Michigan's role in the multi-state crisis continuum co-op: CBHJ mid-year progress report on activities from January 1, 2024 to May 31, 2024

June 2024

Recognizing the urgency of crisis system change, Michigan state government, local philanthropy (Blue Cross Blue Shield of Michigan Foundation, Flinn Foundation, Michigan Health Endowment Fund, and Herrick Foundation), and the Center for Behavioral Health and Justice at the Wayne State University School of Social Work (CBHJ) decided to act. The CBHJ drafted a proposal to begin working on the central objectives of the multi-state crisis continuum co-op, even while the co-op's official tenets have yet to be finalized. A consultant steering the development of the multi-state co-op project suggested seven elements (listed below) necessary to developing a continuum of crisis care services within each state. The CBHJ drafted a proposal to address each of the seven elements in a pre-co-op planning period from June 1, 2023 – May 31, 2024. This report describes the CBHJ's activities from January 1, 2024 – May 31, 2024 relating to each element are described in the corresponding sections of this report.

1. **Full alignment among all stakeholders**: Secure agreement that existing plans developed by the state behavioral health authority should be periodically revised and updated such that they reflect full alignment among all stakeholders (e.g., state and local law enforcement agencies, advocacy, and county officials) regarding the crisis care services that should be available to anyone, anytime, anywhere in the state.
2. **Assess the current state of practice**: Periodically assess current state of practice in a cross-section of communities against the standards stakeholders agree constitutes an effective continuum of crisis care services.
3. **Model/test approaches**: Model/test approaches in a cross-section of sites across the state to understand how, at the community level, effective programs and services are delivered at scale.
4. **Facilitate payment**: Establish state policies which increase consistency across local governments and facilitate payment by Medicaid (to include CCBHC's and 1115 Waivers), Medicare, commercial insurance, and other sources of funding for these services.
5. **Identify metrics**: Identify metrics that will be used to track progress and begin collecting and analyzing data consistent with this plan.
6. **Address workforce shortages**: Design/test new approaches to address workforce shortages.
7. **Provide equitable access**: Determine what improvements to crisis care services are necessary to ensure they are sufficiently individualized and provide equitable access.

Sections 1 and 2 are more detailed, as more of the pre-planning funding was focused on supporting staff to assess communities against SAMHSA's crisis system standards. Section 3 details recommendations and future directions for BHERi funding. Sections 4-6 describe ancillary activities that have propelled momentum of crisis system development. Section 7 acknowledges consideration of equity in site selection.

1) Full alignment among all stakeholders

The Center for Behavioral Health and Justice (CBHJ) interviewed several agencies across Michigan's crisis continuum to assess existing strengths and challenges, using the SAMHSA National Guidelines for Behavioral Health Services in Crisis Care. These guidelines offer a standardized framework for local communities to enhance their behavioral health crisis care through self-assessment and tailored local-level strategies. Ultimately, SAMHSA's guidelines serve as a blueprint for communities to enhance the quality and accessibility of their behavioral health crisis services, leading to better outcomes for people in crisis.

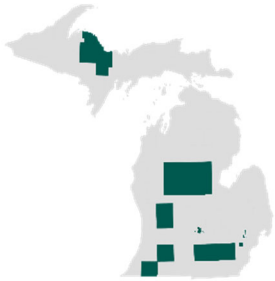
The SAMHSA guidelines were originally designed to assess components of behavioral health systems (e.g., crisis lines, mobile crisis, and crisis stabilization units). However, the traditional emergency response system (e.g., public safety answering points (PSAPs), law enforcement co-response units, and emergency departments (EDs)) also responds to behavioral health crises every day. **People in crisis deserve the same level of care, regardless of whether they first encounter the behavioral health system or the traditional emergency response system;** the CBHJ designed an operational method of applying SAMHSA's guidelines to both behavioral health and traditional emergency response systems.

This report compares the score of 10 sites across Michigan in application of the SAMHSA guidelines as evaluated through crisis mapping sessions and interviews. Interviews were coded deductively according to the SAMHSA guidelines, with each guideline serving as a code (i.e., to operate every moment of every day) and scored as Yes (aligns with the SAMHSA guideline), or No (does not align with the SAMHSA guideline). Each guideline was operationalized by the team and verified by experts in the field, including those who were contributors to the creation of the SAMHSA guideline itself. The SAMHSA guidelines and CBHJ operationalizations are presented in Appendix A.

This report presents successes and challenges in aligning Michigan's crisis continuum of care to the SAMHSA guidelines, suggesting policy changes at both local and state levels to improve care for those in crisis. First, we discuss the assessed sites and the methodology behind assessing the crisis continuums. Next, "someone to call," "someone to respond," and "a place to go" and their respect minimum expectations and best practices are discussed on an aggregate scale. For each minimum expectation and best practice, success and barriers to alignment are presented. Finally, we highlight some common recommendations that we included in several site reports to improve adherence to the SAMHSA guidelines.

2) Assess the current state of practice

The CBHJ conducted qualitative SAMHSA guideline interviews in ten Michigan sites: Cass County, Central Michigan (includes Clare, Gladwin, Isabella, Mecosta, Midland, and Osceola Counties), Jackson County, Kalamazoo County, Kent County, the City of Lansing, the city of Livonia, Marquette County, Oakland County, and Washtenaw County. Sites were chosen to reflect a range of metropolitan, urban, and rural population densities. The CBHJ had crisis system contacts in all the chosen communities from prior crisis response projects.



In July 2024, interview contacts from each site will receive tailored reports that describes the capabilities of its local crisis services, each component's adherence to the SAMHSA guidelines, and recommendations to improve the local crisis continuum.

For each site, the CBHJ assessed seven components of the crisis continuum: the local CMH crisis line, the 988 call line, the local public safety answering point (PSAP, or 911 dispatch), the CMH mobile crisis team, a law enforcement specialist team (Co-response, or CIT), a CMH access or crisis center, and the local emergency department. Each component was awarded one 'point' for each fulfilled SAMHSA guidelines. Call lines (crisis lines, 988, and PSAPs) could earn a possible ten points from SAMHSA's ten minimum expectations and best practices for crisis lines. Response teams (mobile crisis and law enforcement) could receive a possible seven points, and crisis receiving centers (CMH centers and EDs) could earn a possible 18 points. A site could earn a possible 80 points if all its components adhered to all of the SAMHSA minimum expectation and best practice guidelines. Table 1 shows the scorecard for each of the assessed sites, including the total across all components and themes.

Table 1: SAMHSA minimum expectations and best practice guidelines scorecard by site

	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site I	Site J
Crisis Line (/10)	7	5	7	6	7	7	6	5	5	7
988 (/10)	3	5	5	3	7	5	5	5	5	5
PSAP (/10)	6	4	5	4	6	6	6	5	6	6
Call total (/30)	*16*	*14*	*17*	*13*	*20*	*18*	*17*	*15*	*16*	*18*
Mobile Crisis (/7)	7	4	7	3	5	3	7	3	6	6
Law Enforcement (/7)	0	0	3	4	5	3	6	0	4	5
Respond total (/14)	*7*	*4*	*10*	*7*	*10*	*6*	*13*	*3*	*10*	*11*
CMH Center (/18)	11	9	13	12	17	14	16	9	15	13
ED (/18)	12	10	11	13	15	12	10	11	10	16
Go total (/36)	*23*	*19*	*24*	*25*	*32*	*26*	*26*	*20*	*25*	*29*
Total (/80)	***46***	***37***	***51***	***45***	***62***	***50***	***56***	***38***	***51***	***58***

Data source: CBHJ qualitative interviews (n=48), 2023-24

Scores ranged from a low of 37 to a high of 62 out of a possible 80 points. Rural sites tended to fulfill fewer of the SAMHSA guidelines, given the difficulties with implementing innovative crisis programs at scale, the scarce population density, and workforce shortages. Areas with higher population densities had higher scores, given their more abundant resources and developed crisis resources. The mid-sized communities had a wide range from 45 to 58, suggesting local-level innovations could improve practices. The sections below describe themes across the sites' performance across the SAMHSA guideline criteria: Someone to Call, Someone to Respond, and A Place to Go.

Themes: Someone to Call

Table 2 aggregates the ten site scores for each of the SAMHSA guidelines for someone to call. The aggregate scores are grouped by each of the crisis system components (Crisis lines, PSAPs, and 988 call centers). For example, if a cell lists '10', in the 24/7 row and PSAP column, that means all the PSAPs across the ten sites adhered to the SAMHSA guideline of operating on a 24/7 basis. The CBHJ did not get interviews with every PSAP in the ten sites; in cases without interviews, we assigned scores based on a generic PSAP's responsibilities and expectations.

Table 2: 'Someone to call' SAMHSA guidelines scores by agency type

SAMHSA Shorthand	Crisis Line Total	PSAP Total	988 Total
24/7	4	10	10
Clinical Triage	9	0	8
Answer Every Call	9	9	10
Suicide Risk	10	9	10
Mobile Coordination	8	6	2
Warm Handoff	9	2	1
Caller ID	3	10	0
GPS	2	8	0
Bed Registry	0	0	0
Schedule Outpatient Call	8	0	1

Data source: CBHJ qualitative interviews (n=48), 2023-24

The CMH-operated crisis lines demonstrated strong protocols of offering clinical triage, assessing suicide risk, performing warm handoffs, and scheduling outpatient follow-up calls. The crisis lines did not have access to bed registry technology, nor did they have consistent GPS monitoring of mobile crisis teams, Caller ID, or access to the state's bed registry. The PSAPs all operated on a 24/7 basis, could GPS track their co-response or CIT teams, and had caller ID. However, the PSAPs did not have clinical triage, bed registry access, or warm hand-off protocols. The 988 call centers had strong coverage and answered every call, but generally struggled to coordinate with local mental health resources.

Themes: Someone to Respond

Table 3 below aggregates the ten site scores for each of the SAMHSA guidelines for someone to respond. The scores are grouped into mobile crisis and law enforcement components. In the law enforcement component, the CBHJ evaluated the most specialized mental health response among law enforcement protocols. Six of the ten sites had some form of co-response, one had crisis intervention team (CIT) officers, and the other three had traditional law enforcement. Since the CBHJ interviewed ten sites, a '10' means that all of the sites adhered to the guideline.

Table 3: 'Someone to respond' SAMHSA guidelines score by lead agency

SAMHSA Shorthand	Mobile Crisis Total	Law Enforcement Total
Clinician	10	6
Anywhere Anytime	5	3
Warm Handoff Respond	9	7
Peers	7	3
Without LE	7	0
GPS Respond	3	5
Schedule Outpatient Respond	10	6

Data source: CBHJ qualitative interviews (n=48), 2023-24

Mobile crisis teams all had clinicians, and generally offered warm-handoffs to outpatient services. Mobile crisis teams generally were not available 'anywhere at anytime' due to safety concerns, nor did they have active GPS monitoring for their teams. Co-response teams were not 24/7 either. Given the structure of co-response efforts, meeting suggested best practice standards of non-law enforcement response, was not possible Co-response teams often did not have peers, nor did they offer follow-up connections to the same extent that mobile crisis teams did. The rural sites (Cass, Central MI, Marquette) did not have co-response teams, and were awarded 0 points in all of the co-response categories.

The SAMHSA guidelines were not a perfect measure of public accessibility to crisis response teams. For example, it was possible for teams of clinicians and peers to technically be 'available' at any time, but the teams had slow or minimal call volume. The lack of calls could have been due to lack of public awareness about the mobile crisis call number, the teams' lack of referrals from 911 or law enforcement, or strict eligibility criteria to serve existing clients. SAMHSA did not have guidelines on call response times, referral sources, or client eligibility.

Themes: A place to Go

The CBHJ assessed both CMH-operated centers and traditional emergency departments against SAMHSA's guidelines for a place to go in a crisis. SAMHSA's guidelines were originally designed for crisis stabilization units, and the CBHJ applied them to three crisis stabilization units, one behavioral health urgent care unit, six CMH offices, and ten emergency departments. Table 3 shows the counts of sites in their adherence to each of the SAMHSA guidelines.

Table 3: 'A place to go' SAMHSA guidelines score by agency type

SAMHSA Shorthand	CMH Center Total	ED Total
AcceptAll	8	10
NoMedClearanceReq	8	10
MH+SUD	10	10
PhysHealth	2	10
AllStaff	5	2
Psych	9	2
Nurses	5	10
Clinicians	10	7
Peers	8	3
LEDropOff	9	10
AcceptAllNoReject	7	5
SuicideRiskGo	10	10
ViolenceRisk	10	3
CrisisReceiving	5	10
LEDedicatedDrop	6	9
SupportBeds	7	5
BedRegistryGo	0	0
Coordinate	10	4

Data source: CBHJ qualitative interviews (n=48), 2023-24

Standard emergency departments could fulfill basic crisis stabilization unit criteria: accepting all referrals, not requiring medical clearance, addressing physical health needs, employing nurses 24/7, and receiving crisis situations would be expected of any emergency department. The CMH centers more often had clinicians, psychiatrists, peers, support beds, and had stronger coordination of care practices.

Strictly speaking, the emergency departments fulfilled more of SAMHSA's guidelines for places to go than the CMH centers did. The emergency departments' ability to be open 24/7 and handle physical health needs may be why more people show up in emergency departments than they do in CMH offices or other walk-in facilities. However, this is not to say that EDs *should* be the place to go in crisis; instead, behavioral health centers need to perform *better* than emergency departments for the community (people in crisis, family members, first responders) to use it as a realistic option. Specifically, if CMH centers were to handle round-the-clock crisis receiving, did not reject walk-ins or law enforcement drop-offs, and attended to basic physical health needs, their crisis services could exceed those at emergency departments.

3) Model/test approaches

The CBHJ did not propose activities for modeling/testing approaches in the pre-planning phase. However, the pre-planning phase of assessing communities against the SAMHSA guidelines helped us identify key recommendations to target with funded interventions through the BHERi project. The most common recommendations were embedding a clinician public safety answering points, developing a community responder model, and formalize referral pathways from law enforcement to CMH (rural).

Embedding a clinician Public Safety Answering Points

PSAP systems often struggle with behavioral health calls due to inadequate mental health training, automated triage tools, and inconsistent options for behavioral health call routing. Dispatchers typically lack the specialized training needed to manage mental health crises effectively, leading to miscommunication and unnecessary law enforcement responses. Limited resources, such as the lack of direct links to mental health mobile crisis teams, impair their ability to provide necessary referrals or dispatch specialized services. Additionally, the typical 911 system prioritizes immediate emergency responses by law enforcement, which can be counterproductive for behavioral health crises that require de-escalation and care. Addressing these challenges requires additional training, protocols, and coordination strategies to ensure sensitive and effective management of behavioral health calls.

Embedding a mental health clinician within the PSAP systems introduces numerous benefits. Clinicians can assess calls with nuanced understanding, allowing for more precisely tailored responses to mental health crises. The embedded clinician model could reduce unnecessary law enforcement deployments by directing calls instead to various mental health resources (e.g. crisis lines, Peer Warmline, mobile crisis teams, clinical consultation). Skilled mental health professionals are adept at de-escalation which may reduce situations escalating into violence or more acute crises and decreases the criminalization of mental health issues, conserving law enforcement resources for genuine criminal matters. Skilled mental health professionals also possess specialized skills in crisis intervention and de-escalation techniques, which would be employed from the moment a call is received.

Diverting mental health calls away from emergency services to appropriate mental health interventions can reduce the use of expensive emergency services, hospital admissions, officer overtime, and jail stays. Furthermore, clinicians could provide ongoing training and support to dispatchers, enhancing their ability to manage mental health-related calls effectively and empathetically. Integration of the embedded clinician model fosters greater community trust and safety, as the public gains confidence that mental health crises are handled with expert care and consideration. Embedding a mental health professional in PSAPs has the potential of transforming emergency response frameworks into more responsive, efficient, and compassionate community resources.

Actionable alternative options may also include:

- Incorporating additional training (CIT, mental health first aid, trauma informed care, cultural competency etc.…) for 911 professionals.
- Increasing 911 professionals' knowledge of, and connections to, local community resources assisting individuals in crisis in navigating the appropriate referral source.

Developing a community responder model

People with underlying behavioral health concerns often call 911 without obvious indicators of mental health issues (such as mentions of suicide or mental health diagnoses). Instead, the CBHJ estimates that 5-10% of 911 calls involve broader social needs (i.e., non-emergency quality of life concerns such as disturbances, welfare,

and basic needs) that are out of the scope of clinical mobile crisis assessments, or do not need the law enforcement presence of a co-response team. While Michigan counties have developed mobile crisis models and co-response units to acute mental health crises, 911 calls related to social needs remain inadequately addressed by law enforcement. Mobile crisis teams are underutilized and undervalued resources that could address social needs, but Medicaid reimbursement structures and the limited clinical workforce make expansion to 911 calls more challenging. Community responder models target social needs calls by addressing issues like houselessness, food insecurity, substance use, and medical connections without involving law enforcement or [illegible] By providing a specialized response that reduces the likelihood of escalation, community responder teams can alleviate the burden on law enforcement and mobile crisis teams. These teams offer continuous care and follow-up, ensuring individuals remain connected with social services, harm-reduction support, and community resources.

The CAHOOTS (Crisis Assistance Helping Out on The Streets) model exemplifies an alternative to conventional law enforcement and mobile crisis responses, deploying trained crisis responders (mental health and emergency medical technician) adept at addressing social service needs. Utilizing the community responder model approach emphasizes the importance of relationship-building, trauma-informed care, and collaborative decision-making between responders and individuals in crisis. Internal CAHOOTS reports estimate an 8% reduction in law enforcement calls for service (Eugene Police Department Crime Analysis Unit, 2020). Denver's STAR model consists of a similar staffing model, and a peer-reviewed study of the STAR program noted a significant reduction in arrests within targeted precincts in Denver (Dee and Pyne, 2022).

Formalize referral pathways from law enforcement to CMH (rural)

Formalizing a process for the CMH to receive referrals from law enforcement for both urgent and follow-up services could improve collaboration with local law enforcement departments and increase overall connections to care for individuals in crisis. In rural areas, when law enforcement responds to a person in crisis after hours, they primarily rely on the emergency department and after-hours support from select CMH staff. There are instances where law enforcement officers are seeking immediate support (e.g., experiencing longer than typical waits at the ED), and there are less-urgent situations where officers respond to someone in crisis who could benefit from CMH follow-up care. Possible strategies include: establishing urgent/non-urgent criteria, implementing email referral forms, and analyzing current informal referrals.

4) Facilitate Payment

The CBHJ joined Michigan Department of Health and Human Services' delegation to the SAMHSA Crisis Response Policy Academy in Tuscon, AZ. From the two-day session in Arizona, the MDHHS outlined the following goals: 1) Common crisis service definitions across private and public payors, 2) Establish common metrics to measure statewide, and 3) diversify and stabilize crisis service funding across private and public payors. The CBHJ continues to meet with MDHHS, BCBSM, and Michigan's crisis service providers to progress on the three goals, ultimately aiming toward the goal of facilitating payment for crisis services. The CBHJ led six commercial reimbursement workgroup session from November 2023 to May 2024, ultimately deciding to forgo facilitation of the group once MDHHS began organizing crisis payment conversations.

5) Identify Metrics

The CBHJ bought and received statewide inpatient and emergency department data from the HealthCare Utilization Project. The data will show the frequency and descriptions of psychiatric emergencies across the state, which to this point, is unknown. We purchased four years of data (2018-2021) for both ED and inpatient

data, which will include procedure codes, insurance type, diagnostic codes (to determine whether emergencies were psychiatric), and several other variables. We received the data in May 2024, and are beginning to clean and organize the files for analysis. The datasets will be tremendously helpful in assessing crisis system success; an early evaluation idea will be to compare the SAMSHA scorecard adherence (sections 1 and 2) to proportions of emergency department and psychiatric inpatient treatment stays. What components of crisis systems predict reductions in ED use or inpatient stays between counties or over time?

The CBHJ also submitted data requests to receive BCBSM billing data, MI-EMSIS data, and MDHHS crisis services data. We are sorting through legal agreements between WSU and BCBSM. We now believe the MI-EMSIS data to be duplicative of the HCUP data. Our efforts to receive Medicaid billable crisis services data have stalled, but discussions continue on how best to organize the crisis landscape evaluation.

The CBHJ investigated the use of Medicaid billing codes related to crisis response across the state of Michigan. For every CMH region that the CBHJ did a SAMHSA guideline assessment, we counted the frequency of crisis service code usage in the latest data year available (2019). We divided the code usage by the population of the CMH to assess the per capita code usage. The table below shows the frequency of various crisis billing codes in 2019.

Table 4: Crisis-related Medicaid billing codes submitted by CMHs, per 1k population (2019)

	Site A	Site B	Site C	Site D	Site E	Site F	Site G	Site H	Site I	Site J
Crisis intervention (H2011)	2.0	0.0	44.4	16.0	8.4	5.4	8.7	57.2	10.6	12.8
Hospitalization pre-screening (T1023)	1.4	4.8	9.6	3.1	4.5	5.0	5.1	3.6	2.6	1.5
Outpatient partial hospitalization (0912)	0.0	0.0	0.6	0.0	1.6	0.5	1.9	0.0	3.0	3.1
Crisis residential (H0018)	1.1	1.7	5.3	3.6	5.7	10.2	2.7	2.9	3.6	4.4
Psychiatric inpatient (days)	10.1	10.6	35.5	14.5	26.6	23.2	48.5	34.2	17.7	14.0

Data source: SECTION 904 (2)(c) Part 2 TOTAL CMHSP COSTS BY SERVICE CATEGORY AND CMHSP FY 2019

There was wide variation in the usage of crisis billing codes by ten different Michigan CMHs. The crisis intervention code (H2011) is used by mobile crisis teams but can also be used for telephonic or office-based crisis services. Site H used the H2011 code to answer crisis calls for the larger region, not just its own county. Site B did not use the H2011 code at all. The CMH in site F used the crisis residential code at a much greater frequency than the other CMHs. The CMH in site C used the hospitalization pre-screening code at a high frequency too. Given the variation of usage of crisis codes by the CMHs, it will be difficult to determine which type of crisis service predicts fewer inpatient stays and ED visits. Combined with the SAMHSA assessments and HCUP data, however, the CBHJ could get closer to designing a predictive model that identifies the most critical components of a crisis continuum.

6) Address workforce shortages

The Wayne State University School of Social Work (SSW) faculty and staff continue to develop a **crisis credentialing program** in partnership with MDHHS. The CBHJ is not funded in this project to contribute to crisis credentialing at this time, since the CBHJ receives MDHHS funding to do so. The first pilot of the crisis credentialing program is set to begin in June ’24, with the first cohort set to train in September ’24. The curriculum is a mix of asynchronous, synchronous, and in-person skills training for bachelor’s level mental health professionals who work in the crisis field. Trainers are multi-disciplinary and represent regions across the whole state of Michigan. The state will mandate that all crisis workers receive WSU’s crisis training, though

the stipulation of the mandate has yet to be defined. WSU will offer the in-person skills training at various locations across the state of Michigan to accommodate travel needs.

7) Provide equitable access

In selecting sites for BHERi funding, the CBHJ will consider regions and cities that have been historically disenfranchised. Previous crisis projects have focused on evaluating the success of current exemplary crisis programs. The most well-funded programs have been supported in areas of higher relative affluence (e.g. Livonia, Birmingham, Bloomfield Township, Washtenaw). However, even the well-funded programs had shaky and inconsistent measures of race. In attempting to compare outcomes of crisis response models against law enforcement responses, race data was not collected by the co-response models. The mobile crisis sites had self-report race data, but the law enforcement reports collected perceptions of race data. We had too much missing race data to include in our analyses, which given the context of crisis system development, is not good enough.

The BHERi opportunity will allow us to apply the lessons we've learned to sites that do not have the same levels of resources. The CBHJ will need to be intentional about collecting race data from funded programs, and recommending improvement in race-specific data variables among its partner sites. It will be important to consider racial equity, diversity and inclusion into the crisis system development, especially as momentum behind crisis system transformation have emerged from the Black Lives Matter movement.

Appendix A: SAMHSA guidelines and CBHJ operationalizations

Someone to call

	Original SAMHSA Guideline Language	WSU CBHJ Operationalization
Minimum Expectations	1. Operate every moment of every day (24/7/365)	Agency staff answers calls 24/7 without routing to contracted call center.
	2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received	Have at least on clinician available each shift for supervisory purposes.
	3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit	Answer every call or have a system in place that rings to a contracted call center that meets all the minimum crisis call center expectations defined in the toolkit.
	4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call	Assessment tool used meets NPSL standards.
	5. Coordinate connections to crisis mobile team services in the region	Coordinate to send out crisis staff to community during crisis team operating times. If team does not exist N/A.
	6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.	Have direct communication with receiving facility and coordinate for transportation to facility (i.e law enforcement, EMS, mobile crisis team, lyft/uber).
Best Practices	1. Incorporate Caller ID functioning	"Maintain caller ID or other method of locating caller's location that is readily accessible to staff." (SAMHSA, 2020, p. 15)
	2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need	Mobile crisis teams actively use monitored "GPS-enabled tablets or smart phones to support quick and efficient call hub determination of the closest available teams, track response times, and ensure clinician safety (e.g., time at site, real-time communication, safe driving, etc.)." (SAMHSA, 2020, p. 16)
	3. Utilize real-time regional bed registry technology to support efficient connection to needed resources	Actively uses bed registry that includes the required intensive services bed census; show the availability of beds in crisis stabilization programs and 23-hour observation chairs, as well as beds in private psychiatric hospitals, with interactive two-way exchange (such as through an individual referral editor and inventory/through-put status board). (SAMHSA, 2020, p. 17)
	4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.	Crisis staff facilitates scheduling "intake and outpatient appointments for individuals in crisis with providers across the region while providing data on speed of accessibility (average business days until appointment) by provider/program" (SAMHSA, 2020, p. 17). Warm handoffs are a live transfer to another agency while staff from both agencies remains online with caller for a period of time.

Someone to Respond

	Original SAMHSA Guideline Language	WSU CBHJ Operationalization
Minimum Expectations	1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation	Mobile crisis team includes licensed and/or credentialed clinician capable of assessment.
	2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or days/times	Mobile crisis teams are able to meet individuals in the community wherever and whenever the need arises.
	3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations	Mobile crisis team can facilitate connection with facility-based care and coordinate transportation to facility during crisis.
Best Practices	1. Incorporate peers within the mobile crisis team	Mobile crisis team has peers on staff that attend live calls, not just for follow up.
	2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion	Mobile crisis teams only involve law enforcement in special circumstances (i.e., a threat of violence or emergent risk) to the individual or anyone on scene. Accompaniment means the team's standard procedure involves bringing law enforcement with them to a scene. If law enforcement calls the team to a scene, with the intention of handing off the case and clearing the scene, that would align with justice system diversion.
	3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement	"Mobile crisis teams should use GPS-enabled tablets or smart phones to support quick and efficient call hub determination of the closest available teams, track response times, and ensure clinician safety (e.g., time at site, real-time communication, safe driving, etc.)" (SAMHSA, 2020, p. 16). This technology should also allow for the real-time access to resources and track engagement.
	4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care	"Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the region while providing data on speed of accessibility (average business days until appointment) by provider/program." (SAMHSA, 2020, p. 17)

A Place to Go

	Original SAMHSA Guideline Language	WSU CBHJ Operationalization
Minimum Expectations	1. Accept all referrals	Anyone who comes in the door will be accepted and then triaged.
	2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program	Not requiring medical clearance prior to arrival, but rather engage in assessment and support for medical stability.
	3. Design their services to address mental health and substance use crisis issues	Provide substance use or mental health interventions such as counseling, de-escalation, MAT services, recovery coaching, motivational interviewing, etc.
	4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed	Utilizing a nurse or other qualified staff to assess and deliver care for minor health needs and have pathway to transfer to a facility able to address those physical needs.
	5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:	Staffed at all times with a. b. c. d. (see below). (CSUs will be established with certain flexibilities in filling staff roles. CSU policies should not dictate CSU staff be directly employed by the CSU and should allow for or promote the use of telehealth services. Crisis Stabilization Units in Michigan).
	a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)	Psychiatrist must be available to the patient within the time to stabilization as noted criteria for CSU during hours of operation.
	b. Nurses	Staffed w/ Registered Nurse or other medical staff able to determine need for higher level of medical is needed during hours of operation.
	c. Licensed and/or credentialed clinicians capable of completing assessments in the region	Licensed and/or credentialed clinicians during hours of operation.
	d. Peers with lived experience similar to the experience of the population served	Having either peer support specialists of recovery coaches in the ED/CSU/PTG or on call during hours of operation.
	6. Offer walk-in and first responder drop-off options	Have first responder drop off area, as well as door for walk-ins.
	7. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders	Has bedspace to accept incoming individuals' 90% percent of the time with zero percent denial for individuals brought in by first responders.
	8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated	Utilize evidence-based assessment tools and practices to assess for risk of suicide.
	9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated	Utilize evidence-based assessment tools and practices to assess for risk of violence and planning when clinically indicated.