Final Report

Dane County, Wisconsin | Mobile Crisis Consultation

Date Submitted: 4/12/2024
Deadline: 4/15/2024

Centerstone| Crisis Services & Office of Psychology

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Final Report to include recommendations for the following: the most efficient and effective way to organize mobile crisis resources to ensure optimal crisis responses 24 hours per day 7 days per week in the urban and the rural areas of Dane County. This should include approximately the number and configuration of mobile crisis teams that are necessary to ensure optimal crisis responses throughout Dane County. To the degree that there are distinctions between response need and methodology in the urban and rural areas of Dane County, those should be clearly stated.

- The optimal composition of mobile crisis teams, including credentials and level of expertise necessary for individuals on these teams
- The most efficient and effective way to dispatch mobile crisis teams throughout Dane County
- The degree to and method by which mobile crisis teams should co-respond with other first responder resources, including law enforcement, fire, and emergency medical technicians throughout Dane County
- The role mobile crisis teams should play in connecting individuals to facility-based or other forms of post-response care through warm hand-offs or coordinating transportation
- Partnerships necessary to sustain a high-quality mobile crisis response system
- Outcome measures and data to be tracked for both process and outcome measures and for quality improvement
- Relevant suggestions on the implementation strategy for recommended changes
- Other considerations

Note: Based upon the extreme lack of data on actual mobile crisis responses in the county, we are not able to comment on the exact numbers of mobile crisis responders needed in Dane County. If the recommendations are put into place, data collection will inform the numbers of mobile crisis responders needed in Dane County.

Structure of Final Report

Executive Summary

In Dane County, we have seen firsthand the power of a community coming together to address the mental health crisis needs of its members. The county has a remarkable array of mobile crisis programs, each dedicated to providing support and care and demonstrating a profound commitment to ensuring that no one faces a mental health crisis alone.

But even as we applaud the creation of these resources, we recognize that there is always room to grow. Right now, these programs operate in silos, with little collaboration between them and most of the requests for help they receive are not for a mental health crisis. We believe that by working together, you can create an even stronger system that better serves the community as a whole.

Imagine a future where a call for help is met with the most appropriate response, every time. Where a crisis worker, a peer specialist, a paramedic, or a law enforcement officer is dispatched based on the true needs of the individual. Where a dedicated workforce is valued and supported, freeing them to do the vital work they signed up to do. And where resources are used in the most cost-effective way possible, allowing you to do more with no increase cost to the county.

That is the mobile crisis model we envision – a model for how to transform a fragmented system into a united front for mental health crises. A place where innovation meets compassion to create a future of hope and healing for all. And we believe that this model can inspire similar transformations and be a model for the rest of the country. Where those in mental health crisis receive help from the most appropriate professionals and every person has the right support they need.

For this report, recommendations are being made with very limited data from all of the providers offering mobile crisis services (Journey, Madison Police, Madison Fire, and Dane County Sheriff's Department). To make real change in the system, the manner in which data is collected, will need to change. To get started with transformation, first, you will need to get agreement for key stakeholders on what data is vital to understanding mobile crisis service delivery. Think about the values your community cares about – compassion, safety, recovery – and the outcomes we hope to see – decreased suicide deaths, connection to services, fewer hospitalizations, and better client satisfaction. Once you agree on those, you can pick the right metrics to track progress.

Site visits showed us the current co-responder programs in Dane County are not operating in a way to meet the needs of those in mental health crisis. Despite the large investment in these co-responder model efforts between first responders and mental health providers, most requests for help do not appear to involve mental health crises. This means that there is an ineffective distribution of resources to tend to the mental crisis needs of Dane County residents.

We think a community where law enforcement, emergency medical services, the community provider of the mobile crisis team, and the community at large work seamlessly together to respond to crises is ideal. Open communication and true partnership should be the norm. This is the vision behind the recommendations outlined in this report. We recommend that you plan a date to sunset the co-responder programs within the Madison Fire Department, Madison Police Department, and the Dane County Sheriff's Department and that the only mobile crisis team should be operated by a community provider. In this model, all law enforcement, fire, and emergency medical service personnel receive extensive training on working with those in a mental health crisis and they are called upon to respond when indicated based on their area of expertise. We also recommend that the community provider of the mobile crisis team be staff dedicated to this function and are not serving in dual roles (ie. also crisis call takers). If these recommendations are followed and you phase out the co-responder model, you will need a new strategy to keep a collaborative spirit alive. To achieve this we propose you utilize dedicated emergency services liaisons who can act as the glue that holds the new system

together. These liaisons will be out in the field, building relationships, and breaking down silos. They will be the ones training first responders to work side-by-side with the community mobile crisis team, fostering a shared understanding of each other's roles.

In terms of the front door for mental health crisis, we recommend the commnity provider crisis call center be the main avenue for requests for mobile crisis response and is the sole dispatcher for their service. It would be ideal, that in the event they ascertain there is a need for law enforcement or emergency medical presence, they contact Dane County 911 for dispatch of those resources. For the staffing of the commnity provider crisis call center, it is crucial that crisis center staff focus solely on their roles, without the added stress of dual responsibilities as a mobile responder. This dedicated approach enhances their ability to provide quality care and appropriately divert many calls from an in-person response. Historically, hiring for crisis services has been a challenge across the country and in Dane County. To combat this, we recommend the community provider of the mobile crisis team operate their crisis call center in a a virtual manner. A fully virtual crisis call center opens the door to a much wider pool of talented individuals, not just limited to those within Dane County. In fact, many successful virtual crisis centers draw staff from across the country, ensuring a diverse and skilled workforce.

During our time with individuals in Dane County, we heard one of the loudest needs is to improve wages and benefits which would also improve retention. There was also an acknowledgement that recently there has been additional funding to increase staff wages, and this was greatly appreciated. This does seem to be an area that needs further attention and this investment in staff's compensation would demonstrate a commitment to both staff well-being and the delivery of high-quality care.

Follow-up is an essential part of crisis services and ensures no one slips through the cracks. That is the vision behind our recommendation to centralize follow-up services for both the community provider crisis call center, community provider of mobile crisis and the Dane County 911 Center. After a crisis call into the community provider crisis call center or with Dane County 911, mental health diversion staff or mobile crisis assessment, information is instantly shared with one follow-up team who has the responsibility of helping individuals navigate their needs post crisis.

Technology can be leveraged in some areas of the system. A system like Trek Medic's Beacon platform allows for real-time monitoring of deployed workers and streamlined dispatching of the community provider's mobile crisis team. A centralized portal, like one used in the state of Illinois, can be developed for making electronic referrals for mobile crisis team dispatch. Other potentials areas for technology use are a shared platform between the community provider of the mobile crisis team and Dane County 911 for follow-up and a platform for inpatient psychiatric bed searching.

During our time gathering and analyzing information about the current mobile crisis system operating in Dane County, we unearthed a few issues that need attention to improve the system. First, the current statute outlining the process for involuntary commitments to inpatient psychiatric facilites is grossly outdated. Updating this statute should be a high priority. Second, the community provider of the mobile crisis team should not be expected to respond to emergency rooms for mental health crisis. Those hospitals whould have the internal capacity to deliver care to these patients in their facilites. This frees up a great amount of time for the community provider of the mobile crisis team to respond in the community inculding underserved rural areas of the county. Third, current processes for "medical clearance" for those in mental health crisis are causing unnecessary visits to the emergency room, which can be unpleasant and tramuatizing for the individual in crisis and quite costly to the person and the system as a whole. Agreed-upon guidelines for when "medical clearance" is warranted need to be establsihed and followed. Fourth, the lack of collbaroration amongst key stakeholders is very apparent. This group must come together to develop and implement an improved mobile crisis system in Dane County. Fifth, the funding of the mobile crisis system should be expanded so all payers are contributing. Also the manner of funding should account for the cost to be avaialble 24/7/365 , which is not the case in a fee-for-service structure. Something like a Per-Member-Per-Month (PMPM) structure should be considered. Sixth, the lack of data related to mental health crisis, mobile crisis response, and other non-mental health crisis requests is a real achilles of the system. It should be of the highest priority to establish process for comprehensive data collection.

Making these changes will take time and stakeholder collaboration. We are proposing a phase-based approach to build trust with joint initiatives (collaborative implementation plan). Collaborative implementation plans are crucial in breaking down silos between teams. Silos occur when different teams work in isolation, leading to miscommunication, mistrust, duplicated effort, and ultimately, project failure.

In light of the interview data, it would be in the project's best interest to have a neutral facilitator as a project manager for the first two years to ensure a collaborative process-- and to provide oversight and accountability. If this is not feasible, then someone within Dane County government should take the lead though this is not ideal. It is vital for leaders at all of these organizations to be held accountable to each other for the success of mobile crisis response in Dane County. A collaborative implementation plan promotes cross-functional alignment, ensures everyone understands their role, and fosters a sense of shared ownership over the project's success. Without this collaborative approach, teams will continue operating in silos, hindering the overall implementation process.

We hope this executive summary sets the stage for the rest of the report and the model we are proposing. To us, this is not just a proposal – it's a blueprint for a future where crisis response and recovery are truly integrated, and where every person gets the support they deserve.

Co-responding Model

Analysis of Current Co-responding Model

I. Journey

Source(s):
2022 Journey Annual Report
On-site meeting with Becky Stoll & Neesha Roberts

Operations

The Journey Crisis Services program (Crisis call center and Mobile Crisis Team (non-co-response) operates in "all hands-on deck" fashion in a central location in Madison. This 24/7/365 operation assigns staff to Crisis Call or Mobile Crisis roles when on shift, but when the need outweighs the resource assigned, in either area, staff are pulled to fill the need. At times, telehealth is used for mobile crisis services, but no other part of the operation is virtual. While the "all hands-on deck" strategy has been employed to provide the presented volume of telephonic and face-to-face mobile crisis services with the current staffing levels, it is not the optimal manner in which to operate Crisis Services. The skills required for handling telephonic crisis versus face-to-face mobile crisis assessment are different. It is not reasonable to expect staff to be highly skilled, confident, and competent in both areas and move between the two during the course of a shift.

The request for face-to-face mobile crisis assessment is most often a respond to hospital emergency departments. This seems mostly due to current law that mandates Journey crisis staff and law enforcement personnel each play a role in involuntary commitments to inpatient psychiatric facilities. As such, law enforcement often takes individuals in a mental health crisis to emergency rooms for this evaluation. Most often there is no medical reason to do so. It also appears this occurs because inpatient psychiatric facilities require "medical clearance" for all accepted admissions. Inpatient psychiatric facilities should not

have a blanket requirement for "medical clearance" for all admissions. Hospital emergency departments should not serve as the "go to" location for someone in a mental health crisis unless there is a medical reason to do so as this ties up the majority of Journey's mobile crisis bandwidth.

Staffing

With the demands for their crisis services, Journey reports being unable to hire the number of staff needed to fulfill the need. This is especially true when it comes to responding to requests in rural counties, which they are unable to do. In order to meet the demand and provide these services to everyone in need in Dane County, more funding will need to be provided for staffing. This does not necessarily have to be new funding but could be a reassignment of current funding from the co-response models. Complicating this further is the salary/benefits for mental health crisis roles is better/higher when employed by the city or county versus Journey. This will need to be addressed in order to hire the appropriate number of staff to meet the need. Another complication is with no to limited access to data from Journey and the co-responder programs, there is no accurate information on volume/demand, so it is not possible to project needed numbers of FTEs.

Co-Responder Operations (Journey's View)

Within the Journey system, there seems to be varying opinions on the benefits of operating Co-Responder models in Dane County... As such, there does not seem to be a clear internal vision on the feasibility and effectiveness of operating multiple co-responder models in Dane County. Due to their significant crisis workforce staffing challenges, they would benefit greatly by having the mental health positions assigned to the Madison Police Department, Dane County Sheriff's Department, and the Madison Fire Department reassigned to their internal operations.

Technology

Journey Crisis Services is not employing any type of technology for the dispatching/monitoring of mobile crisis. They might benefit from employing one to assist them in using their limited resources most effectively. In addition, operations related to crisis services are paper based. Technology tools would be of assistance to aid them in streamlining operations.

Documentation

Crisis calls and mobile crisis assessments are documented within Journey's electronic health record, which currently does not interface with any of the other key stakeholders including their co-response partners. The overall crisis service system would benefit from collaboration in this area.

Data Collection

While Journey collects some crisis services data, industry standard crisis data elements are not being collected. The collecting of crisis services industry standard data elements should be a priority. This information will be vital in planning for and implementing changes to the system and starting to meet community need.

II. Embedded Law Enforcement – Madison Police Department

Data Source(s):
2022 Madison PD Mental Health Unit Report
On-site meeting with Becky Stoll & Neesha Roberts

Operations

With the Madison Police Department/Journey co-responder model not being dispatched by 911, responses are limited to being initiated by the responders themselves, who listen for calls they think are appropriate to respond to, or other police officers requesting assistance. Many responses do not appear to be for mobile crisis assessments, but instead a "catch all" of various situations. Some are social service in nature, post critical incident response, and some grief oriented.

The team indicates the goals of the program are to deescalate situations, decrease transports to the emergency department and involuntary commitments, and conduct assessment/safety planning. While these things do seem to occur, the overall sense is that more time is spent doing non-mobile crisis assessment work and follow-up activities than true mobile crisis response.

Staffing

The Madison Police Department has 6 dedicated Mental Health Officers who serve in this program for three years and they can request to stay assigned for another "term" when their time is up. This takes 6 commissioned police officers off regular police patrol.

The 2 contracted Journey staff positions have been difficult to keep fully staffed with one vacant for 1 ½ years. With the Journey Crisis System desperate for crisis staffing, it seems these positions would be better used in that system.

Co-Responder Operations

As with the other co-responder models that are in play in Dane County, it appears this one was born out of a need for assistance on some mental health calls where Journey has not had the resources to respond. There is no clear indication that there is a great need for a law enforcement presence for the overwhelming majority of calls that are truly for mobile crisis assessments. Everyone that was interviewed acknowledged that almost all request for deployment of this team did not need a police officer present.

Given all of this information, it does not seem the best decision to operate a co-responder model in the Madison Police Department. To do so takes away significant law enforcement resources and allocates precious mobile crisis resources that Journey could use in their mobile crisis operations, especially responding to rural counties. Two other factors support this analysis; 1) there is acknowledgement within the program that it is almost never necessary for a law enforcement officer to be present and 2) the contacts being handled are not mobile crisis assessments the majority of the time and often the staff are actively looking for calls to respond to.

Technology

No technology is being used in this operation. Given the small staffing numbers, it is not needed.

Documentation

Documentation of contacts are made in two separate places: within the Madison Police Department system and in Journey's electronic health record. These do not interface with each other or with any of the other key stakeholders. The overall crisis service system would benefit from collaboration in this area.

Data Collection

Data collection is not being captured in any real significant way. For example, there is no data on the number of mobile crisis assessments they respond to per year. When asked, the response was "a lot". With limited data, it is hard to ascertain exactly how many of the encounters are true face-to-face mobile crisis assessments. Until there is more comprehensive data, it will not be feasible to estimate the number of mobile crisis assessment requests coming out of the Madison Police Department.

III. Embedded Sheriff's Department

Data Source(s):
2023 Sheriff Department Mental Health Team Report
On-site meeting with Becky Stoll & Neesha Roberts

Operations

The Dane County Sheriff's Department/Journey co-responder model is the location where the needs of rural community members are attempting to be addressed (37 different municipalities with multiple towns in many). This is a large area with a minimum drive time of 45 minutes to each.

The CARES model could not be replicated in these areas as the fire/Ems departments are most often volunteer staffed. This program was born out of the need to fill a gap in mobile crisis response services in rural areas. Journey indicates they strive to respond to requests for rural mobile crisis services but lack the staffing to do so.

Descriptions of many requests for response do not appear to be mental health crisis assessments, but instead a "catch all" of various situations. They do see cases of psychosis and suicidal ideation, but many calls are from older adult caregivers of someone with a chronic mental health condition asking for help due to their stress level. They also have many repeat callers. Dane County Sheriff's Department indicates these calls take significantly longer to handle than their other types of calls. More of the staff's time is spent on follow-up activities than actually responding to request for mobile crisis assessments. Since this is not a 24/7/365 operation, many calls are handled the next time someone comes on duty.

The Sheriff Department team indicates the goals of the program are to divert from jail, identify need, safety planning, and transports to emergency departments for emergency detention. While these things do occur, more time is spent doing follow-up activities than true mobile crisis response.

In all conversations related to this program, the large need for "case management" in rural areas was brought up. This information paired with the lack of information to suggest there are a large number of requests for mobile crisis assessments indicates this model might not be the most beneficial to the areas.

Staffing

The Dane County Sheriff's Department has 4 dedicated Mental Health Deputies who serve in this program. This takes 4 commissioned deputies off regular patrol. Leaders in the department indicate they want to add more Mental Health Deputies.

Currently only 1 of the 4 mental health staff positions is filled. There are long standing issues with filling these positions with all 4 vacant almost the entire time the program has been in place. With the Journey Crisis System desperate for crisis staffing, it seems these positions would be better used in that system. Dane County Sheriff's Department would like to employ the mental health crisis positions themselves, but that request was not approved. They identified the barriers to hiring as limited workforce to draw from, Journey lower salaries than they could pay, and unattractive shifts.

Due to the lack of staffing of the mental health crisis positions, this program has never operated in the way in which it was intended. To this point, the work is solely being done by the Mental Health Deputies, which is not a co-responder model.

Co-Responder Operations

As with the other co-responder models that are in play in Dane County, it appears this one was born out of a need for assistance on some mental health calls where Journey has not had the resources to respond. There is no clear indication that there is a great need for a law enforcement presence for the overwhelming majority of calls that are truly for mobile crisis assessments. Everyone that was interviewed acknowledged that almost all requests for deployment of this team did not need a deputy present.

Given all of this information, it does not seem the best decision to operate a co-responder model in the Dane County Sheriff's Department. To do so takes away significant law enforcement resources and allocates precious mobile crisis resources that Journey could use in their mobile crisis operations, especially responding to these rural counties. Two other factors support this analysis: 1) there is acknowledgement within the program that it is almost never necessary for a law enforcement officer to be present and 2) the contacts being handled are not mobile crisis assessments the majority of the time and overall case management is the biggest need.

Technology

No technology is being used in this operation. Given the small staffing numbers, it is not needed.

Documentation

Documentation of contacts are made in two separate places: within the Dane County Sheriff's Department system and in Journey's electronic health record. These do not interface with each other or with any of the other key stakeholders. The overall crisis service system would benefit from collaboration in this area.

Data

Dane County Sheriff's Department shared that their data collection has gotten better in the last year, but there are improvements that could be made to make it more comprehensive. It is also difficult to collect data on the program when it is not operating as intended due to the vacant mental health positions. With limited data, it is hard to ascertain if the program is impacting the need for mobile crisis response in rural areas and exactly how many of the encounters are true face-to-face mobile crisis assessments. Until there is more comprehensive data, it will not be feasible to estimate the number of mobile crisis assessment requests coming out of the Dane County Sheriff's Department.

IV. Embedded 911 *(future)*

Data Source:
On-site meeting with Becky Stoll

Operations

Madison 911 operations dispatch all fire stations and some law enforcement entities for the entire county except for a few areas. Calls requesting fire or EMS response cannot be put on hold so if the call bounces back after an attempt to dispatch those resources including the CARES program, then the calls go to law enforcement where it can often sit for long periods of time. In some cases, this makes calls for mental health crisis assistance to wait for extended periods of time.

Calls regarding mental health are increasing especially on the night shift.

There are plans in place to implement a "Mental Health Diversion" program, which will embed mental health staff in the 911 call center. The staff in this program will handle mental health related calls that come into the 911 center. They will handle some calls only telephonically when that is the appropriate course of action. For those that cannot be handled by phone only, they will dispatch the CAREs team or reach out to other resources.

The hours for this program will start M-F 8am-8pm. To expand to 24/7, they will need a total of 10 frontline staff.

Staffing

The proposed staffing of the "Mental Health Diversion" program are a mental health Masters' degree prepared Supervisor plus 4 embedded mental health workers.

With the current salaries being paid by 911 plus opportunities for increased income via overtime, they do not have any issues with hiring staff.

Co-Responder Operations

They only dispatch for mental health calls to the CARES program. They play no role with either law enforcement co-response or Journey crisis services. However, this is a prime location for centralization of dispatching law enforcement and the CARES program to assist when requested by the community provider of the mobile crisis team.

Technology

Of all the entities involved in the crisis system, 911 has the most capabilities when it comes to technology. All of their calls are recorded and used for quality improvement. They also have an Auto Vehicle Locator (AVL) system.

Documentation

Currently all calls are documented in their internal system, which does not interface with other key stakeholder systems. The overall crisis service system would benefit from collaboration in this area.

Data Collection

The 911 center has its own tech department and seems to be the location with the most availability of data as it relates to their operations.

V. Embedded Fire Department (CARES)

Data Source:
On-site meeting with Becky Stoll & Neesha Roberts

Operations

All requests for response to the CARES program (Madison Fire Department/Journey co-responder model) is dispatched by 911. The distance of these calls can be within 1 hour.

When the teams are in service, they are responding to 9-10 calls a day. Most of the "presenting problems" are 20-25% "check welfare", which can be a) concern for someone who has not been heard from and b) someone who has been witnessed to need assistance. Approximately 10 times a year (their guess) calls response results in the discovery of a deceased body, which has been upsetting to some of the mental health staff resulting in their leaving the position. 52% of the calls have a "mental health" component though the scope is very broad and the information for each call is often vague. Many of the individuals seen often are already connected to needed resources so there is not much to provide to them.

One of the main goals of the program is to divert individuals from emergency departments. This is a sound goal to have but could also be addressed by a) making changes to the involuntary commitment laws and b) the requirement for medical clearance by inpatient psychiatric facilities.

Part of the program does involve providing follow-up activities.

Staffing

The Madison Fire Department has 2 CARES teams operating in the east, middle of Madison, and 1 additional team will be starting soon.

The Madison Fire Department has 6 dedicated civilians, not "commissioned" paramedics who serve in this program. This takes the potential for 6 "commissioned" paramedics off regular duty.

Journey is contracted for 6 staff positions. With the Journey Crisis System desperate for crisis staffing, it seems these positions would be better used in that system since many of these calls are not for mobile crisis assessment.

There is a desire to expand to 24/7/365 operations, though more money would be needed for the additional staffing.

The Madison Fire Department would like to employ the mental health crisis positions themselves, but that cannot happen due to statute. They identified the barriers to hiring as limited workforce to draw from, Journey lower salaries than they could pay, and unattractive shifts.

Co-Responder Operations

As with the other co-responder models that are in play in Dane County, it appears this one was born out of a need for assistance on some mental health calls where Journey has not had the resources to respond. There is no clear indication that there is a great need for an emergency medical/paramedic presence for the overwhelming majority of calls that are truly for mobile crisis assessments. Everyone that was interviewed acknowledged that almost all requests for deployment of this team did not need a paramedic present.

Given all of this information, it does not seem the best decision to operate a co-responder model in the Dane County Fire/EMS Department. To do so takes away significant emergency medical resources and allocates precious mobile crisis resources that Journey could use in their mobile crisis operations, especially responding to these rural counties. Two other factors support this analysis; 1) there is acknowledgement within the program that it is almost never necessary for a paramedic to be present and 2) the contacts being handled are not mobile crisis assessments the majority of the time.

Technology

CARES uses the CAD for communication and PSC for dispatch.

Documentation

Documentation of contacts are made in two separate places: within the Madison Fire Department system and in Journey's electronic health record. These do not interface with each other or with any of the other key stakeholders. The overall crisis service system would benefit from collaboration in this area.

Data Collection

The Madison Fire Department has a data dashboard for this program, but do not know how many of the calls are related to social service needs versus the need for mobile crisis assessment. They meet with 911 operations monthly to review data/calls.

Co-responding Model

Summary of Proposed Mobile Crisis Model

Our assessment of mobile crisis operations, in Dane County, found a robust array of programs in place to attempt addressing the mental health crisis needs of community members. However, all of the different capabilities (Journey's Crisis Service, Madison Police Department Co-Response, Dane County Sheriff's Department Co-Response, and the Madison Fire Department's CARES Co-Response) operate independently with little to no collaboration. All of the co-Responder programs have been developed and implemented as a result of the perceived need to fulfill unmet needs for those who reach out to these organizations for various types of assistance. While this shows a commitment to mental health care by having so many mobile crisis resources in one county, there is no evidence to suggest they are all warranted. During our many discussions, we heard repeatedly that:

1. Often times the call for service is not appropriate/not related to conducting a mobile crisis assessment, but instead are social services or case management oriented.
2. The presence of a law enforcement officer or paramedic is <u>rarely</u> needed.
3. The available workforce pool is insufficient, which makes it problematic with all the different programs vying for the same workers.
4. The salary disparity between Journey and city/county entities is significant.

With all of this in mind, we recommend the following structure for a mobile crisis system in Dane County. Implementation of this model would take time to come to fruition but could be a national model of collaborative mobile crisis care.

Proposed Mobile Crisis Model

<u>Function:</u> *Mobile Crisis Team*

Based on our evaluation of the current system, the only Mobile Crisis Team operating, in the county, should be one provided by a community based mental health provider who can fulfill the Mobile Crisis Team requirements identified in a Request for Funding from the county... A timeline should be developed to sunset the Co-Responder models within the Madison Police Department, Dane County Sheriff's Department, and the Madison Fire Department. Our recommendation would be within the next 6-12 months (see implementation strategy for a suggested timeline). Based on this timeline, decisions will need to be made on whether to hire any vacant co-responder positions or move these vacant positions to the community provider of the mobile crisis team (currently Journey). Our recommendation is to not hire them in the police/sheriff/emergency medical service departments. The funding for mental health positions in these organizations should be moved as quickly as possible to the community provider of the mobile crisis team to increase capacity to respond to mobile crisis calls especially in rural counties. Moving these 10 positions (2 in Madison Police Department, 4 in Dane County Sheriff's Department, and 4 in Madison Fire Department) would have a big impact in the community provider's capacity to response to the community as a whole. Suggestions on increasing the pool of potential crisis workers is outlined below.

Function: *Crisis Calls and Dispatching of the Community Provider of the Mobile Crisis Team*

Crisis calls enter the system via 911, the community provider of crisis services, and the 988 Crisis call center. Each of these entities will utilize triage/assessment tools to identify calls appropriate for telephonic-only services (estimated to be roughly 50%). Calls/chat/texts that are assessed to be of high to imminent risk of self-harm or acute psychosis are most often identified as the cases needing a mobile crisis face-to-face assessment.

Community Provider of Crisis Call Operations and Mobile Dispatching

It is recommended that the Community Provider dedicate staff solely to a Crisis call center and not use staff in dual roles. The crisis call center staff should have special training in crisis call center specific skills for telephonic-only work. Since Journey has historically experienced difficulties with hiring staff in Crisis Services, it would be beneficial to have this Crisis call center operate 100% virtually. This would definitely open up the potential workforce pool to those who live outside of Dane County. Other virtual crisis call centers hire staff from all over the country and successfully operate their centers with a high-quality service. This would be a fundamental shift in current operations, but one that will significantly address some of the workforce shortage problems.

The community provider of the crisis call center would handle crisis calls being received into their system as well as the dispatching of their mobile crisis team. If data showed a high volume of requests for the dispatching of the mobile crisis team, they could further delineate roles and have one team within their crisis call center handling true crisis calls from the community and another team, with no clinical background required, handling the requests for the dispatching of the mobile crisis team. This decision should be made after a review of several months of data.

The community provider can leverage a technology solution for the dispatching of their Mobile Crisis Team and the monitoring and safety of deployed workers. A product like Trek Medic's Beacon platform is one such solution. Trek Medics International | Beacon Dispatch

Staffing for the Community Provider of Crisis Positions

- Mobile Dispatch Team (if needed) – require a high school diploma or certification as a Peer Specialist
- Crisis call center Team – require a bachelor's or master's degree in a mental health related field or certification as a Peer Specialist with 24/7 access to a Licensed Mental Health Professional
- Mobile Crisis Team – require a bachelor's or master's degree in a mental health related field with or certification as a Peer Specialist with 24/7 access to a Licensed Mental Health Professional.
- Telehealth for Involuntary Commitment Assessments (if warranted) – Unless otherwise prohibited by statute, require a bachelor's or master's degree in a mental health related field with 24/7 access to a Licensed Mental Health Professional.

Crisis Services: Training

Crisis call center and mobile crisis staff should receive extensive multi-week training in crisis intervention and cultural competencies. Due to the specific skills needed for those doing only telephonic, chat, and/or text work, training for Crisis call center staff should incorporate both mandatory Lifeline training, including a review of the Lifeline suicide safety policy, clinical requirements/guidelines, and internal community provider standards to ensure that the highest quality of clinical services are provided.

The Community Provider's onboarding and clinical training for Crisis call center staff should incorporate the Lifeline Core Clinical Trainings during the initial week of training. In addition, staff should complete the Lifeline Simulation Trainings within the first six months of employment and should be required to complete six additional

continuing education hours each year. All Crisis call center staff should be encouraged to participate in Lifeline CE webinars including Crisis Conversation Skill Builders. The below clinical trainings should be required annually after onboarding.
Staff should receive a multi-day training on clinical policies, including:

- Counseling on Access to Lethal Means (CALM)
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Active Engagement
- Imminent Risk
- Engaging and Dispatching Emergency Services
- Follow-up Procedures
- Situations requiring Clinical Consultation
- Confidentiality
- Code of Ethics
- Duty to Warn
- Mandatory Reporting

Dane County 911 Mental Health Diversion Operations

The Dane County 911 Center would handle crisis calls received into their system by use of their embedded mental health staff. If there is a case where the dispatching of the Community provider of the mobile crisis team is needed, they will contact that Crisis call center with the request.

While Dane County 911 and the Community Provider have their own systems for documentation, it will be imperative that some interoperability be developed. Aspects of this should include basic information sharing for requests for mobile dispatch, and follow-up...

A system could be leveraged where Dane County 911 requests for the Community provider of the mobile crisis team dispatch be handled through a portal to reduce the number of phone calls in each system. One such system is currently being utilized in Illinois and has shown to greatly decrease phone calls between entities and centralizes these requests.

Staffing for 911 Center Mental Health Positions

- 911 Center Mental Health Diversion Team – require a bachelor's or master's degree in a mental health related field or certification as a Peer Specialist with 24/7 access to a Licensed Mental Health Professional.

988 Crisis Call Center Operations

If there is a case where the dispatching of the Community provider of the mobile crisis team is needed, they will contact their Crisis call center with that request. If a portal for dispatching request were established, it could also be used by the 988 Crisis call center.

Addressing Non-Mobile Crisis Needs Currently Being Met by Co-Responder Models

As noted previously, most of the requests for response in all three of the Co-Responder models currently in operation are non-mobile crisis oriented. It is obvious these are not programs responding to a multitude of mental health crisis calls, which is the intent of operating a Co-Responder program. Given the size of Dane County this is not surprising. However, it is important to acknowledge that much work has gone into creating these Co-Responder models and if the recommendation is accepted to sunset these three programs, there will be a sense of loss for some. Finding a path forward to provide for those who are in need, but not in a mental health crisis, should be informed by data. This is another area where a lack of data creates difficulty in developing programmatic strategies. Could/should the Madison Police Department, Dane County Sheriff's Department, and/or the Madison Fire Department (CARES) hold responsibility for addressing these unmet needs via some type of programming? Or should partnerships with community organizations identified as having the appropriate resources for these unmet needs be leveraged? We strongly recommend that to get these answers, you use the time before sun setting these programs to gather specific data on the types of requests being received. Only then can you ascertain the "categories" of these requests (basic needs, issues with older adults, care giver burden, social determinants, loneliness, and other social serve type needs) in order to make an informed decision on the best way to service the citizens of the county. That could possibly be within these departments using resources currently allocated for co-response (police officers, sheriff's deputies, and emergency medical personnel but not mental health staff) or it might be strengthening partnerships with community organizations to establish systems for response to these needs. Once the data is collected, key stakeholders should convene to review the data and develop potential strategies to address the identified needs via response to request for help and following up with these individuals until they are connected to appropriate resources.

Access to Law Enforcement and/or Emergency Medical Service When Needed

To ensure that law enforcement and emergency medical service personnel are available during mobile crisis encounters, when needed, the Community provider of the mobile crisis team should call the 911 Center to access these resources in real time. The responsibility of deciding who is needed on scene during a mobile crisis assessment should lie with the Community Provider of the Mobile Crisis Team.

Available Personnel for any Mobile Crisis Response

The following list of professionals should be available for all mobile crisis encounters and only those that are needed are deployed:

1. Mobile Crisis Worker – present at all request or face-to-face mental health crisis
2. Engagement Specialist (Certified Peer) – on scene in those cases where the presence of someone with lived experience will be beneficial to addressing the immediate crisis
3. Law Enforcement Officer – on scene only in those cases where a law enforcement officer's presence is needed to secure or maintain safety/security.
4. Paramedic- on scene only in those cases where emergency medical services personnel is needed for an immediate medical situation that can be handled in the field.

Follow-Up

All crisis calls and mobile crisis encounters should receive follow-up services until the individual is connected to services, no longer needs assistance, or indicates they do not wish to have follow-up services. All of these encounters should have an attempt at follow up contact within 24 hours of the crisis contact. If the person is not reached in this initial contact, then up to three attempts should be made before ceasing follow-up activities. This service should not take the place of needed services in the community such as case management, therapeutic services like medication management and counseling services, and assistance with basic needs. These non-mental health related services should be funded in addition to the funding for mental health crisis programs. Simply responding to one's mental health crisis, including

issues with suicidality, is only one part of the equation. The system should also aim to aid Dane County citizens in addressing their needs, so they feel as if they have lives worth living.

Follow-Up services could be centralized for both the Community Provider's Crisis Service and the Dane County 911 Center. It makes the most sense to house this within the Community Provider's crisis services program. Technology could come be developed to allow the Dane County 911 Center to send information to the Community Provider's for those needing follow-up. This could be done via a shared platform. These staff should be solely dedicated to this team and is an optimal place for the employment of Certified Peer Specialist. This team could also operate 100% virtually. In cases where there is a need for an in-person visit, partnerships with organizations who provide community-based services could be utilized. Data needs to be collected on the number of crisis calls, chat, texts, and mobile crisis assessments in order to determine how many staff are needed in Follow-up services.

Role of Mobile Crisis in Post-Response Care, Transportation and Facility-Based Care

If the recommended model for mobile crisis operations is accepted, then the Community Provider of the mobile Crisis Team should be held accountable for utilizing the least restrictive level of care for someone in a mental health crisis. This would include referring individuals to facility-based mental health care (inpatient psychiatric unit, Crisis Stabilization Unit, Crisis Respite, and 23 Hour Crisis Observation) and when these are not indicated other levels of mental health care (partial hospitalization, intensive outpatient, outpatient therapy and medication management. When the need for transportation to a facility level of care is needed, the Community Provider should hold the responsibility for coordination.

Development of a Liaison Program

If these recommendations are followed and all three Co-Responder models are no longer operating, steps will need to be taken to ensure there is a strong collaboration between all key stakeholders in the community. At the core, this includes law enforcement, emergency medical services, the Community Provider Mobile Crisis Team, and the community at large. In order to address this issue and foster this much need collaboration, the development of dedicated liaisons between central entities is imperative. Their sole function will be to laisse between all of the key players. Their duties can include training, building partnerships, outreach, two-way messaging/communicating, and assisting with data collection.

Emergency Services Liaisons

The notion that the mental health crisis system is better when law enforcement and paramedics have a better understanding of mental health crisis is a good one. There is no doubt that if all of the Co-Responder models are taken out of services that it will feel like a loss for these departments. The solution to addressing mental health crisis, in the entire county, is to have the system operate as a cohesive unit. Law enforcement and emergency medical services will have a role to play without ineffectively leveraging precious resources. To ensure all law enforcement officers and emergency medical personnel are trained in an appropriate level of mental health crisis knowledge, Emergency Service Liaisons positions should be established. One position can serve law enforcement and one emergency medical services. If it is cost-prohibitive to have both, begin with one position who does both. They would be responsible for initial and on-going training and serve as a liaison to between the Madison Police Department, Dane County Sheriff's Department, Madison Fire Department, Dane County 911, and Community provider of the mobile crisis team. These positions could be staffed by someone with a bachelor's degree or Certified Peers.

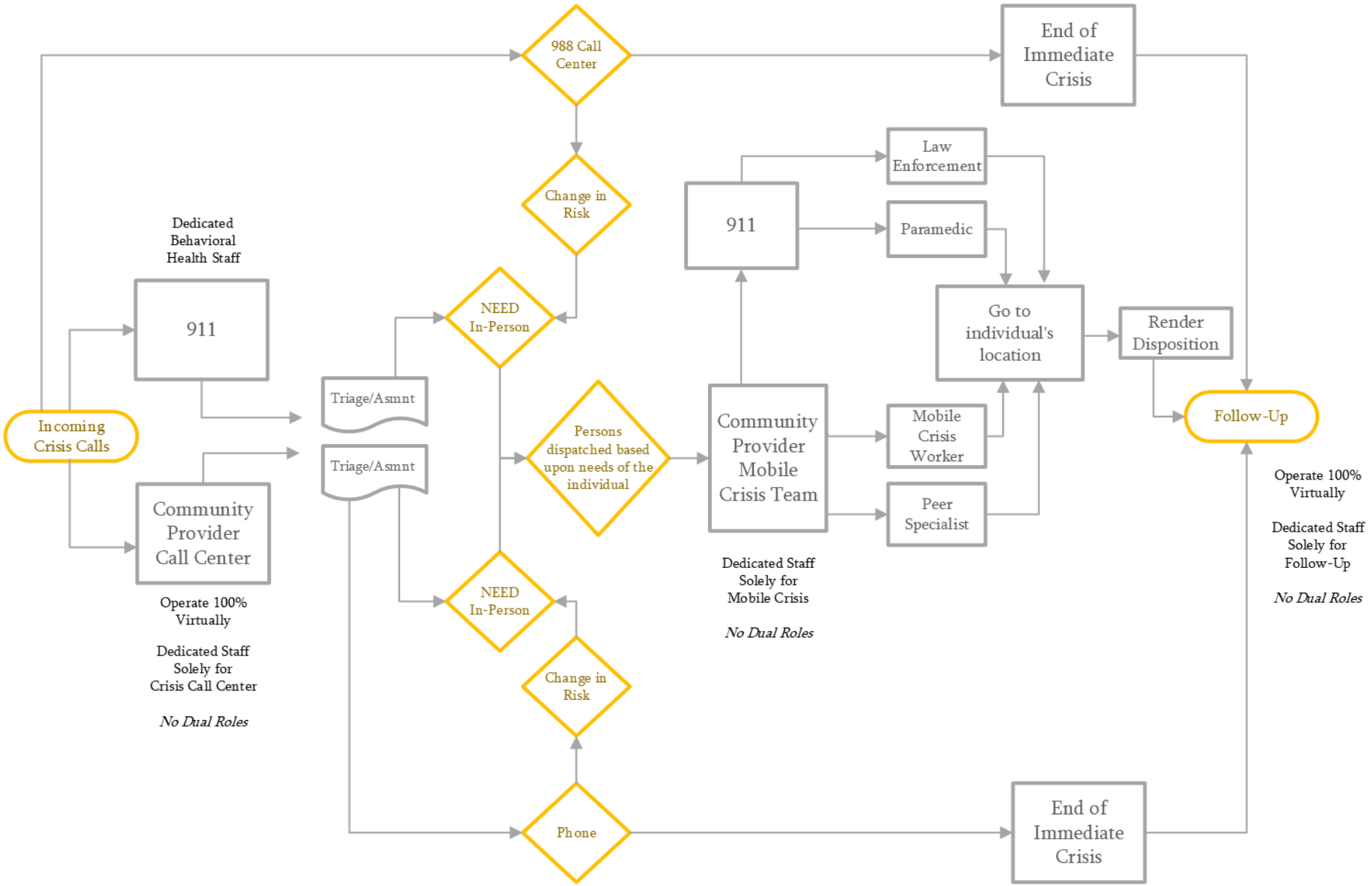
Community Liaisons

With the significant feedback about the lack of mobile crisis response in the rural part of the county, more work needs to be done to) engage these communities around access to mental health crisis care and provide mobile crisis response when needed just as it is in Madison proper. These comminutes are

where some of the minority population live, so it is important to conduct targeted outreach in these areas. This can be done with collaboration of a multitude of entities, schools, churches, employers, civic groups, etc. To ensure the mental health crisis needs and access to services improves, Rural Community Liaisons positions should be established. To begin, two positions can be dedicated to this work with a data analysis in subsequent years to assess whether more positions are needed. They would be responsible for being the liaison between the crisis services system in the county and rural entities and citizens. These positions could be staffed by Certified Peer but would not require a degree above a Bachelors.

Proposed Mobile Crisis Model

(See visual on next page)


988 Call Center
End of Immediate Crisis
Change in Risk
Law Enforcement
911
Paramedic
Dedicated Behavioral Health Staff
911
NEED In-Person
Go to individual's location
Render Disposition
Incoming Crisis Calls
Triage/Asmnt
Persons dispatched based upon needs of the individual
Community Provider Mobile Crisis Team
Mobile Crisis Worker
Follow-Up
Triage/Asmnt
Peer Specialist
Community Provider Call Center
Operate 100% Virtually
Dedicated Staff Solely for Crisis Call Center
No Dual Roles
NEED In-Person
Dedicated Staff Solely for Mobile Crisis
No Dual Roles
Operate 100% Virtually
Dedicated Staff Solely for Follow-Up
No Dual Roles
Change in Risk
Phone
End of Immediate Crisis

Current Statute on Involuntary Commitments

The current statute that requires law enforcement personnel to place a key role in the involuntary commitment process should be changed as quickly as possible and seen as an extremely high priority. Research should be done of other state's involuntary commitment legislation to find language that leverages appropriate resources. The National Association of State Mental Health Program Directors would be a good place to begin this research. Welcome | National Association of State Mental Health Program Directors

Until the time comes where this statute is changed, the involuntary commitment assessments currently done by Journey's Mobile Crisis Team within emergency departments could be done exclusively via telehealth and remotely. If the volume warranted it, dedicated staff within the Mobile Crisis Team could be assigned every day/shift to conduct these assessments via telehealth to cut down on the number of staff resources being deployed to emergency departments for this purpose.
This would cut down on the resources being used to respond to emergency rooms for this sole purpose.

Funding the Community Provider's Mobile Crisis Team's Response to Emergency Departments

As part of a plan to overhaul the mobile crisis system in Dane County, there should be consideration of not requiring the Community Provider Mobile Crisis Team to respond to hospital emergency departments for mental health crisis assessments and instead focus on responding within the community and in rural areas of the county. The hospitals in the county should either utilize their own social work departments to handle mental health crises or contract with a provider for that service.

Requiring Medical Clearance Prior to Inpatient Psychiatric Placement

One of the reasons many individuals are taken to emergency rooms during a mental health crisis is that they must be medically cleared if there is a possibility of being referred to an inpatient psychiatric facility. This is a waste of resources on many fronts, it ties up emergency room beds, increases wait times for the individual in crisis to receive mental health care, and is very costly to the health care system. A group of key stakeholders should be convened to establish guidelines for when it appropriate to require medical clearance for someone who is being admitted to an inpatient psychiatric facility. The Sierra Sacramento Valley Medical Society has developed the SMART Medical Clearance protocol that provides guidance on when medical clearance should be required. States, like Tennessee, have successfully adopted this protocol after a collaborative project where key stakeholders convened to address the problems with requiring blanket medical clearance for all individuals being referred for inpatient psychiatric care. smartmedicalclearance.org

Key Stakeholders for the Development of a Comprehensive Mobile Crisis System

There are many key stakeholders who are going to need to work together in order for Dane County to offer the most effective mobile crisis service it can. The Madison County 911 Department, Community Provider Crisis Services, Madison County Police Department, Madison County Fire Department, Dane County Sheriff's Department, County Government, 988 Crisis call center, and all hospitals in the county are the initial group of stakeholders who should come together to formulate a shared vision. This is the type of collaboration is lacking in the current system. The development and implementation of strategies for change will be a significant lift and will take time. In order to be successful, the use of Implementation Science should be employed.

Funding

In the spirit of operating of a crisis services continuum as the responsibility of multiple organizations, where feasible, there should be resource contribution by all. In addition to state and county funding, a primary source of crisis services funding is Medicaid. An alternate Medicaid funding strategy to the current fee-for-service model is to consider implementing a "Per Member Per Month (PMPM)" payment. This structure allows the organization operating the crisis services continuum at the community level to have enough funding to operate the firehouse model required of crisis services... When providers are only paid when they provide a service, it does not take into account the expenses required to have crisis operations available 24/7/365 in case they are needed. Other services like law enforcement, fire, and emergency medical care are funded in a firehouse model and the mental health crisis service system should receive parity. Those organizations would not be able to operate unless they were funded to be available to respond in case they are needed.

Other options are to utilize funding from Certified Community Behavioral Health Clinic (CCBHC) grants, which require crisis services to be a part of their operations and to approach commercial insurance companies operating within the state to work with them on paying their share of operating the crisis service system.

Co-responding model

Partnerships

Partnership between Journey, Madison Fire Department, Madison Law Enforcement, Dane County Sheriff's Department and Dane County 911.

For an integrated mobile crisis model to succeed, all staff across teams must be willing to come to the table as partners. This means fostering a collaborative approach where everyone's expertise and insights are valued. By working together, teams can combine their diverse perspectives and resources to develop a comprehensive and effective model that meets the mobile crisis needs of the community. Each staff member plays a crucial role in the success of the model, and a willingness to collaborate ensures a cohesive and coordinated response to crisis situations.

Partnership with NAMI

Developing an active and ongoing partnership with NAMI is crucial as they can leverage your stories and data to advocate for changes in the law regarding Chapter 51 evaluation. NAMI would be able to effectively communicate the real-world experiences and challenges such as: time spent at ERs and time spent transporting clients to Winnebago. By collaborating with them, you can amplify your voice and influence policymakers to enact meaningful reforms. This partnership helps bridge the gap between lived experiences and legislative action, creating a powerful advocacy force for positive change.

Partnership with Receiving Partners

Some partners re-assess clients because their admission criteria are not known and integrated into mobile crisis assessments. Often times they also require medical clearance prior to accepting an individual into their program. An active partnership with all receiving treatment partners would streamline the transition process including addressing medical clearance requirements, reducing delays and ensuring continuity of care for individuals in crisis. This partnership ultimately improves access to critical services, enhances the client's treatment experience, and supports better outcomes for individuals seeking care.

Implementation Strategy
Interview Data Analysis
Implementation Strategy
Wages

Interview Data Analysis

About the Interviews

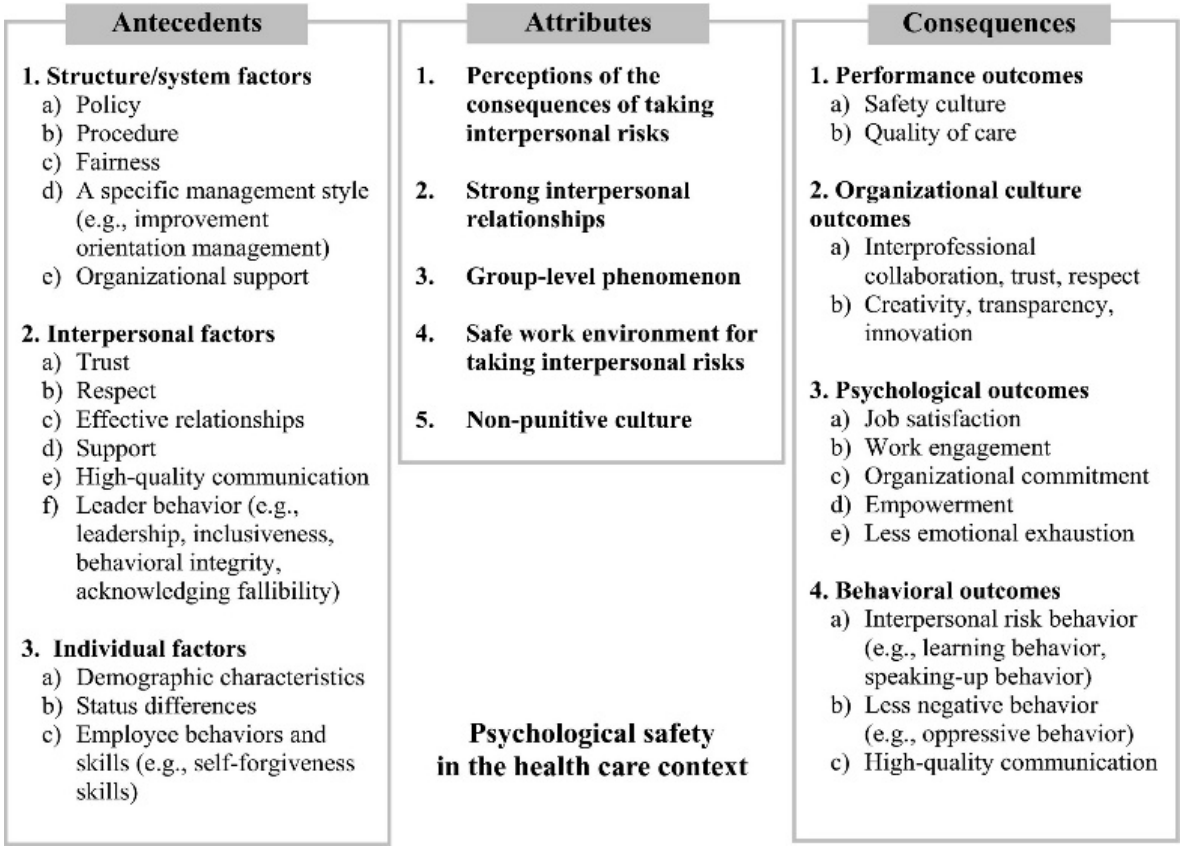
Neesha Roberts of Centerstone's Research Institute conducted interviews during a three-day visit as part of this project. The purpose of these interviews was to gather qualitative data as a supplement to mobile crisis data to inform a recommended implementation strategy.

Eight (8) of the interviews were one-on-one and two (2) were group interviews. Becky Stoll was also present for the site-visit, but she was not present for the interviews. Roberts met with a combination of leaders and field staff from Journey, Madison PD (Downtown & South), Dane County Sheriff's Department, Dane County 911 and the Fire Department.

The questions asked about mobile crisis were as follows:

- What's going well?
- What's not going well?
- If you could change anything about your role, what would you change?
- If you could change anything about mobile crisis, what would you change?

Psychological Safety Determines Effectiveness of Teams
A team's effectiveness is determined by the level of its psychological safety, and when a team is psychologically safe the impact is multi-level and widespread – quality of care improves, staff are satisfied with their jobs, staff are more engaged, less burned out, more committed to the organization and feel empowered (Ito, A. 2022). This is based on the conceptual model of psychological safety on the next page. This concept and theoretical orientation were created by conducting a thematic analysis of 88 articles about psychological safety within the healthcare context.



"The concept analysis found that psychological safety captured perceptions of the consequences of interpersonal risk behaviors in the work environment. Interpersonal risk behavior has often caused team members to be labelled ignorant, incompetent and disturbers in work environments, including behaviors such as asking questions, reporting errors and bringing up concerns (Edmondson, 2019).

On the page following the graphic, you will see comments from interviews in the Antecedents and Consequences columns. No one category of the Antecedents column produces the impact of a psychologically safe work environment. For this reason, it's important not to draw conclusions about one category's impact on outcomes (consequences), but to look at it in its totality. All categories in Antecedents contribute to or impede attributes of a psychologically safe work environment that in turn impact outcomes, culture, behaviors and psychology. Similarly, the Consequences (or outcomes) of a psychologically safe environment cannot be drawn back to one antecedent in particular.

The interview data was categorized according to this theoretical orientation in order to highlight structural/systemic factors, interpersonal factors and individual factors impacting psychologically safe teaming.

Ito, A., Sato, K., Yumoto, Y., Sasaki, M., & Ogata, Y. (2022). A concept analysis of psychological safety: Further understanding for application to health care. Nursing open, 9(1), 467–489.

https://doi.org/10.1002/nop2.1086

Factors Potentially Fostering Psychologically Safe Teaming

Analysis

Across all teams, there seems to be trust, respect, support and effective relationships *within each individual team* regardless of the team composition. This includes teams with embedded workers. Based upon the interview data we can say mobile crisis team leaders are effective at building an environment where staff support one another within each individual team. Similarly, embedded teams report having collaborative relationships with their co-responding counterpart within the team. They report knowing each other's roles and having respect for each person's expertise.

When developing a project plan the team working on this can brainstorm how to incorporate aspects of the current structure/systems and interpersonal factors into the next initiative. This would include aspects such as: maintaining flexibility, not mandating mental health roles within law enforcement, having access to records, and transparency between supervisors and supervisees.

Now we move into interview data that indicates problems in need of attention within structure/systems, interpersonal factors and individual factors. It would be strategic to consider and address these factors as part of an implementation plan, where possible.

Factors Potentially Impeding Psychologically Safe Teaming

Analysis

The interview data in Structures/Systems and Interpersonal Factors (Antecedents) can be understood as symptoms of the organizational work environment responsible for the lack of a psychologically safe environment. The impact of these symptoms is seen in the 'Consequences' column. Progress toward improved organizational and psychological outcomes will correspond to progress within 'Antecedents.' Psychological safety is important for interdisciplinary teams because it is what makes a team effective--or not-- which has cascading impacts on the quality of the work, client outcomes, organizational culture, psychological culture and behavioral outcomes. All of these are directly impacted by the degree to which a team operates within psychological safety. The attributes of psychological safety-- which are a combination of individual and group-level factors-- are:

Perceptions of the Consequences of Taking Interpersonal Risks
Strong Interpersonal Relationships
Group-level Phenomenon
Safe Work Environment for Taking Interpersonal Risks
Non-punitive Culture

Below are the reported concerns within structures/systems and interpersonal factors which may be impeding a psychologically safe work environment.

Structures/Systems: Impact of Staffing Shortages, Hiring & Retaining Staff

These factors combined can erode trust, increase job dissatisfaction, and create an environment where staff are less likely to speak up, share ideas, or collaborate openly. Unfortunately, field staff and leaders from Journey, Madison Fire Department and Madison Police Department have eroded trust due to ongoing staffing shortages, vacant positions, low wages, and problems with retention in non-county funded positions. Additionally, staff feel that those in leadership positions "aren't involved in the program—yet they are making decisions without ever speaking to us."

With all of this in mind, including the proposed integrated model, we are suggesting building consensus between the Community Provider of Mobile Crisis, Madison Fire Department, Madison Law Enforcement, Sheriff's Department, and Dane County 911 regarding the values and desired outcomes for the first phase of implementation. After these stakeholders have reached a consensus, it should be shared with the County Board for their reflection and response. This consensus-building phase is an opportunity for staff to be consulted and to have an active part in decision-making regarding mobile crisis.

Structures/Systems: Impact of Procedure & Protocol Issues

Problems with procedures and protocols can significantly impact psychological safety in the work environment by creating confusion, uncertainty, and a lack of clarity for staff. When there are inconsistencies or gaps in protocols, staff may feel unsure about how to perform their tasks effectively, leading to stress and anxiety.

The interview data show there is a lack of standardization across teams as it relates to utilizing triage/assessment tools, procedure, protocol, data collection and documentation of services. For this reason, joint initiatives to address all of these issues with consensus are being recommended as part of the implementation strategy. This will be essential for building an integrated, collaborative team.

Impact of Interpersonal Factors

Problems with interpersonal factors, such as conflict or lack of high-quality communication, can have a significant impact on psychological safety in the work environment. When there is unresolved conflict or a hostile atmosphere among colleagues, staff may feel uncomfortable, stressed, and unable to fully engage in their work. Additionally, a lack of open and honest communication can create misunderstandings, silos, and a sense of isolation, all of which contribute to a lack of psychological safety. These issues can lead to decreased job satisfaction, increased turnover rates, and a toxic work culture that hinders collaboration and innovation.

The interview data show problems with interpersonal factors and buy-in within the system.

In light of the interview data, it would be in the project's best interest to have a neutral facilitator as a project manager for the first two years of the project to ensure a collaborative process. If this is not feasible then someone within Dane County government should take the lead though this is not ideal. It is vital for leaders at all of these organizations to be held accountable for their attitudes and perceptions in collaborating with others for the success of mobile crisis resources in Dane County.

When systems transition from being fragmented to integrated, typical issues around power and trust often emerge within organizations. It has been made known to the consultants that these issues already exist between teams, and they are operating independent of one another. If the proposed model is utilized and as integration begins, questions of power dynamics will arise, as individuals or departments lose control over their embedded workers. This shift can lead to concerns about equity, transparency, and the fair distribution of resources or benefits across the mobile crisis program. Trust becomes a critical factor, as stakeholders must believe that a mobile crisis program as an integrated system will serve the organization's interests fairly and effectively. Lack of trust can manifest as resistance to change, reluctance to share data or information, and skepticism about the motives behind integration efforts. Building trust requires clear communication, inclusive decision-making processes, and demonstrating the benefits of integration through tangible results. Addressing these power and trust issues is crucial for successful integration, as it lays the foundation for collaboration, efficiency, and organizational alignment.

When trust and power dynamics are significant factors in a project, it's crucial to choose implementation strategies that help navigate these challenges effectively. Here are implementation components we recommend based upon the interview data and our proposed model.

See Resource: “Change that Sticks” for Skills on How to Build Trust on pg. 65-68

Proposed Implementation Strategies & Phases

Implementation Strategy: Phase-based Approach to Build Trust -- with Joint Initiatives
Estimated lengths to complete each phase are not prescriptive. Change as needed.

Phase 1: Consensus Building & Planning, *3 months*

1 month: Consensus Building among Dane County government leadership, Journey, Madison Fire Department, Madison Police Department, Dane County Sheriff’s Department, and Dane County

- Reach consensus on values and desired outcomes of mobile crisis response
- Select metrics and data collection that will capture the values and desired outcomes for proposed integrated mobile crisis model

1 month: Consensus Building among Dane County Board

- Reflect and respond to proposed values and desired outcomes for proposed mobile crisis model
- Reflect and respond to Board members regarding selected metrics and data collection that will capture the values and desired outcomes for proposed mobile crisis model

1 month: Build out detailed Project Plan

Phase 1.1: Data Collection of Co-Responding Teams, *Concurrent with 3 months of Phase 1*

Data Collection of Co-Responding Programs before they are Sunset

- Assess Data
- Determine Needs and Program Response

Phase 2: Joint Initiatives for Proposed Integrated Mobile Crisis Model, *3 months*

Joint Protocol Development, Training & Cross-Team Exercises

- Joint protocol development ensures consistency and uniformity in how different teams handle mental health crisis situations
- It establishes a common set of procedures that all team members can reference and follow, regardless of their department or role
- Standardization reduces confusion, improves coordination, and enhances the overall effectiveness of crisis response efforts

Establish Joint Training Sessions

- Joint training sessions create a shared understanding of roles, responsibilities, and protocols among all teams involved
- Participants learn about each other's expertise, perspectives, and approaches to mental health crisis response
- This common ground fosters a sense of unity and purpose, laying the foundation for effective teamwork

Create & Execute Cross-Team Exercises

- Mock Crisis Scenarios
- Joint Training Workshops
- Role Playing Skills

Phase 3: Implement Proposed Integrated Model, *18+ months*

- Approach: Iterative development based on feedback and QI Tools in previous document
- Tools: Shared platform for operations (follow-up, mobile crisis dispatch request, bed search)
- Communication: Regular status updates, Open-door policy for feedback
- Decision-Making: Consensus-driven decisions in stakeholder meetings
- Conflict Resolution: Mediation by a neutral party when conflicts arise
- Feedback: Joint debriefings

Wages

The Board's decision to increase wages for staff is commendable. They are not only investing in their employees but also ensuring that those on the frontlines of care can afford to do this vital work. This action to increase wages will help to retain top talent, reduce turnover, and ultimately provide higher quality care for those in need. Staff also indicated they would like to receive benefits comparable to city and county benefits. This would be part of a proactive next step to retain staff over-time.

When the interviewer asked staff for the reasons for chronic staffing issues, the consensus was "wages and benefits." Prior to the recent wage increase all field staff (not management) were making under $30/hour. As you will see in the chart below, less than $30/hour is not a livable wage for many types of families in Dane County, Wisconsin except for those who have zero children or those with 2 working adults with two children or less in the home. This means many of your staff are now able to meet their family's basic needs due to the recent wage increase.

	1 ADULT				2 ADULTS (1 WORKING)				2 ADULTS (BOTH WORKING)			
	0 Children	1 Child	2 Children	3 Children	0 Children	1 Child	2 Children	3 Children	0 Children	1 Child	2 Children	3 Children
Living Wage	$21.62	$41.44	$56.33	$74.67	$30.75	$36.09	$41.01	$44.18	$15.05	$22.42	$29.53	$35.40
Poverty Wage	$7.24	$9.83	$12.41	$15.00	$9.83	$12.41	$15.00	$17.59	$4.91	$6.21	$7.50	$8.79
Minimum Wage	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25	$7.25

The data above is the living wage, poverty wage and minimum wage for Dane County, Wisconsin as of February 2024.

(Disclaimer: The interviewer submitted a Living Wage Data Request via Living Wage Institute, an institute of Massachusetts Institute of Technology, in an effort not to scrape the data. The request was for Dane County, Wisconsin. Kavya Vaghul, Co-Founder of Living Wage Institute, provided express permission via email for the interviewer to use the data on the site, as-is, since only one county is being reviewed—Dane County, Wisconsin.)

This investment in staff's compensation demonstrates a commitment to both staff well-being and the delivery of high-quality care. By addressing wages, the Board is taking proactive steps to retain skilled professionals and ensure the sustainability of mental health services in the county.

From here, a retention plan is vital for keeping staff. Partners and the Board need to proactively develop strategies that foster employee engagement, recognition, and professional growth. A well-rounded retention plan encourages employees to stay loyal to the agency long-term, boosting productivity and reducing hiring and training costs. It demonstrates to staff that their contributions are valued and promotes a positive work culture.

Similarly, the following description shares what is considered basic needs and what is not considered basic needs in the living wage model:

> *The Living Wage Calculator's estimates are based on the costs of eight components, each of which represents a basic need: childcare, civic engagement, food, health care, housing, internet & mobile, transportation, and other necessities. It also includes relevant income and payroll taxes … In general, it is assumed that families select the lowest cost option that enables them to meet each of these basic needs at a minimum but adequate level.* ***As such, the living wage does not budget for eating out at a restaurant or meals that aren't prepared at home; leisure time, holidays, or unpaid vacations; or savings, retirement, and other long-term financial investments.***

To promote long-term staff retention, here is an example of a structured wage progression plan:

Tiered salary structure: Establish a clear hierarchy of roles within the agency, with corresponding salary ranges. This provides transparency and a roadmap for advancement

Skill-based advancement: Tie wage increases to the acquisition of new skills or certifications relevant to roles. This encourages ongoing professional development

Performance-based raises: Connect wage progression to demonstrated job performance. Employees who consistently meet or exceed expectations can earn higher wages over time

Annual cost of living adjustments: Commit to regular, annual wage increases to keep pace with inflation and market rates for similar roles

Competitive benchmarking: Regularly compare wages with those at similar mental health agencies to ensure competitiveness and attract top talent

Additionally, a benefits package comparable to what city and county employees receive is a specific need to retain staff long-term.

By implementing this wage progression plan and benefits package comparable to the city and county, the agency can proactively address compensation concerns, motivate staff to stay and grow within the organization, and ultimately provide higher quality care to those they serve.

Quality Improvement
Literature Review: Mobile Crisis Best Practices

Question in Review: What intervention practices are best supported, or evidenced-based, for mobile crisis teams for individuals at risk for suicide or other mental health crisis?

Step 1 | Literature Review

1. Research Question
   What intervention practices are best supported, or evidenced-based, for mobile crisis teams for individuals at risk for suicide or other mental health crisis?

2. Keywords
   Mobile Crisis
   Crisis Intervention Teams
   Crisis Intervention
   Behavioral Health

3. Scope of Review

   Number of Years Covered: 127
   Number of Studies Reviewed: 28

   Sources of Reviewed Studies: 9
   North Carolina Medical Journal
   Behavioral Sciences & the Law
   Psychiatric Times
   American 140 A. J. Mitchell et al. Psychiatric Association
   National Institute of Corrections

4. Databases Selected for All Searches

   Social Sciences Full Text (H.W. Wilson)
   APA PsycArticles
   Health Business Elite

MEDLINE with Full Text

5. See the annotated bibliography for articles most relevant to this review. A bibliography with all references has also been included in a separate document.

Step 2 | Research Synthesis, Conclusion & Resources

Research Synthesis

Mobile crisis teams (MCTs), are a mental-health based response service comprised of mental health and emergency service interdisciplinary teams who rapidly respond to behavioral health crisis incidents in the community with a goal to provide the least restrictive and most effective response for an individual in crisis (IACP / UC Center for Police Research and Policy, 2021). The Substance Abuse and Mental Health Service Administration (SAMHSA) separate mobile crisis best practices into six different categories: follow-up, incorporating family and peers, triage/screening, assessment, de-escalation protocol, and coordination across services. (National Guidelines for Behavioral Health Crisis Care).

Incorporating family and peer support during instances of crisis aid in building a supportive community for the client seeking crisis intervention services. "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" (Roadmap to the Ideal Crisis System, 2021). In addition, family support aids in the client receiving ongoing support and care outside of the crisis. According to *Mobile Response Team Framework (2018),* a guiding principle to mobile response teams include recognizing that family have the primary care of children/ family preferences should guide care for adults. Another best practice for mobile teams includes incorporating peers within services. "The role of the peer is unique in that it is based on the concept of mutuality or sharing similar experiences. Peers offer a nonhierarchical relationship that differs from individuals' relationships with clinicians" (SAMHSA, 2022).

One of the main goals of a mobile crisis unit is to decrease the likelihood that an individual in a behavioral crisis is subjected to arrest. One component that supports this goal is providing training and aligning with law enforcement programs. "To become certified as a CIT program, law enforcement offices must take a 40-hour training to learn how to identify signs of mental health crisis and are provided resources for diverting people in crisis from serving jail time" (Murphy, 2012). Crisis Assistance Helping Out On The Streets (CAHOOTS) is a service that was originally developed by the White Bird Clinic in 1989 that incorporates police dispatch with mental health service providers (Climer and Gicker, 2021). Currently, CAHOOTS operates in two ways; once a behavioral crisis call is received by law enforcement and there is no immediate safety risk, 911 officers will dispatch a crisis intervention worker who is skilled in counseling and de-escalation techniques as well as a medic who is either an EMT or a nurse (Climer and Gicker, 2021). Having licensed behavioral health providers available to the team for consultation when needed is critical based on their expertise in delivering mental health assessments, giving opinions and options to those in crisis rather than being told what to do, and providing partnerships between hospitals, police officers and community organizations (Kirst et al. 2015). An article by Ghelani (2022) evaluated the impact of social workers at the scene of a behavioral crisis with the support of a MCIT unit. Results indicated that through engagement, brief counselling, referrals, and transport to suitable services, these teams bridge the divides between people seeking support and community programs offering it. When providing professional support is difficult due to staffing, funding or due to location restrictions, telehealth can be an important asset for increasing the capacity of mobile response teams, especially in rural areas, geographically large counties, or urban areas where traffic patterns make meeting the 60- minute response time a challenge (Mobile Response Team Framework, 2018). An article by Holland et al (2021) evaluated telehealth during crisis response intervention in a school setting. Evidence within this study found that risk assessment and safety planning conducted using telehealth, was both safe and effective. An intervention used within Holland et al. (2021) was the *Crisis Care* app, which provides skill-based content that is based on cognitive behavioral strategies dealing with suicidal feelings for both youth and their

families. A pilot study of the Crisis Care app had a sample size of 20 caregivers and adolescents indicating high suicidal risk. The app indicated promising results regarding usability, utility, and acceptability. Post-discharge adolescents reported decreased feelings of loneliness and isolation as a result of family-focused intervention and the app usage. Both caregivers and youth reported similar ratings of the usefulness of the *Crisis Care* app during a crisis situation.

If law enforcement is necessary due to the safety of the individual, safety plans are implemented for arranging care and supervision of the individual with friends and family, removing weapons from the environment, and follow up from the mobile crisis team and psychiatric evaluations (D. Trantham and A. Sherry, 2012). A study by Stanley et al. (2018) evaluated a combination intervention, Safety Intervention plan (SPI) with SPI+, which consisted of the Safety Planning Intervention (SPI) administered in the ED and structured follow-up following ED discharge to prevent suicidal behavior and enhance treatment engagement. "Patients in the SPI+ condition were less likely to engage in suicidal behavior (n = 36 of 1186; 3.03%) than those receiving usual care (n = 24 of 454; 5.29%) during the 6-month follow-up period, yielding a number needed to treat of 44.43" (Stanley et al. 2018).

Staff training is another key component to mobile response best practice. During training, staff are provided knowledge and resources for assessment, history taking, safety planning, de-escalation, and providing other behavioral health resources to clients and their families through practice-specific training and role playing (Roadmap to the Ideal Crisis System, 2021). Another example of training includes crisis intervention team (CIT) training. CIT training includes a 40-hour training week in which participants receive didactic, experiential, and role-play content provided by police training staff and content experts from the community (Watson et al. 2021). Trainees also engage in experimental exercises, have the opportunity to hear from people who have experienced mental illness and visit local mental health agencies (Watson et al. 2021). Staff training also includes effective and continuous supervision. An article by Allen et al. (2002) reported that the clinical directors of mobile response units developed explicit written criteria for all behavioral staff and provide adequate supervision, provide experience in medical screening and assessment, and treatment of psychiatric emergencies. In addition, having thorough written assessment models assisted in the development of appropriate treatment plans (Allen et al. 2002).

Follow up services are also a key component to mobile crisis best practice. "Having rapid access to walk-in services, follow-up care provided by qualified professionals, and psychiatric evaluation the next business day makes it possible for mobile crisis clinicians to divert many cases from 24-hour psychiatric care" (D. Trantham and A. Sherry, 2012). Additional research suggests providing continued crisis stabilization and care coordination services as indicated for up to 72 hours (Mobile Response Team Framework, 2018). In rural communities where crisis services may be limited, incorporating telehealth services can offer access to support services (SAMHSA National Guidelines, 2020).

Conclusion

Based on the evidenced based practices presented in this literature review recommendations for mobile crisis teams include incorporating peers and family into treatment to support current and ongoing client care, implementing crisis training to law enforcement to decrease the likelihood that an individual will be subjected to arrests during a crisis, ensuring licensed behavior crisis staff are available for consultation to the team when needed, creating safety protocol in the event that safety is concerned for clients and staff, available and affordable follow up care resources that are local to the client and providing staff training for all crisis team members. Resources for these best practices are provided in the resource table below.

Although CAHOOTS is a program that utilizes evidence-based strategies we are not recommending the program for Dane County, Wisconsin, due to the size of the county and the lack of evidence that calls coming into law enforcement and fire departments for assistance are overwhelmingly related to a mental health mobile crisis response need. The population density and geographic spread do not warrant the implementation of such a specialized mobile crisis response program. Instead, we are proposing all mobile crisis teams be deployed from the central location of the community provider of crisis services which

is better suited to the unique needs and characteristics of the mental health needs in Dane County. This approach ensures that resources are allocated effectively to address the community's mental health and crisis intervention requirements.

Additionally, we are not recommending the use of licensed social workers for the mobile crisis program in Dane County, Wisconsin, due to insufficient funding and a lack of workforce. While licensed social workers could offer valuable expertise and support in crisis intervention, the current budget constraints make it impractical to implement this approach. Even if the funding were available, this work force is not. There is only a small fraction of mobile crisis program across the country hiring licensed mental health professionals exclusively for mobile crisis work. Instead, we advise exploring the alternative strategies that we laid out that align with the available resources, ensuring the program remains effective and sustainable in meeting the community's needs.

Resources

Evidence-based Practice *for Mobile Crisis Teams*	**Resources** Source + Link	**Example #1** Source + Link	**Example #2** Source + Link
Assessment and Screening	Brodsky et al. (2018)		
Incorporating family and peers within the crisis response	SAMHSA Best Practice Tool Kit (19-21) Trantham et al. (2012) Mobile Response Teams Framework Roadmap to the ideal crisis system (132,134) SAMHSA Peer Support in Crisis Care	Mobile Response and Stabilization Services in New Jersey Massachusetts Mobile Crisis Intervention/ Emergency Services Program Milwaukee County Mental Health Clinic Children's Mobile Crisis Team	

Law Enforcement Training	Murphy et al. (2012) Watson et al. (2017) SAMHSA Best Practice Tool Kit (33) ACP / UC Center for Police Research and Policy	Maine Behavioral Health Care Crisis Team	New York 911 Distressed Caller Diversion Program
GPS Technology	SAMHSA Best Practice Tool Kit (18,49)	Carolinas Health Care System (CHS) service line for behavioral health	Law: American Rescue Plan Act of 2021
Staff Training	Trantham et al. (2012) Allen et al. (2002), (59) Roadmap to the ideal crisis system (134)	Virginia Thomas Jefferson Area Crisis Intervention Team Training	
Safety Planning	Stanley Brown et al. (2018)		
Referral/ Follow Up Care	Trantham et al. (2012) SAMHSA Best Practice Tool Kit (18,49)	King County Children's Crisis Outreach Response System	

Quality Improvement: QI Process & Metrics Tools
Metrics & Data Collection

To enhance quality, demonstrate impact, and secure funding for mobile crisis services, a robust collection of metrics and data is crucial. To this end, we are recommending the frameworks found in *Quality Measurement in Crisis Services* to guide stakeholders in deciding the values and desired outcomes of mobile crisis, and consequently selecting metrics and data collection.

Quality Measurement in Crisis Services (pg. 40-49 of PDF)

The frameworks detailed in this document are designed to be a guide to agencies for selecting metrics and data by visualizing what data is being captured in the flow of operations. This is not specific to mobile crisis but captures crisis services as a whole. It shares five distinct zones of the workflow, those being: community, triage/intake, crisis, intervention, discharge planning and execution, and post-discharge services. Additionally, it provides language to determine what percentage of your services are person-centered with the acronym: ACCESS TO HELP.

It is vital for all stakeholders to come together to define the values and desired outcomes of mobile crisis. Once this is completed, they should select metrics to capture the values and desired outcomes. From there, the group would adapt the General Organizational Index (GOI) for the selected metrics. The monthly, quarterly, and annual results of the GOI provides areas of improvement to apply the "Plan Do Study Act Cycles" between data collection.

GOI Scale (pg. 50-52 of PDF)

The General Organizational Index (GOI) is a tool developed by the World Health Organization (WHO) to assess the overall functioning and quality of an organization, particularly in the healthcare sector. For continuous quality improvement, the GOI can be utilized by organizations to assess baseline performance, identify improvement areas, develop action plans, implement changes, monitor progress, and adaptation and evolution. By using the GOI as a framework for assessment and improvement, organizations can systematically enhance their overall functioning, efficiency, and quality of services provided. The GOI will need to be adapted according to the metrics of the Quality Measurement document.

Plan Do Study Act Cycles (pg. 53-54 of PDF)

To utilize Plan Do Study Act (PDSA) cycle worksheets for quality improvement in a mobile crisis program, begin by identifying a specific aspect of the program that needs improvement, such as response time, client satisfaction, or resource utilization. *Regularly using PDSA cycle worksheets ensures a systematic approach to quality improvement, allowing the mobile crisis program to adapt and enhance its services effectively based on real-time data and feedback.*

Annotated Bibliography

Mobile Crisis Teams

ACP / UC Center for Police Research and Policy. (2021). Assessing the Impact of Mobile Crisis Teams: A Review of Research Academic Training to Inform Police Responses Best Practice Guide. Bureau of Justice Assistance US Department of Justice , 1–21. Retrieved January 17, 2023, from https://bja.ojp.gov/library/publications/assessing-impact-mobile-crisis-teams-review-research

- This document is a best practice guide to training and informing law enforcement in behavioral health crisis response.
- Research generally suggests mobile crisis teams can increase connection to community-based services following a crisis incident, mitigate pressure on the mental health system by reducing unnecessary ED visits/hospital admissions, and promote cost effectiveness
- There are 3 overarching goals to an effective mobile crisis response team; to provide services in the community and interact in natural environment, provide crisis services to difficultly reaching populations, and reduce frequency of unnecessary hospitalizations
- Examples of agencies putting these ideals into practice can be reviewed on page 4.
- Limitations to mobile crisis teams can include lengthy response times, limited capacity for response, and safety concerns for mental health professionals.

Murphy, K. (2012). Crisis intervention teams and mobile crisis management. *North Carolina Medical Journal*, *73*(3), 200

- "To become certified as a CIT program, law enforcement offices must take a 40 hour training to learn how to identify signs of mental health crisis and are provided resources for diverting people in crisis from serving jail time" (200).
- Relationships between mobile crisis teams and law enforcement starts in training; a member of the mobile crisis team teaches officers how to contact mobile crisis dispatch and access mobile crisis services.
- "A mobile crisis management clinician will meet the person in crisis and the CIT officer wherever they are for a face-to-face assessment. If involuntary commitment is not needed, the clinician can assist in transporting the person in crisis to an appropriate location for other assistance"(200).

Trantham, D., & Sherry, A. (2012). Mobile crisis management teams as part of an effective crisis management system for rural communities. *North Carolina Medical Journal*, *73*(3), 199–203

- This article examines effective mobile crisis team practices within a rural community setting.
- "The ACS model, which provides licensed clinicians, emergency dispatch, ED response, facility-based crisis services, and walk-in centers, provides a robust crisis response in a challenging rural setting" (203).
- "Safety plans include items such as arranging for care and supervision with safe friends or family members, removing weapons from the environment, follow up by mobile crisis, psychiatric evaluation, or next working day follow up with the primary provider" (200).
- "Clinicians receive extensive training in clinical and risk assessment, medical risk factors, and involuntary commitment procedures, and all eligible staff are credentialed to complete the first exam for involuntary commitment" (201).

- At all times, each mobile crisis team has active oversight and supervision as well as on call consultation from directors and team leaders.
- "Having rapid access to walk-in services, follow-up care provided by qualified professionals, and psychiatric evaluation the next business day makes it possible for mobile crisis clinicians to divert many cases from 24-hour psychiatric care" (201).
- The success of mobile crisis teams in rural areas is based on positive relationships between community stakeholders, law enforcement, hospitals, department of social services and organizations such as homeless shelters and behavioral health clinics.
- These relationships are formed by mobile crisis team leaders marketing the effectiveness of mobile crisis teams during educational conferences and presentations, reaching out to stakeholders and facilitating meetings between hospitals and other community organizations.
- "Although a mobile crisis team can resolve many crises, and can facilitate local admission for most adults, the wait time for some populations places a severe strain on hospital EDs, law enforcement (who often wait in the emergency department until a disposition is found), clients and families" (202).
- "Commercial insurance and Medicare do not reimburse for mobile crisis services. Only 26% of those served have Medicaid coverage, and nearly 50% have no insurance of any kind" (201).

Watson, A. C., Compton, M. T., & Draine, J. N. (2017). The crisis intervention team (CIT) model: An evidence-based policing practice? Behavioral Sciences & the Law, 35(5–6), 431–441. https://doi.org/10.1002/bsl.2304

- "A foundational component of the model is the collaboration between police, mental health services, advocates, and people with the lived experience of mental illness" (950)
- "a CIT Advisory Council made up of representatives from police, mental health, advocacy, and peer organizations that meets regularly, first to develop the local program, and then to monitor ongoing operation" (1950)
- "CIT programs identify a designated facility (or facilities) where officers can bring a person in need of emergency psychiatric assessment" (1951).
- "CIT training is a 40-h training week in which participants receive didactic, experiential, and role-play content provided by police training staff and content experts from the community" (1951).
- Didactic training includes identifying "signs and symptoms of mental illness, developmental disabilities, co-occurring substance abuse disorders, as well as suicide risk assessment and intervention , response policy and procedures, de-escalation and community resources" (1951)
- During training, trainees engage in training exercises and also are presented with the opportunity to hear from people who have experienced mental illness and visit local mental health agencies. Trainees also role-play de-escalation skills.
- Results also linked types of geographic location (e.g more rural areas) to an increase in arrests based on police place-based perspective.

Mobile Response Teams Framework. (2018, August 29). Retrieved January 13, 2023, from https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf

- "Teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises" (2).

- "Services include evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources" (2).
- "The primary goals of MRTs are to lessen trauma, divert from emergency departments or juvenile/criminal justice, and prevent unnecessary psychiatric hospitalizations" (4).
- This framework defines 7 primary goals for mobile crisis teams (MRTS). Goals include to focus on the family and their strengths as well as well as resources rather than the client's deficits, recognizing the family have the final decisions for children while guiding care for adults, providing services in the least restrictive possible and being able to obtain behavioral services in their home. Goals also include responding to the impact of the trauma and creating opportunities for individuals to rebuild a sense of control, being culturally and linguistically competent, providing care coordination and emphasizing services across providers and systems. Finally, making programmatic outcome data is accessible to mangers, stakeholders, and decision makers, and that the data is meaningful and useful to those individuals.
- "Mobile response services are available 24/7 with the ability to respond within 60 minutes to new requests" (6).
- The framework also recognizes that telehealth is an important for increasing the capacity of MRTs especially in rural areas, geographically large counties, or urban areas where congested traffic patterns make meeting the 60- minute response time a challenge.
- "Research suggests that best practice is to provide continued crisis stabilization and care coordination services as indicated for up to 72 hours" (6).
- "Best practice suggests these professionals play a vital role to stabilize the crisis until the individual is connected to a behavioral health services provider for ongoing services, if necessary" (6).
- "There are currently twelve (12) publicly-funded MRTs in Florida" (9).
- Review page 10 for specific examples of States putting principles discussed into practice.

Climer, B. (2021, January 29). Cahoots: A model for Prehospital Mental Health Crisis Intervention. Psychiatric Times. Retrieved January 17, 2023, from https://www.psychiatrictimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention

- This news article examines a mobile crisis-intervention program called CAHOOTS (Crisis Assistance Helping Out on the Streets) that was created in 1989 as a collaboration between White Bird clinic and City of Eugene, Oregon.
- "CAHOOTS was absorbed into the police department's budget and dispatch system. It continues to respond to requests typically handled by police and EMS with its integrated health care model" (*How Does it Work?*).
- CAHOOTS operates directly with a crisis intervention worker who is skilled in counseling and de-escalation techniques, and a medic who is either an EMT or a nurse at the crisis site.
- "If necessary, CAHOOTS can transport patients to facilities such as the emergency department, crisis center, detox center, or shelter free of charge"(*How Does it Work?*).
- CAHOOTS operates by police contacting the team directly after receiving a crises call. Individuals in crisis may also request CAHOOTS assistance.
- "CAHOOTS, to a large extent, operates as a free, confidential, alternative or auxiliary to police and EMS" (*How Does it Work?*).
- "Tele-psychiatry services, while important, are no substitute for direct human contact, especially given that some patients will need to be transported to a higher level of care and many do not have the means or ability to participate in telehealth services" (*Barriers and How to Help*).

Allen M., Forster P, Zealberg J, and 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. American 140 A. J. Mitchell et al. Psychiatric Association
Microsoft Word - Emergency Services Final - Use This One.doc (psychiatry.org)

- This framework defines recommendations across crisis response services. This annotated bibliography focuses on recommendations for mobile psychiatric emergency services.
- Telephone Assessments and Triage (53)
    - Clients should have 24 hours access to licensed mental health practitioner.
    - Staff should be trained in assessment implementation and management of crisis phone calls and identify priority of call and interventions.
    - Calls should answered within 2 minutes.
    - Screening telephone calls should include evaluation of the client's risk of harm to themselves and others, identify any cognitive signs suggesting delirium, whether the client is in need for an immediate full assessment and or emergency intervention.
    - Written procedures for handling phone calls should be available at all times and include prioritization and coordination with available means This framework recommendations having a visible map present to assist dispatching processes.
    - Electronic identification and call tracing should be implemented for accurate location.
    - Protocols for ensuring police and mobile response team both meet the patient on site
    - Psychiatrist or nurse on each team should be presented and visible.
    - Urgent calls should lead to in person response within 1 hour, if not possible mechanism for patient to receive emergency care should be defined.
    - A log of all calls should be implemented including name, date of birth, social security number, address, telephone number and contact information for each client.
- Treatment and Treatment planning (56)
    - Client should have access to immediate care to stabilize a behavioral emergency.
    - Written protocol should be presented that specifies the most effective and least restrictive approaches to common behavioral emergencies seen in the service.
    - Individual treatment plans should include psychiatric diagnosis(s) and incorporate patient preferences to treatment.
    - Patients should receive appropriate psychoeducation relevant to condition diagnosed.
    - If crisis stabilization is required, there should be protocol and procedures for transporting client.
    - After a client is admitted or requires additional observation, response to treatment is assessed at least 4 hours by nursing staff.
- Staffing (59)
    - Staff are continuously trained in alternatives to seclusion and restraint and training is adjusted to reflect current quality improvement information.
    - Every year, each staff member receives a full day training in managing behavioral emergencies in the least restrictive ways and receives training on how to debrief with other emergency personal on site.
    - Staff are continually evaluated, monitored and enhanced for quality purposes.
    - Clinical director(s) have developed explicit written criteria for staff qualifications.
    - Staff have adequate supervision and experience in medical screening/assessment and treatment of psychiatric emergencies.
    - Staff have or are trained in having skills such as history gathering, competence in development assessment, psychiatrist should be available by phone and perform face to face evaluation.
    - Programs should have processes for assessing and anticipating staffing needs.
    - Adequate training is provided to ensure staff are competent to provide services to patients.
    - Each crisis team member's role is defined in writing to ensure successful service delivery.
- Quality Improvement (61)
    - Staff performance on key measures is compared to the performance of comparable services elsewhere.

- Programs should have processes for evaluating patient satisfaction.
- Every patient death within 30 days of discharge from the service is reviewed as part of a critical event review.
- All patients give informed consent for treatment except those who are not competent to make these

Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021, March). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. National Council for Behavioral Health.

- "A new report from the Committee on Psychiatry and the Group for the Advancement of Psychiatry, released by the National Council for Mental Wellbeing, outlines the steps we must take now – before the launch of 9-8-8 – to ensure people in crisis receive the high-quality behavioral health services they need. The report, "Roadmap to the Ideal Crisis System," provides a detailed vision for communities creating mental health crisis systems to guide this important work" (National Council for Mental Well Being, 3.27.2021).
- 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 (130).
- This framework defines measurable criteria for an ideal crisis system. Review this criteria below.
    - Hiring standards (131)
        - "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".
    - Role playing and practice (131)
        - "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".
    - Trauma Informed Principles (131)
        - "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"
        - "Avoidance of re-traumatizing triggers or actions whenever possible and ability to talk about the impact of triggers when they cannot be avoided"
    - Listed below are the trauma-informed care and welcoming guidelines for practice. (132)
        - Protect
            - Promote a safe and calm environment that includes transparent and direct communication.
        - 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

        - When connecting with patients ensure that there is cohesion and shared mission and values. Work collaboratively with the client and encourage care coordination and family engagement.
    - 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. Understand the relevance of culture of origin and culture of choice to clients. Culture includes race, ethnicity, language, and sexuality, as well as the full range of individual/family/ community affiliations.
- Intentional tracking of race/primary language/housing status
        - Monitor for and address differential treatment of certain groups in the community
    - The ideal crisis system includes opportunities for staff to learn how to utilize collaborative network-based approaches to psychiatric care.
    - "Open dialogue involves providing immediate help including a treatment meeting with individual and their families within 24 hours of a call to crisis service, employs listening and communication rather than hospitalization" (133).
    - "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" (132).
    - Listed below are recommendations for staff training within an ideal crisis system (134).
        - "Staff receive training around the importance of strength-based approach to family and collateral involvement"
        - "Staff are trained to not discharge clients with risky behavior or ideation"
        - "Staff are trained to provide proactive engagement efforts"
        - "Staff have skills and access to resources for helping families remain engaged in care following the crisis"
        - Practice-specific training and role playing of crisis response.
        - HIPAA and confidentiality regulations and training.

Admin. (2020, April 8). National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (2020). National Institute of Corrections. Retrieved January 17, 2023, from https://nicic.gov/national-guidelines-behavioral-health-crisis-care-best-practice-toolkit-2020

- This document is intended to assist mental health authorities, agency administrators, service providers, state and local leaders develop the structure of crisis systems that meet community needs.
- This document separates crisis system best practices into 4 different categories; regional or statewide crisis call centers coordinating in real time, centrally deployed, 24/7 mobile crisis, 23-hour crisis receiving and stabilization programs, and essential crisis care principles and practices.
- Minimum Expectations to operated mobile crisis team services (18)
    - Include a licensed and or credentialed clinician capable of assessing needs of clients

    - Respond to the location where client is and not restrict services based on days ,time, locations
    - Ability to connect clients to facility based treatment as needed through "warm hand-offs" and coordinating transportation when the situation warrants it
- Best Practice to Operate Mobile Crisis Team Services (18)
    - Incorporate family and peers within the mobile crisis team
    - Respond without law enforcement unless circumstances warrant inclusion in order to support for safety reasons
    - Implement GPS technology with the region's crisis call center support connection, resources and tracking of engagement
    - Schedule outpatient follow-up appointments to support ongoing care.
- Essential Elements of Mobile Crisis Services (19-21)
    - Triage/screening
        - Determining the level of risk for the client and assess best response.
    - Assessment
        - Determining causes that lead to client's crisis event.
        - Evaluate client's safety and risk for the individual.
        - Strengthen and provide resources for client (family, outpatient etc.).
        - History of inpatient hospitalizations and or relationship with current mental health providers.
        - History taking for medications the client has and or is currently take and client's medical history.
    - De-escalation/resolution
        - Engage individuals in counseling throughout service and intervene to deescalate when needed.
    - Peer Support
        - Incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services
    - Coordination with medical/behavioral health
        - Linking individuals in crisis to all necessary medical and behavioral health services that help resolve situation and prevent future crisis.
    - Crisis planning/follow up
        - Creation or update of a range of planning tools including a safety plan during instances of escalation.
- Recommendations for law Enforcement within a crisis response include: (33)
        - Provide local law enforcement with CIT training.
        - Unite law enforcement and crisis providers (EMS, dispatch etc) in meetings to discuss crisis response collaborations.
        - Law enforcement and response teams should share aggregated outcomes data (number of clients served, percentage stabilized, community connections and ongoing care).
- Mobile crisis teams should have systems in place to reach rural communities. Listed below are areas that programs should consider (35):
    - Learn how other first responders operate in that area and what medical services are available.

    - Meet and coordinated with first responder transportation systems to offer access to care that align with emergency services in the area.
    - Incorporate telehealth services to offer greater access to limited licensed resources.
    - Develop crisis response teams with other members of the community with limited demand for crisis response.
    - Establish rural reimbursement rates for emergency services.
    - Create crisis service response time expectations that consider the geography of the region while still supporting timely access to care.
- This toolkit also provides information how to fund mobile response teams.
    - The Firehouse Model (36)
        - $300 per day versus inpatient rates of $1,000 per day.
        - Sometimes users may pay a fee for service calls but the station and the equipment are available to anyone in need regardless of ability to pay.
        - Health coverage (e.g., Medicaid) will pay for professional fees as if services were delivered as part of a routine office visit but few entities pay for the infrastructure of a crisis system with rates that reflect the "firehouse model" expenses involved in being available for the next call or referral
    - Multiple payer solution (38)
        - Within multiple payer systems when responsible payers (health plans) each pay for services at rates that support operations. Therefore, it is recommended that states, counties or local jurisdictions establish rates for their communities that can be applied to all payers
    - Mobile crisis services represent community-based support where people in crisis are; either at home or a location in the community. Services should be billed using the nationally recognized HCPCS code of H2011 Crisis Intervention Service per 15 Minutes. Limiting the use of this code to only community-based mobile crisis team services positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much as it does for a fire department or ambulance service reimbursement rate. When applicable, transportation services should be billed separately
- Mobile Team Staffing
    - mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual
- This toolkit also examines how to evaluate the degree of implementation of essential element application tips (49).
    - Include a licensed and/or credentialed clinician that is skilled in assessing the needs of clients served within the region.
    - Respond where the client is (home, work, park, etc.) and not restrict services to select locations within the region or to particular days/times.
    - Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed.
    - Incorporate peer support within the mobile crisis team.
    - Respond to crisis' without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion.
    - 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.

    - Schedule outpatient follow-up appointments in a manner synonymous with a warm "handoff" to support connection to ongoing care.
- It is recommended to regularly monitor key performance indicators that support continuous quality improvement efforts. Listed below are the performance metrics that should be assessed (50):
    - Client served per 8-hour shift,
    - Average mobile team response time.
    - Percentage of calls responded to within 1-2 hours.
    - Longest call response time.
    - Percentage of mobile crisis responses resolved in the community.

Stanley B, Brown GK, Brenner LA, et al. Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry. 2018;*75*(9):894–900. doi:10.1001/jamapsychiatry.2018.1776

- A study by Stanley et al. (2018) evaluated a combination intervention, Safety Intervention plan (SPI) with SPI+, which consisted of (1) the Safety Planning Intervention (SPI)administered in the ED and (2) structured follow-up following ED discharge to prevent suicidal behavior and enhance treatment engagement.
- Within the study, 5 Veterans Affairs (VA) ED intervention sites implemented SPI+ as standard care and 4 VA ED comparison usual care were included in the analyses.
- The SPI has 6 key steps:
  (1) identify personalized warning signs for an impending suicide crisis;
  (2 determine internal coping strategies that distract from suicidal thoughts and urges;
  (3) identify family and friends who are able to distract from suicidal thoughts and urges and social places that provide the opportunity for interaction;
  (4) identify individuals who can help provide support during a suicidal crisis;
  (5) list mental health professionals and urgent care services to contact during a suicidal crisis
  (6) lethal means counseling for making the environment safer
  (7) additional component: consists of telephone contact 72 hours after discharge from the ED, usually done by project staff who were social workers or psychologists and trained and supervised by senior project staff
- Usual care generally consisted of an initial assessment by a nurse or social worker followed by a secondary evaluation by an ED physician, however did vary across sites.
- Results indicated that SPI+, compared to usual care, did not differ significantly from those in usual care on Global Assessment of Functioning at the index ED visit. However, Patients in the SPI+ condition were significantly less likely to have had the following lifetime diagnoses: major depression, bipolar disorder, PTSD, and substance abuse. Patients in the SPI+ condition were less likely to engage in suicidal behavior (n = 36 of 1186; 3.03%) than those receiving usual care (n = 24 of 454; 5.29%) during the 6-month follow-up period, yielding a number needed to treat of 44.43.

Brodsky BS, Spruch-Feiner A and Stanley B (2018) The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. Front. Psychiatry 9:33. doi: 10.3389/fpsyt.2018.00033

- The Brief Intervention and Contact (BIC), a 1-hour information session and follow-up contact after ED discharge was associated with a reduced number of suicide deaths in the 18 months following discharge in a five-country RCT (Brodsky et al. 2018, 3).
- "The Columbia Suicide Severity Rating Scale (C-SSRS) is a validated and reliable instrument that measures current and past suicidal ideation, suicide attempts, preparatory behaviors as well as non-suicidal self-injury (NSSI), a deliberate self-harm behavior performed with no intent to die" (Brodsky et al. 2018, 2)
- The Suicide Assessment Five-step Evaluation and Triage (SAFE-T) instrument guides clinicians to identify risk and protective factors, inquire into suicidal thoughts, plans, behavior and intent, determine risk level, and choose an appropriate intervention. SAFE-T incorporates the American Psychiatric Association Practice Guidelines for suicide assessment (Brodsky et al. 2018, 2)

Holland, M., Hawks, J., Morelli, L. C., & Khan, Z. (2021). Risk Assessment and Crisis Intervention for Youth in a Time of Telehealth. Contemporary School Psychology, 25(1), 12–26. https://doi.org/10.1007/s40688-020-00341-6)

- An article by Holland et al (2021) evaluated telehealth crisis response in school settings. The article lists recommendations for implementing risk assessments, Safety planning, interventions via telehealth.
- Evidence suggested that risk assessment and safety planning conducted through telehealth is both safe and effective. Though some individual interventions, such as CBT, DBT, and mindfulness were identified as current best practice for follow-up care with at-risk youth, outcome research is either scant or mixed in a telehealth modality.
- Collaborative Assessment and Management of Suicidality program (CAMS) is a EBP that has recently adapted adult treatment to teen and children
- Crisis Care app provides skill-based content that is based on cognitive behavioral strategies dealing with suicidal feelings for both youth and their families.
- A pilot study of the Crisis Care web application of 20 caregivers and adolescents with high suicidal risk evidenced the app showed promising results regarding usability, utility, and acceptability. Post-discharge from a crisis care facility adolescents reported decreased feelings of loneliness and isolation as a result of family-focused intervention and app usage. Both caregivers and youth reported similar ratings of the usefulness of the app during a crisis situation (O'Brien et al. 2017)

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Quality Measurement in ***CRISIS SERVICES***

I. Introduction

Mental health crisis systems are becoming increasingly sophisticated and multimodal as localities invest in addressing issues such as emergency department boarding, unnecessary law enforcement involvement in responses to non-criminal health care crises, and inadequate and inequitable access to mental health care services. Crisis systems often share the goals of providing rapid access to care for individuals experiencing mental health challenges to alleviate distress as quickly, safely and effectively as possible. As these systems evolve, it is necessary to use performance metrics that can advance these goals in a consistent, measurable way.

All systems are essentially an aggregation of linked processes working in concert to achieve and consistently replicate specific, intended outcomes. However, they are prone to error (human and otherwise), and few are as complex as the web of services that make up a mental health crisis care continuum. Measuring processes and outcomes provides the means to determine how closely these systems are adhering to their intended function and goals and to determine when deviations occur, so they can be corrected.

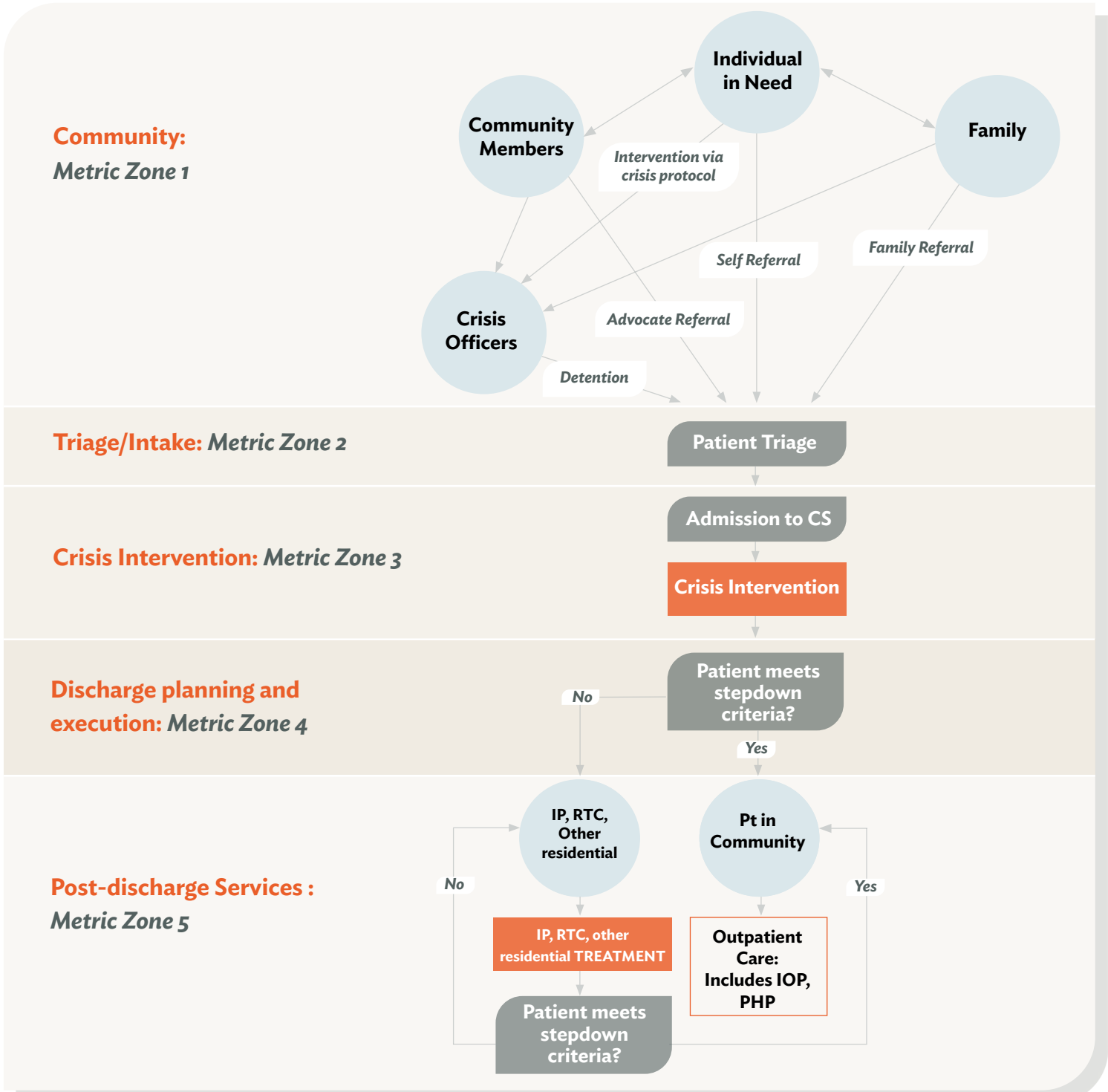
As crisis systems mature across the US, there are increasing demands for measuring their quality, including:

- Reporting mandates tied to funding and accreditation.
- Demonstrating success and value (or the lack thereof).
- Identifying weaknesses to inform continuous quality improvement (CQI) and plan-do-see-act cycles.
- Maintaining a focus on the needs of service recipients based on their own recovery goals.

For optimal performance, crisis systems should employ a "balanced scorecard" approach, i.e., an approach to measuring success that tracks system performance across a combination of different types of metrics. This brief report provides a framework for developing a set of metrics.

II. A Conventional Framework for Crisis Metrics

Health care delivery has been distinctly late in adopting foundational human engineering principles to ensure quality outcomes. An objective view of current crisis service outputs, outcomes, gaps and best practices is a critical starting point for most communities. Whether enhancing crisis services or designing them "from scratch," many funding streams, political pressures and community factors must be considered. In this section, we'll use a workflow engineering orientation to broadly define the organizational and treatment inputs that support optimal patient outcomes.



Five distinct zones along the workflow display critical data groupings:

Community: Is the community aware of crisis services, and can they use the services easily?

Triage/intake: Does the triage function facilitate efficient entry into the appropriate intervention?

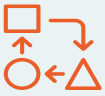
Crisis intervention: Is the intervention effective and expertly tailored to the patient's condition and circumstance?

Discharge planning and execution: Did the patient arrive at the post-crisis service venue safe, without delay in service continuity, and able to participate in the services of the new venue?

Post-discharge services *(This metric lays the groundwork for local health system adequacy determinations):*

- Are the available ***service slots adequate*** for the volume of crisis service discharge referrals?
- Is the ***service intensity*** array optimal for patient outcomes post-discharge from crisis services?
- Are ***specialized services*** available to facilitate optimal outcomes for crisis service patients post-discharge?

Metrics are also categorized and sorted:



Structural components and metrics include traditional infrastructure such as buildings/space, software, computers and space configuration. "Structural" also describes key functional areas with role-based accountabilities.

Process engineering and metrics refer to the design of workflows and automatic inputs as well as rapid, expert exception recognition and management.

Outcomes metrics refer to well-chosen, critical-to-success service result measures. Outcomes can be standalone items that are considered critical to the crisis program. The following categories are used to distinguish the types of outcomes commonly measured:

- ***Clinical:*** *Did both objective and subjective signs of the clinical condition(s) improve?*
- ***Satisfaction:*** *Did [stakeholder] find crisis services to be [positive attribute]?*
- ***Efficiency:*** *Were there fewer steps, transitions, later hospitalizations because of the service?*

III. Person-Centered Approach to Crisis Metrics

Crisis system metrics must look at the performance of the entire crisis system, as well as the performance of each individual service process or component. While they may follow the more conventional structure already described, there is a strong argument that measuring the quality of crisis services should be based on the experience of primary and secondary customers: the people served, their families and loved ones, first responders and other service providers with whom the crisis system collaborates.

By framing metrics from the customer's perspective, the crisis system's performance can be aligned with the values described by service recipients, as described in Table 1, which uses the mnemonic ACCESS TO HELP to describe a core set of measurement concepts that can guide metric development.

Table 1. When I (or the person I am involved with) experience a mental health or substance use crisis, I (we) experience ACCESS TO HELP.

	Value	Meaning	Examples
A	***Accessible/ Affordable***	I am welcomed wherever I go. I am not turned away.	• Percentage of help-seekers who receive appropriate care vs. all who have sought care. • Percentage of persons seeking care who are turned away due to lack of coverage vs declined due to not being able to afford care.
C	***Collaborative***	Helpers work in partnership with me, my family, my caregivers, and other responders.	• The programs assess consumer/family satisfaction surveys and/or net promoter scores.
C	***Comprehensive***	I get help for all my issues that are part of the crisis.	• Access to medical screening. • Able to treat co-occurring substance use disorder (SUD), intellectual/developmental disorder (I/DD), etc.
E	***Equitable***	The quality of services I receive are not affected by my race, ethnicity, gender, sexual orientation, etc.	• Stratify outcome metrics (e.g., return to crisis centers, access to care) by race/ethnicity and other key demographics (e.g., ZIP code). What percentage of poor outcomes are disproportionately influenced by performance in underrepresented populations?
S	***Safe***	My experience of help is safe and not harmful. I am never traumatized by asking for help.	• What percentage of individuals presenting in crisis end up injured, hurt or killed while doing so?
S	***Successful***	The care I receive meets my needs.	• Readmission rates. • Symptom reduction.

	Value	Meaning	Examples
T	***Timely***	I get help quickly enough to meet my needs.	• Time to intervention (e.g., call answer times, mobile dispatch times, facility door-to-doctor times). • Abandonment rate (e.g., call abandonment, left without being seen, etc.). • Lag time between seeking care and receiving care.
O	***Ongoing***	I receive help to move from my crisis situation to ongoing support that wrap around me to help me thrive.	• Successful linkage to continuing care at adequate intensity: 3-, 7-, 30-, 60-, 90-day follow up.

	Value	Meaning	Examples
H	***Hopeful***	I am helped to feel more hopeful, and I make better decisions as a result.	• Decrease in suicide, violence, self-harm. • Personal Outcome Measures (POMS).
E	***Engaging***	I am treated as a valuable customer, with respect and dignity.	• Complaints, adverse incidents, escalation.
L	***Least Intrusive***	I receive help in a place that is designed to meet my needs.	• Avoidance of inappropriate emergency department use or arrest diversion, voluntary conversion.
P	***Publicized***	I know who to call and/or where to go.	• Information about call lines and walk in centers, increased use of 988 vs. 911.

IV. How to Select Crisis System Metrics

Given that every system is different and has its own values, and because crisis systems involve multiple systems and stakeholders, it is essential to begin by developing consensus in defining the system's values and desired outcomes. A useful process for building consensus follows:

- Convene a stakeholder group composed of all users (providers, payers, service users and their families, law enforcement, emergency medical services, hospital systems, crisis workers, call center leads, mental health system leads).
- Define and memorialize the system's values, goals and intended results. These will serve as a foundation and framework for the system's definition of quality benchmarks.
- Determine component pieces of the system.
- Determine optimal operational flow through the system. (Logic models can be very effective here.)
- Assess current gaps. (Process maps, such as Ishikawa charts, also called fishbone diagrams, can be very helpful in this regard.)
- Define success and agree on how it is to be measured. Goals and intended results should be specific, measurable, actionable, realistic and time-bound (SMART).

For example, in Philadelphia's crisis system redesign, the stated values for the system include:

Reducing trauma. Relevant metrics include the rate of law enforcement involvement in behavioral health crisis situations and the use of coercive treatment (e.g., involuntary commitment).

Achieving equity. Relevant measures include tracking disparity at all levels in the system.

Increased crisis resolution in the community. Relevant metrics include call center metrics such as call answer rate, percentage of calls resolved by speaking with a counselor, rates of referral to community mental health services such as, mental health outpatient services.

Mobile team-specific metrics. These include timeliness, as measured by the time from dispatch to engagement of the individual on the scene. Other relevant metrics include the number of dispatches that result in a resolution of the crisis as compared to those that result in referral to a higher level of care.

Crisis Center Metrics. These reflect the value of reducing trauma and resolving crises at the least-restrictive level of care. They include facility door-to-care time, average length of stay and rates of referral to higher-level services such as inpatient care.

Increased individual, family, community satisfaction with crisis response: Relevant metrics include the percentage of service users who rate services as being at least satisfactory (i.e., 3 on a 5-point Likert scale).

CASE EXAMPLE: CALL CENTER METRICS

Systems that value crisis resolution in the community might choose to engage individuals in crisis by phone. Evidence suggests that up to 80% of crises can be resolved telephonically. Such systems might choose to track metrics such as call type, frequency, answer rate and approximate measures of acuity such as call duration and outcome. Paired with quality assessment processes such as randomized review of recordings, this set of call-related metrics would permit that system to track the functioning of the system's telephonic resolution of crisis calls.

V. How metrics inform CQI and Plan-Do-Study-Act (PDSA) cycles

Implementing quality improvement begins with stakeholders' consensus on chosen metrics. Next steps include collecting and sharing metrics, selecting members of the quality committee, determining quality improvement methodology, piloting interventions to improve performance and reviewing pilot results.

Methods for obtaining and calculating metrics need to be transparent and communicated to all stakeholders in a timely manner. For metrics involving the wider crisis system, members of the quality committee should represent all involved services, such as first responders, mobile crisis services, crisis centers, inpatient providers, outpatient providers and care transition providers, among others. It should also include key staff, such as psychiatrists and medical directors, content experts and those doing the work at the ground level. Reviews of metrics should occur at a frequency that supports sound patient care and timely piloting of corrective interventions.

Although one type of quality improvement methodology is not superior to any other, sustained focus on the goal of improved care and a multi-dimensional analysis of root causes — before jumping to conclusions or corrective actions – is essential. In addition, the system may need to validate the quality of the metrics, collect new metrics and/or review individual charts to clarify the source of the problem.

A deeper discussion of using crisis services metrics to improve system performance (both for individual crisis programs and the system as a whole) will be addressed in a subsequent publication from this group.

VI. Complexity in Measurement

Crisis services are among the most intersectional areas of health care, with interfaces between emergency and mental health specialty call centers, emergency medical services, mobile crisis teams, police and jails, and many other agencies.

Determining how well we are serving our clients goes beyond defining metrics using existing data — we must consider novel approaches to linking data systems to strengthen informatics opportunities. Measuring the performance of a crisis system requires a robust ability to share, aggregate and manage information across multiple types of providers. Best practices for linkages include matching along key identifiers (name, date of birth, social security number), though these data are rarely collected in full by call centers. Therefore, systems need to implement call-specific IDs that bridge data systems to facilitate retrospective linkages that can traverse call center, mobile unit, health system and criminal justice data systems. Fortunately, recent and pending changes to HIPAA, Office of the National Coordinator for Health Information Technology (ONC)/ Centers for Medicare & Medicaid Services (CMS) interoperability and 42 CFR part 2 and the common expanded permissions when the episode of care is an emergency make sharing information more feasible and efficient.

Such approaches allow for going beyond performance measures like response times and get into more meaningful process measures (e.g., post-crisis routine care utilization, post-crisis acute/crisis care reutilization, post-crisis arrest/jail entry, etc.) as well as actual outcomes (all-cause morbidity/mortality, housing status, patient-reported outcomes).

Interpreting such measures can be a complex task. Reutilization, for example, may be interpreted as a negative outcome since the crisis service was unable to divert from higher intensity care settings, but post-crisis acute service utilization for appropriate reasons (e.g., worsening symptoms, risky behaviors) should be encouraged. There is need to understand at a population level what a "reasonable" benchmark rate is for these key process outcomes. Furthermore, service providers may adopt practices akin to cherry-picking, in which certain groups are excluded from engaging with services; these practices can be accounted for in measurement with strategies such as risk adjustment.

Finally, equity must be an essential aim for crisis services measurement. To understand potential disparities in delivery of crisis care, it is necessary to routinely collect relevant demographic data such as gender identity, sexual orientation, race, ethnicity and language preferences. Reporting of metrics outcomes should be stratified by sub-groups to allow for identification of disparities and, when found, monitoring should ensure that remedies are effective at advancing equity in service delivery.

VII. Conclusion

Measuring the quality of care in crisis systems is no easy task. Fortunately, multiple approaches are available to systems that seek to ensure high-quality, person-centered, equitable delivery of crisis care. Whether using conventional or more person-centered approaches, systems can benefit from overcoming barriers to measurement and ensuring that they are employing CQI practices to improve crisis care for all.

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For more information, to request technical assistance, consulting or to contact the Crisis Services Subcommittee, please email communications@thenationalcouncil.org.

General Organizational Index (GOI) Scale

	1	2	3	4	5
G1. Program Philosophy. The program is committed to a clearly articulated philosophy consistent with the specific evidence-based model, based on the following 5 sources: 1. Program leader 2. Senior staff (e.g., executive director, psychiatrist) 3. Practitioners providing the EBP 4. Clients and / or families receiving EBP 5. Written materials (e.g., brochures)	No more than 1 of the 5 sources shows clear understanding of the program philosophy OR All sources have numerous major areas of discrepancy	2 of the 5 sources show clear understanding of the program philosophy OR All sources have several major areas of discrepancy	3 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one major area of discrepancy	4 of the 5 sources show clear understanding of the program philosophy OR Sources mostly aligned to program philosophy, but have one or two minor areas of discrepancy	All 5 sources display a clear understanding and commitment to the program philosophy for the specific EBP
***G2. Eligibility / Client Identification.** All clients with severe mental illness in the community support program, crisis clients, and institutionalized clients are screened to determine whether they qualify for the EBP using standardized tools or admission criteria consistent with the EBP. Also, the agency tracks the number of eligible clients in a systematic fashion.	=20% of clients receive standardized screening and / or agency DOES NOT systematically track eligibility	21%-40% of clients receive standardized screening and agency systematically tracks eligibility	41%-60% of clients receive standardized screening and agency systematically tracks eligibility	61%-80% of clients receive standardized screening and agency systematically tracks eligibility	>80% of clients receive standardized screening and agency systematically tracks eligibility
***G3. Penetration.** The maximum number of eligible clients are served by the EBP, as defined by the ratio: $\frac{\text{\# clients receiving EBP}}{\text{\# clients eligible for EBP}}$	Ratio = .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

*These two items coded based on all clients with SMI at the site or sites were the EBP is being implemented; all other items refer specifically to those receiving the EBP.

_____ Total # clients in target population

_____ Total # clients eligible for EBP % eligible: ____%

_____ Total # clients receiving EBP penetration rate: ____

GOI Scale (continued)

	1	2	3	4	5
G4. Assessment. Full standardized assessment of all clients who receive EBP services. Assessment includes history and treatment of medical / psychiatric / substance use disorders, current stages of all existing disorders, vocational history, and existing support network, and evaluation of biopsychosocial risk factors.	Assessments are completely absent or completely non-standardized	Pervasive deficiencies in two of the following: Standardization, Quality of assessments, Timelines, Comprehensiveness	Pervasive deficiencies in one of the following: Standardization, Quality of assessments, Timelines, Comprehensiveness	61%-80% of clients receive standardized, high quality assessments at least annually OR Information is deficient for one or two assessment domains	>80% of clients receive standardized, high quality assessments, the information is comprehensive across all assessment domains, and updated at least annually
G5. Individualized Treatment Plan. For all EBP clients, there is an explicit, individualized treatment plan *related to the EBP* that is consistent with assessment and updated every 3 months.	=20% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months	21%-40% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months	41%-60% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months. OR Individualized treatment plans updated every 6 months for all clients	61%-80% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months	>80% of clients served by EBP have an explicit individualized treatment plan, *related to the EBP*, updated every 3 months
G6. Individualized Treatment. All EBP clients receive individualized treatment meeting the goals of the EBP.	=20% of clients served by EBP receive individualized services meeting the goals of the EBP	21%-40% of clients served by EBP receive individualized services meeting the goals of the EBP	41%-60% of clients served by EBP receive individualized services meeting the goals of the EBP	61%-80% of clients served by EBP receive individualized services meeting the goals of the EBP	>80% of clients served by EBP receive individualized services meeting the goals of the EBP
G7. Training. All new practitioners receive standardized training in the EBP (at least a 2-day workshop or its equivalent) *within 2 months of hiring*. Existing practitioners receive annual refresher training (at least 1-day workshop or its equivalent)	=20% of practitioners receive standardized training annually	21%-40% of practitioners receive standardized training annually	41%-60% of practitioners receive standardized training annually	61%-8-% of practitioners receive standardized training annually	>80% of practitioners receive standardized training annually
G8. Supervision. EBP practitioners receive structured, weekly supervision (group or individual format) from a practitioner experienced in the particular EBP. The supervision should be client-centered and explicitly address the EBP model and its application of *specific client situations.*	=20% of practitioners receive supervision	21%-40% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision on an informal basis	41%-60% of practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision monthly	61%-80% of EBP practitioners receive weekly structured client-centered supervision OR All EBP practitioners receive supervision twice a month	>80% of EBP practitioners receive structured weekly supervision, focusing on specific clients, in sessions that *explicitly address the EBP model and its application*

GOI Scale (continued)

	1	2	3	4	5
G9. Process Monitoring. Supervisors and program leaders monitor the process of implementing the EBP every 6 months and use the data to improve the program. Monitoring involves a standardized approach, e.g., use of a fidelity scale or other comprehensive set of process indicators.	No attempt at monitoring process is made	Informal process monitoring is used at least annually	Process monitoring is deficient on 2 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 months; (3) Used to guide program improvements OR Standardized monitoring done annually only	Process monitoring is deficient on 1 of these 3 criteria: (1) Comprehensive & standardized; (2) Completed every 6 months; (3) Used to guide program improvements	Standardized comprehensive process monitoring occurs at least every 6 months and is used to guide program improvements
G10. Outcome Monitoring. Supervisors / program leaders monitor the outcomes for EBP clients every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome related to the EBP, e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs	Outcome monitoring occurs at least once a year, but results are not shared with practitioners	Standardized outcome monitoring occurs at least once a year, and results are shared with practitioners	Standardized outcome monitoring occurs at least twice a year, and results are shared with practitioners	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners
G11. Quality Assurance (QA). The agency has a QA Committee or implementation steering committee with an explicit plan to review the EBP, or components of the program, every 6 months.	No review or no committee	QA committee has been formed, but no reviews have been completed	Explicit QA review occurs less than annually OR QA review is superficial	Explicit QA review occurs annually	Explicit review every 6 months by a QA group *or steering committee for the EBP*
G12. Client Choice Regarding Service Provision. All clients receiving EBP services are offered choices; the EBP practitioners consider and abide by client preferences for treatment when offering and providing services.	Client-centered services are absent (or all EBP decisions are made by staff)	Few sources agree that type and frequency of EBP services reflect client choice	Half sources agree that type and frequency of EBP services reflect client choice	Most sources agree that type and frequency of EBP services reflect client choice OR Agency fully embraces client choice with one exception	All sources agree that type and frequency of EBP services reflect client choice

Activity L6.1

Apply the Plan-Do-Study-Act (PDSA) Cycle to your work

NIRN NATIONAL IMPLEMENTATION RESEARCH NETWORK
FRANK PORTER GRAHAM CHILD DEVELOPMENT INSTITUTE

The purpose of this activity is to provide you and/or your Team with the "space" to discuss and reflect on the components of the Plan-Do-Study-Act Cycle (PDSA) and apply it to your work.

Scenario A: Health Setting

Imagine you are in a hospital setting, and a new program is not going as intended. Give the program a name and name the stakeholders, then work through the sample PDSA.

Scenario B: Education Setting

Imagine you are a District Implementation Team, and a new literacy program in your elementary schools is not going as intended. Give the literacy program a name; name the stakeholders; then work through a sample PDSA.

Apply It Now

Program Name:

Program Providers:

Program Recipients:

Plan

How would you identify barriers to implementation? Name some measures you could use to monitor outcomes.

Do

Once barriers are identified, how might you go about alleviating them? What kinds of information, training, coaching might persons need?

Study

At what point would you have enough data to assess whether there was an impact or change?

Act

Once the problem is solved, list one strategy for communicating this information to the following stakeholders:

Scenario A (Health)	Scenario B (Education)
Nurses	Elementary grade teachers
Physicians	Building principals
Allied health practitioners	District curricula coordinators
Administrators	Literacy Coaches
Patients	School Board members
Community Members	Parents

CHANGE THAT STICKS

SKILL 1: SHIFTING YOUR OBJECTIVE TO CREATE SPACE AND LISTEN

"TELLING AND SELLING"

IS HOW WE NORMALLY TALK ABOUT CHANGE WITH STAFF, BUT SKILL #1 IS ALL ABOUT SHIFTING TO A NEW APPROACH. HAVE FAITH THAT BY JUST LEAVING SPACE FOR LISTENING, YOU'LL MOVE TOWARDS BUY-IN.

Kick off the conversation:

1. **Identify the purpose of the conversation**: "I want to hear your thoughts about this change so that I can support you."
2. **Clarify where flexibility lies**: "Even though we don't have a choice about this, I still want to support you the best I possibly can. To do that well, I want to hear from you."
3. **Define your roles in the conversation**: "Today, I'm not here to try to convince you or sell you on anything. I'm hoping that you might share with me the good, bad, and ugly of how you're feeling about this change."
4. **Anticipate the awkward**: "I know this might feel different from the way we usually talk about change, and that's okay! This is new for me, too. I promise to simply listen and learn from you in this conversation."
5. **Forecast the after**: "If you're willing to share with me, I also want to be sure that we identify the next right step. I'm here to advocate for your perspective with senior leaders."

Keep in mind:

- If your staff says something inaccurate or untrue, resist the urge to correct them! Remind yourself that righting reflexes can come later.
- If it feels awkward, you're probably doing it right! Lean into the awkward and normalize it with staff.
- If it feels unproductive, remember that – just like with clients – when we can meet staff where they are and listen, it goes a long way.

If all else fails, remind yourself:

"My job isn't to fix the problem right now. My job is to listen and learn."

CHANGE THAT STICKS

SKILL 2: DIG FOR MEANING

YOU'LL FIRST HIT SURFACE-LEVEL REACTIONS OF DISSENT OR COMPLIANCE:

"Well, that's a nice idea, but there's just not enough time," or "That's fine by me. I don't have any major thoughts or feelings about this."

DIG DEEPER TO FIND THE FEELINGS UNDER THE SURFACE RESPONSE:

"I'm sensing some frustration. Am I off on that?"

IF YOU GET STUCK...

Look for tone and body language to help you discern emotions, just like you would with clients: "I noticed everyone just went silent. Can someone put voice to what's going unsaid?"

Let them know that you empathize: "I know when I first saw this change, I felt _____. I'm wondering if anyone else feels that way?"

GO EVEN DEEPER TO FIND ROOT CAUSES DRIVING FEELINGS:

"Thank you so much for sharing your honest reaction with me. Can you tell me more about what's contributing to your feeling of frustration?"

REMEMBER, ROOT CAUSES COULD COME FROM SEEMINGLY UNRELATED PAST EVENTS OR PERSONAL BELIEFS:

- Memories of bad experiences with change (e.g., lack of follow-through/accountability from leaders in the past)
- Guarding against burnout/unrealistic- expectations/damaged connection with clients
- The change challenges staff's competence (e.g., "I designed the current system and feel attached to this way of doing things")
- Misalignment between the change and values/beliefs (e.g., "the vaccination policy goes against my value of personal choice")

HELPFUL LANGUAGE TO FIND THE ROOT CAUSE:

- "Help me see my blind spots on this change: what am I missing?"
- "What's important for us not to lose sight of?"
- "What problem do you see on the horizon?"
- "What's important for us to get right as we do this?"

CHANGE THAT STICKS

SKILL 3: RESPOND SUPPORTIVELY

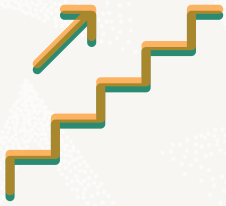
IF YOU FOUND THE ROOT CAUSE,

YOU'VE ACCOMPLISHED THE HARD PART. NOW IT'S TIME TO LEAN INTO THESE CLINICAL SKILLS...

1. **Demonstrate that you're tracking with them** (eye contact, nodding) and give them your undivided attention
2. **Reflect what you hear and check for understanding:** "I'm hearing you say that you're wondering why we need to change this when our current system is working. Did I get that right?"
3. **Be open to correction:** "I must have misinterpreted what you said. Do you mind telling me again and let me see if I hear you correctly and understand?"
4. **Focus on what's true rather than countering what isn't.** For instance, if your staff vocalizes a concern about having time to enact a change, you might be skeptical about whether time is actually the true issue. For now, simply focus on what's true: "I appreciate that you want to ensure you have the time to do this well and do this right. I know how much you care about our clients."
5. **Vocalize non-verbal responses:** "I see everyone nodding in agreement as you said that."
6. **Show appreciation and be sure to acknowledge the bravery of those willing to voice dissent or go against you:** "I admire that you are always advocating for our team and for our clients. Thank you for being that voice in the room that's speaking up."
7. **Validate and empathize:** "I want to affirm your feelings of anxiety. I hear you. I think everyone would feel similarly in that situation."

CHANGE THAT STICKS

SKILL 4: "WALKING THE WALK"... ESTABLISHING ACCOUNTABILITY AND OWNERSHIP



BE CLEAR AND SPECIFIC ABOUT WHAT THE NEXT STEP IS:

Your job is to do the 'next right thing,' not to solve problems that are beyond what you can tackle... These steps confirm that you heard your staff and support them via realistic expectations and actions (not just talk!).

STEP 5 Invite continued dissent: "I want to keep having these conversations. I'm here to get it right, not to BE right, and I always want to hear what you think."

STEP 4 Make it a joint venture, but take the lead: "I'll commit to sending that email. Can you review it for me to make sure I've captured your thoughts well?"

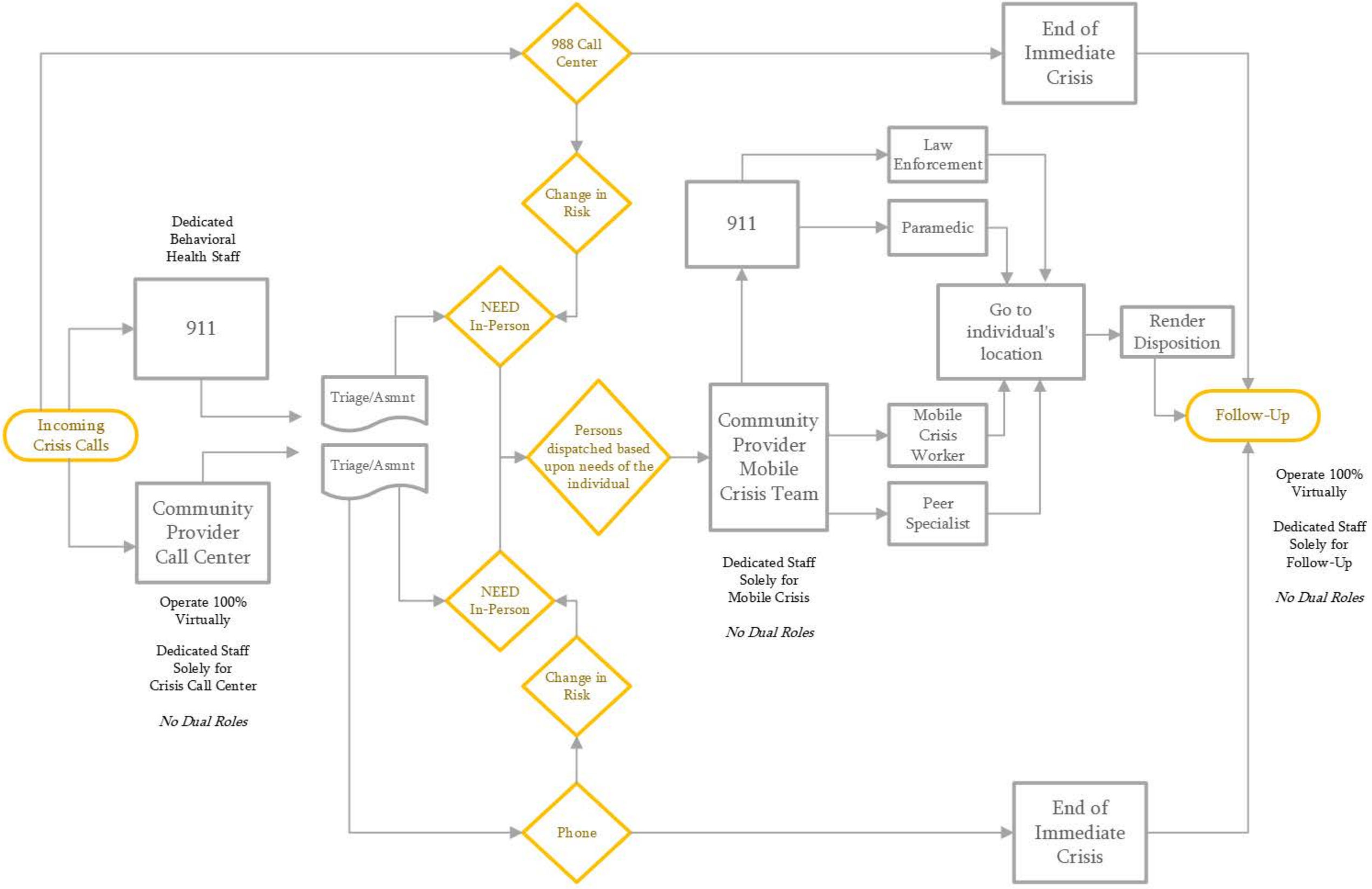
STEP 3 Identify a small step forward, clearly stating what you're committing to doing. "I'd like to send an email summarizing our discussion and copy the VP to see if they're open to a conversation. What do you think about that?"

STEP 2 Be honest about the scope of the issue and don't over-promise: "We won't solve this overnight, but I'm committed to taking the next step to start to address this."

STEP 1 Summarize the core theme that you heard and reiterate appreciation: "I'm so glad that you shared with me. It sounds like you value client care above all else and you want to make sure that we don't neglect that."

TIPS:

- You don't have to solve it all. Voice concerns to those above you in the hierarchy.
- Give your leaders a "heads up" that you're having these conversations, which may result in some new and different correspondence.
- You're not looking for a rubber stamp from a senior leader – you're looking for engagement and problem solving.


988 Call Center
End of Immediate Crisis
Change in Risk
Dedicated Behavioral Health Staff
911
NEED In-Person
Triage/Asmnt
Incoming Crisis Calls
Triage/Asmnt
Persons dispatched based upon needs of the individual
911
Law Enforcement
Paramedic
Community Provider Mobile Crisis Team
Mobile Crisis Worker
Peer Specialist
Go to individual's location
Render Disposition
Follow-Up
Community Provider Call Center
Operate 100% Virtually
Dedicated Staff Solely for Crisis Call Center
No Dual Roles
Dedicated Staff Solely for Mobile Crisis
No Dual Roles
Operate 100% Virtually
Dedicated Staff Solely for Follow-Up
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NEED In-Person
Change in Risk
Phone
End of Immediate Crisis