*
- The stabilization phase focuses on skill-building, coordination of support, and linkages for the young person and their family.

Figure 2: MRSS Triage Response Levels

Triage Response Levels		
Level of Response	**Description**	**Response & Time**
Information & Referral	• Information, linkage, referral, support • Examples: requests for agency phone numbers; information about benefits or resources; listing of services; • Ask if they have any emergent need that they are calling about.	Over phone by triage staff
Non-immediate	• Family-driven response • Per family or referrer request a scheduled response is requested instead of an immediate response.	Phone stabilization and scheduled response based on family need. Mobile response within 8 – 24 hours
Immediate	• Family-driven response • Response requires a clinician with a license to provide a diagnostic impression. • Response team is a clinician who can provide a diagnostic impression plus one other staff • High degree of distress • Reports of high-risk behaviors: Examples: Unresolvable/escalating conflict; non-life-threatening emergency; ideation with no plan; non-compliance that impacts functioning; aggression	Mobile response within 1 hour
Emergency	• **Substantial risk of self-harm or harm to others**: Actively suicidal; homicidal; active self-harm behaviors; domestic/family violence; active threat of harm to others; overdose; medical emergency • **If the call is deemed an emergency, the hotline will call 911 while the family is on the phone.** • **The MRSS team will then be dispatched to the location of emergency stabilization (hospital, home, etc.).** • **In emergencies, MRSS team is expected to follow-up once the life-threatening situation is stabilized.**	911; Lethality pre-screening; and dispatch MRSS Team to stabilization site.

A recent program update by the Ohio Department of Medicaid and Department of Mental Health and Addiction Services included information about the selection of vendors for development and management of a statewide Call Center for MRSS, and development and implementation of a statewide data management system; updates on piloting of fidelity reviews; updates to provider certification; and use of a benchmarking tool.

Colorado

For over a decade, the state of Colorado has implemented a statewide approach to crisis services that is designed to be available for *any* person in need of crisis services. Colorado was the first state to contract for a statewide crisis call center that would be connected to mobile crisis services across the state. They also have crisis stabilization centers. Like most states, Colorado is also reviewing its current design and identifying new opportunities to strengthen its crisis system, including exploring ways to take advantage of CMS' enhanced FMAP of 85% for mobile crisis services.

In addition to the work Colorado is doing to continue to evolve its crisis system and improve access, the state's ***first response system*** is innovating to address the needs of those with significant crisis needs. One example of this is the Community Assistance Referral and Education Services (CARES) program[xvi] operated by the Colorado Springs Fire Department (CSFD). The CSFD Community and Public Health Division encompasses mobile response teams such as the Community Response Team (CRT) and multiple navigational programs that operate under the CARES umbrella.

The CSFD CARES program assists frequent users of the 9-1-1 and emergency departments (six visits to the ED or six 9-1-1 calls within a 6-month period) in Colorado Springs with their physical, medical and behavioral health needs through outreach, assessment, connection to community resources and care navigation. Referred patients are offered the opportunity to participate in a voluntary intervention designed to find resources and address barriers to healthcare access. This intervention can last for up to

12 months. The CARES team consists of intake providers, medical navigators, and behavioral health clinicians.

The CSFD Community Response Team (CRT) Mobile Response Program responds to behavioral health crisis calls from 9-1-1 and the state crisis line to reduce the wait time for definitive services. The CRT team identifies behavioral health needs and works to connect patients to a larger collaborative healthcare team.

The City of Denver has implemented a Support Team Assisted Response (STAR)[xvii] program that also deploys Emergency Medical Technicians and Behavioral Health Clinicians to engage individuals experiencing crises related to mental health issues, poverty, homelessness, and substance abuse. The program is overseen by a local Advisory Committee that tracks data to access the effectiveness of the program and fidelity to the program's core values.

A Place to Go

SAMHSA, in its National Toolkit[xviii], defines ***crisis receiving and stabilization services*** or **A Place to Go** as a crisis facility that offers the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire, and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure, and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space.

SAMHSA's Minimum Expectations to Operate Crisis Receiving and Stabilization Services:

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

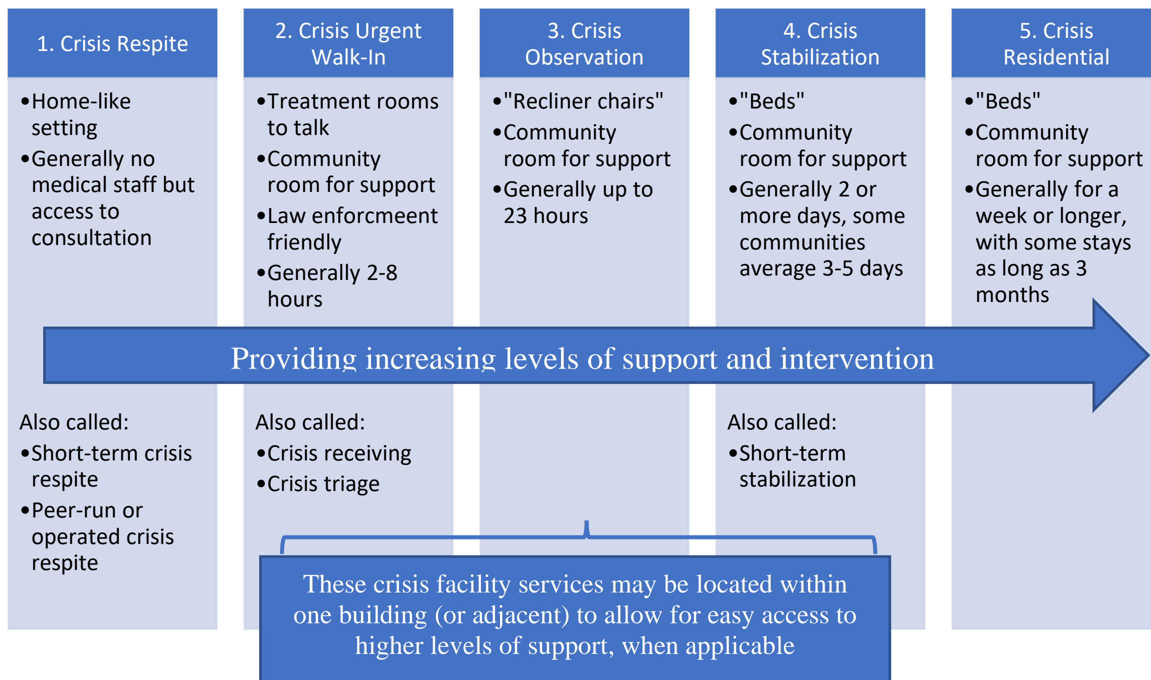
SAMHSA’s Best Practices to Operate Crisis Receiving and Stabilization Services:

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

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

Across the nation and within Washington State, *there are many characteristics* of **A Place to Go** (Fig.3)

Figure 3: “A Place to Go” – Crisis Facility Characteristics



Arizona

Building on Figure 3 above, there are different models of **A Place to Go** in Arizona.

Figure 4: Examples of Arizona - "A Place to Go" Programs

Provider Name	Figure 3 Services	Metro or Rural
ChangePoint Integrated Health[xix]	Columns 2, 3, and 4	One location in a rural county (Yavapai) in northern Arizona
Community Bridges[xx]	Columns 2, 3, 4 and 5	Seven locations throughout AZ some in small rural areas
Connections Health Solutions[xxi]	Columns 2, 3, and 4	Two locations located in 2 largest counties
Polara Health[xxii]	Columns 2, 3, and 4	One location in a rural county (Apache) in northern Arizona
RI International[xxiii]	Columns 2, 3, 4 and 5	Four centers in largest county (Maricopa)

All of these programs have the following attributes but may use different terms:

- Anyone can walk in (all service adults, Connections service children/youth in Tucson)
- Peer supports – some use the term “peers first”, meaning they are the first point of contact
- No wrong door (addresses mental health and substance misuse conditions)
- Police drop-off
- Screen for involuntary
- Service Medicaid and Non-Medicaid individuals

The *Crisis Now: Transforming Crisis Services in Arizona*[xxiv] video showcases many of the programs outlined above.

California

The “Alameda Model” was developed as a regional solution to address the issue of psychiatric emergency room boarding.[xxv] The model itself includes a crisis stabilization unit contiguous with a dedicated psychiatric hospital. This regionalized care model focuses on providing timely treatment for patients experiencing a mental health crisis, significantly reducing wait times for treatment while also decreasing psychiatric admissions.[xxvi]

Peer Run Respite Models - Michigan and Wisconsin

Building on Figure 3, Column 1 above are several programs in Michigan and Wisconsin that identify as a “peer-run respite”:

- Michigan: Hope365[xxvii] is a peer respite and wellness center for peer-to-peer recovery support that opened in the spring of 2022.

- Wisconsin has multiple peer-run programs funded by the State of Wisconsin's Department of Health Services[xxviii]:

- The Monarch House[xxix] is a peer-run respite described as a voluntary, non-medical overnight program in a supportive, home-like environment for people who are experiencing mental health and substance use related crises or any other emotionally distressing challenges.
- The Solstice House[xxx] peer-run respite provides a resource for individuals in need of extra support related to mental health and/or substance use concerns. The program offers human connection in a home-like environment. Figure 5: *Solstice House* shows the home-like environment for the program.

Figure 5: Solstice House

End Notes

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[ii] Ibid.
[iii] National Association of Mental Health Program Directors, *Crisis Now Transforming Crisis Services* (2021) available at https://crisisnow.com/
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[v] National Governors Association, *Improving Outcomes and Reducing Cost of Care for Complex Care Populations with Behavioral Health and Social Support Needs: Toolkit for Governors* (2020) available at https://www.nga.org/center/publications/complex-care-populations-behavioral-health-social-support/
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[xv] Case Western Reserve University and Ohio Department of Mental Health and Addiction Services, *Mobile Response and Stabilization Service Tool Kit and Recourse Guide, Version 1.0*, 2021, Retrieved at https://wraparoundohio.org/wp-content/uploads/2022/04/MRSS-Tool-Kit-V1.0.pdf
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[xxi] Connections Health Solutions, webpage, retrieved at https://www.connectionshs.com/
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