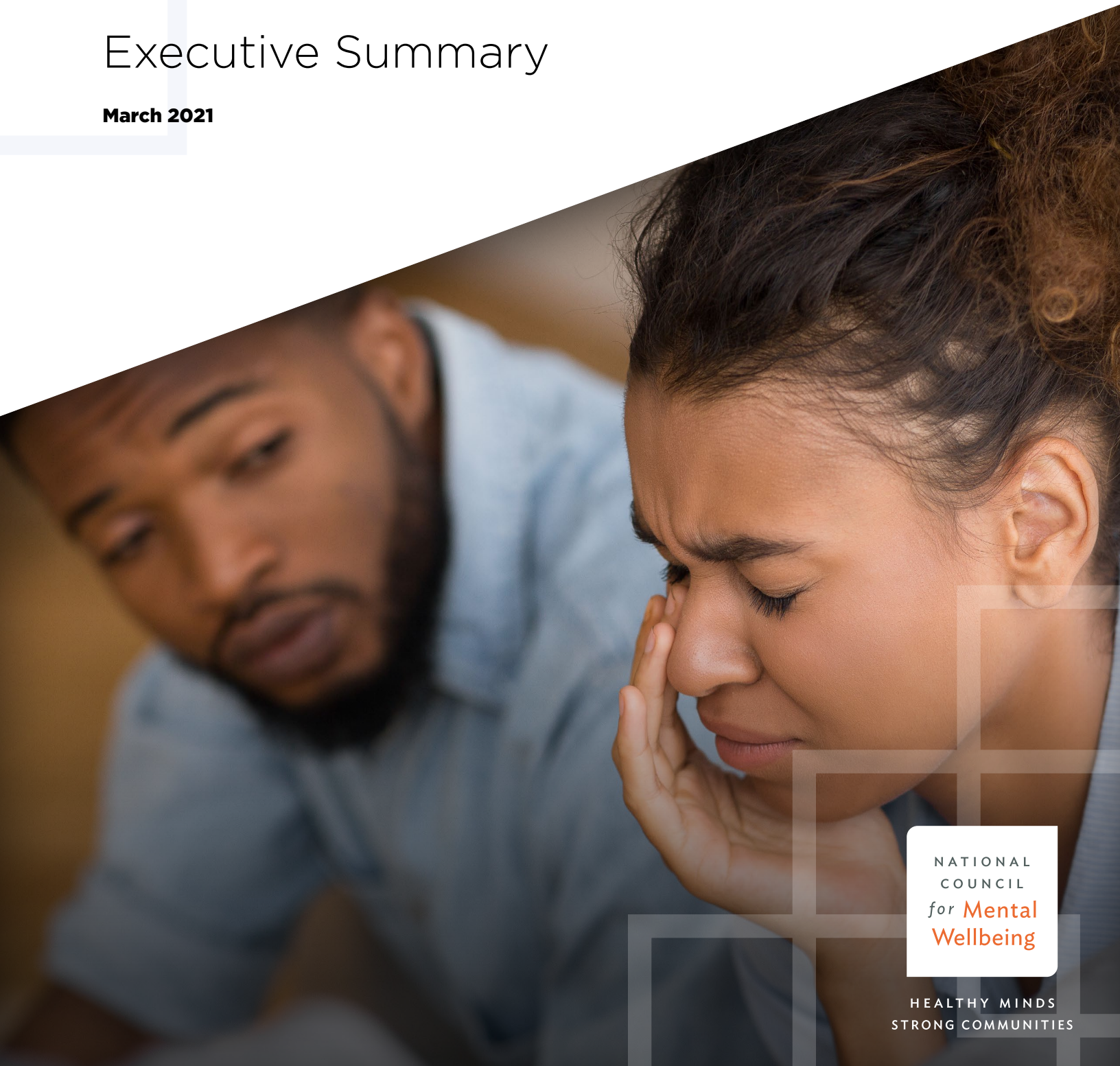
GROUP for the ADVANCEMENT of PSYCHIATRY

ROADMAP TO THE IDEAL CRISIS SYSTEM

Executive Summary

March 2021



NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

ROADMAP TO THE IDEAL CRISIS SYSTEM:

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

March 2021

Authored by Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry
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CONTRIBUTORS:

Kenneth Minkoff, MD (co-chair)
Jacqueline Maus Feldman, MD (co-chair)
Curtis Adams, MD
Sarah E. Baker, MD, MA
Margie Balfour, MD, PhD
XinLin Chen, MD
Dianna Dragatsi, MD
Michael Flaum, MD
Ann Hackman, MD, MA
Judge Steven Leifman
Stephanie LeMelle, MD, MS
Mark Munetz, MD
Keris Jän Myrick, MBA, MS
Fred Osher, MD
Paula G. Panzer, MD
Joseph Parks, MD
John Santopietro, MD
Yvonne Yang, MD

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

EXECUTIVE SUMMARY

THE CHALLENGE

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

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

Thankfully, this situation is changing, as there is growing recognition that behavioral crisis needs special attention to ensure appropriate response for everyone, on par with that provided for medical crises, disaster response, fire response and public safety. Table 1 lists a series of reports over the past decade that describe various components of state-of-the-art behavioral health crisis services. Among the most recent is a toolkit from the Substance Abuse and Mental Health Services Administration (SAMHSA) that proposes national guidelines for crisis services (SAMHSA, 2020). Another important driver has emerged from work on reducing inappropriate criminal justice involvement, recognizing the need for focus on "Intercept 0" (an effective community crisis system) in the Sequential Intercept Mapping process (Bonfine, 2019) so that law enforcement involvement in behavioral health crises is minimized. Even more important, federal legislation (National Suicide Prevention Hotline Improvement Act) has led to the initiation of implementation of a national suicide prevention and behavioral health crisis line number – 988 – that is intended to go live nationally by 2022. This major initiative provides an opportunity for the creation of high-quality community crisis response systems that approximate the level of response that we have grown to expect from medical, fire and public safety emergency response since the implementation of 911 several decades ago.

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

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

Table 1. Recent Reports on Behavioral Health Crisis Services and Systems: (Full citations in the bibliography)
• SAMHSA (2009). Practice guidelines – Core elements in responding to MH Crises.
• SAMHSA (2014). Crisis services – effectiveness, cost-effectiveness, and funding strategies.
• National Suicide Prevention Lifeline (2014). Lifeline best practices for helping callers.
• Suicide Prevention Resource Center (2015). Zero suicide toolkit.
• National Action Alliance for Suicide Prevention (2016) Crisis now: Transforming services is within our reach.
• Meadows Mental Health Policy Institute (2016, December). Behavioral health crisis services: A component of the continuum of care.
• National Association of State Mental Health Program Directors (NASMHPD) and Treatment Advocacy Center (2017, October). Beyond beds: The vital role of a full continuum of psychiatric care.
• NASMHPD (2018, August). A comprehensive crisis system: Ending unnecessary emergency room admissions and jail bookings associated with mental illness. (Assessment Paper No. 5).
• NASMHPD (2018 August). Making the case for a comprehensive children's crisis continuum of care. (Assessment Paper No. 8). TBD Solutions (2018). Crisis residential services best practices handbook.
• U.S. Department of Veterans Affairs (2018). National strategy for preventing veteran suicide: 2018-2028.
• National Suicide Prevention Lifeline.org (February 7, 2019). National suicide hotline improvement act: The SAMHSA report to the Federal Communication Commission.
• Policy Research Inc. and National League of Cities (2020, January). Responding to individuals in behavioral health crisis via co-responder models: The roles of cities, counties, law enforcement, and providers.
• SAMHSA (2020). National guidelines for behavioral health crisis care – a best practice toolkit.
• NASMHPD (2020). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies

RESPONDING TO THE CHALLENGE

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

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

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

DEFINITIONS

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

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

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

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

What is Behavioral Health?

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

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

What is a Behavioral Health Crisis?

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

What is a Behavioral Health Crisis System?

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

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

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

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

These definitions lead to the aspirational vision for this report.

THE VISION

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

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

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

ACHIEVING THE VISION

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

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

WHO SHOULD READ THIS REPORT?

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

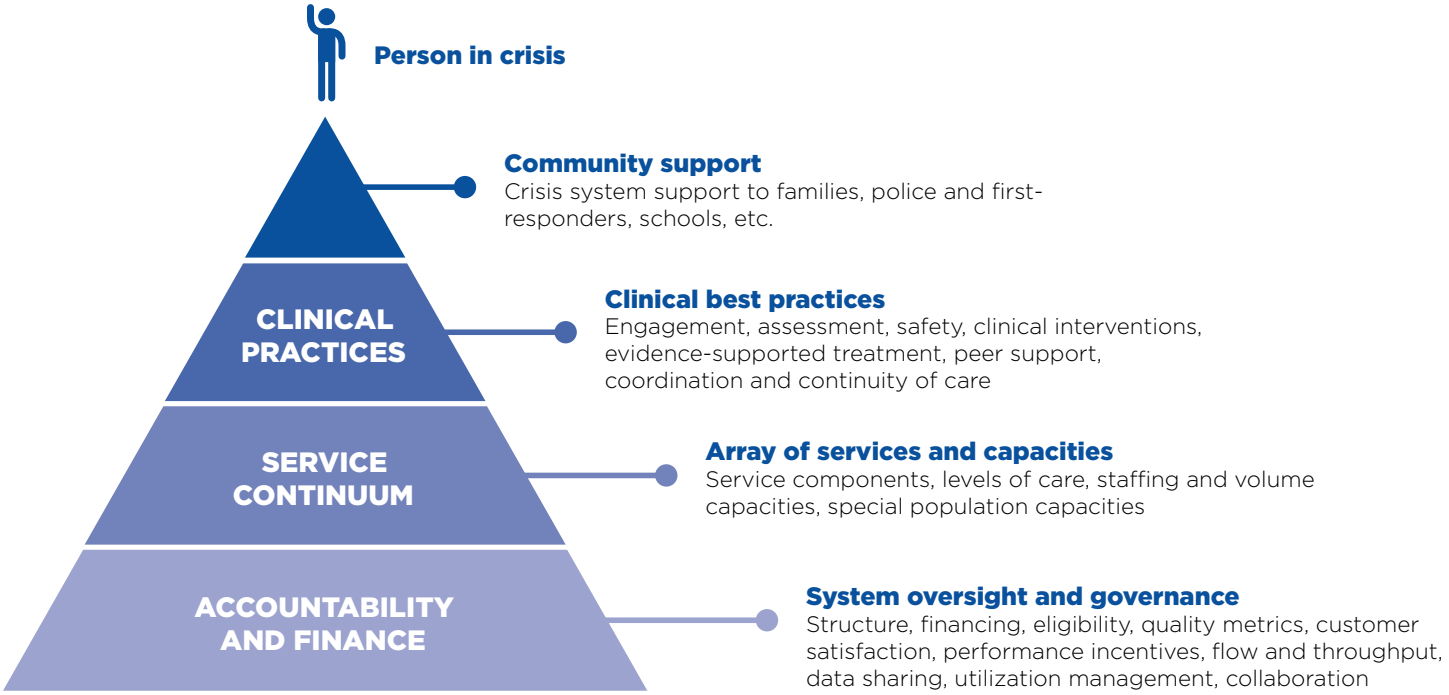
READING THE REPORT

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

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

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

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



Section I: Accountability And Finance

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

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

FINANCING

FLOW AND THROUGHPUT

ELIGIBILITY (ALL-PAYER)

COMPREHENSIVE CLIENT TRACKING DATA SYSTEM

GEOGRAPHIC ACCESS AND NETWORK ADEQUACY

FORMAL ASSESSMENT OF CUSTOMER SATISFACTION

QUALITY METRICS

STANDARDIZED UTILIZATION MANAGEMENT AND LEVEL OF CARE DETERMINATION

PERFORMANCE INCENTIVES

RELATIONSHIP TO THE REST OF THE SERVICE SYSTEM

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

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

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

OVERALL DESIGN ELEMENTS

ELEMENTS OF THE CONTINUUM
(see inset below)

POPULATION CAPACITIES

STAFFING CAPACITY

SERVICE COMPONENTS

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

Section II: Key Takeaways

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

Section III: Basic Clinical Practice

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

CORE COMPETENCIES FOR ENGAGEMENT, ASSESSMENT AND INTERVENTION

POPULATION-SPECIFIC CLINICAL BEST PRACTICES

SCREENING AND INTERVENTION TO PROMOTE SAFETY

COLLABORATION, COORDINATION AND CONTINUITY OF CARE

PRACTICE GUIDELINES FOR INTERVENTION AND TREATMENT

Section III: Key Takeaways

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

WORKING EXAMPLES

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

Examples include:

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

USING THIS REPORT TO IMPROVE COMMUNITY CRISIS SYSTEMS: 10 STEPS FOR COMMUNITIES; 10 STEPS FOR SYSTEM LEADERS AND ADVOCATES

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

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

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

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

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

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

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

10 STEPS FOR COMMUNITIES

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

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

10 STEPS FOR SYSTEM LEADERS AND ADVOCATES

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

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

REPORT CARD

Introduction and Purpose of the Report Card

This instrument is designed to provide a process to assist communities working on enhancing their crisis system to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.

Scoring the Report Card

All items are scored on a 1 – 5 scale. The scale reflects a complete continuum ranging from non-existent/not started in our community through fully implemented and functioning well.

Anchors

These may be useful in assigning a score on individual items:

1. Not started and/or not on our radar and/or If interest does exist in moving on this, barriers seen as too overwhelming to make it worthwhile to put any energy into moving forward.
2. At least some awareness of this as a desirable goal within our system, and/or initial efforts to explore implementation, but no actual movement or specific plans yet.
3. Active steps that are beginning the process toward implementation; early stages of implementation.
4. Active steps being taken toward full implementation, but still incomplete, with intent to implement further.
5. Implemented in our system in a manner that is functioning well.

Tips on Scoring and Using This Report Card

Keep in mind this is not an exact science; Not all items will fit neatly with the specific anchors suggested above. In general, **if you find yourself between two scores (which will happen commonly) choose the lower score.** This may prompt you to set the higher score as a short or intermediate term goal.

Also remember that there is neither a "perfect score" for the instrument as a whole or a "right answer" for individual items. The goal is to ensure that stakeholders are aware of each of the specific aspects or ingredients of an ideal crisis system and have a common language and a process by which to discuss and assess where their community is at with regard to each of these. Hopefully, this can be used to assist in goal setting (short-, medium- and long-term) and prioritization.

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION I: ACCOUNTABILITY AND FINANCE			
1A	Accountable entity identified and established.		
1B	Behavioral health crisis system coordinator identified.		
1C	Community behavioral health crisis system collaborative meets.		
1D	All services are accountable for system values.		
1E	Multiple payers contribute to financing services and capacity in the continuum.		
1F	Accountable entity coordinates financing.		
1G	Financing is adequate for population need.		
1H	Everyone is eligible, regardless of insurance.		
1I	The crisis continuum meets standards for capacity and geographic access for the population.		
1J	Quality metrics are established and measured for each service and the crisis continuum as a whole.		
1K	Data is collected and used collaboratively for customer oriented continuous improvement.		
1L	Provider contracts include incentives for performance in line with values and metrics.		
1M	System metrics include attention to how clients flow through the continuum timely/successfully.		
1N	The crisis system has data and capability to keep track of client progress through the continuum.		
1O	Satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) measured/improved.		
1P	Consistent level of care determination and utilization management criteria throughout the system.		
1Q	All services in the crisis system function as safety-net support partners for behavioral health system programs.		
1R	Standards define how the crisis systems works collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).		
1S	Standards define how community systems work collaboratively with the behavioral health crisis system.		
	Section I Total:	/ 95 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there

4 = substantial progress | 5 = nearly completed or completed

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COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION II: CRISIS CONTINUUM: BASIC ARRAY OF CAPACITY AND SERVICES			
2A	Safe, welcoming, values-based services throughout the continuum.		
2B	Services address the continuum of crisis experience from pre-crisis to post-crisis.		
2C	Spaces and security practices are safe, warm, welcoming, therapeutic.		
2D	Families and collaterals are partners/customers.		
2E	First responders are priority customers		
2F	The service continuum responds to all ages		
2G	Continuum of capacity for people with co-occurring needs: mental health/substance use disorder (MH/SUD), behavioral health/ intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).		
2H	Cultural/linguistic/immigrant capacity.		
2I	Continuum of services described operationally.		
2J	Capacity for seamless flow and continuity of care.		
2K	Client information sharing thru the continuum.		
2L	Clients are kept track of through the continuum.		
2M	Family/collateral outreach and engagement.		
2N	Outreach/consultation with community providers.		
2O	Telehealth utilized effectively throughout the continuum.		
2P	Crisis hub secure access and urgent care center(s).		
2Q	Crisis call/text/chat center (911/non-911).		
2R	Crisis-trained first responders deployed.		
2S	Available, low barrier, medical screening/triage.		
2T	Mobile crisis for all ages, to homes, schools, etc.		
2U	23-hour observation.		
2V	Residential crisis services: high and low medical.		
2W	Peer respite/Living Rooms.		

2X	Detox and sobering support center capacities.		
2Y	Psychiatrically capable emergency room services.		
2Z	Psychiatric inpatient capacity: all ages, both general units and specialized units.		
2AA	Continuity of crisis intervention: home and office.		
2BB	Emergency and non-emergency transport.		
2CC	Adequately staffed multidisciplinary teams in all settings.		
2DD	Clinical, nursing, medical leadership.		
2EE	Access to specialty consultation.		
2FF	Peer support throughout the continuum.		
	Section II Total:	/ 160 (total points possible)	

1 = just getting started | 2 = making initial progress | 3 = about halfway there

4 = substantial progress | 5 = nearly completed or completed

COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:	
Size of Population:	
Adult/Child/Both:	
Date Completed:	

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION III: BASIC CLINICAL PRACTICE			
3A	Crisis system framework for practice improvement and competency development.		
3B	Universal competencies: welcoming, hopeful, safe, trauma-informed, culturally affirming.		
3C	Engaging families and other natural supports.		
3D	Competency in information sharing.		
3E	Using crisis plans and advance directives.		
3F	Basic core competencies for call center staff and first responders.		
3G	Basic core competencies for behavioral health crisis staff.		
3H	No force first: maximizing trust and minimizing restraint.		
3I	Suicide risk screening and intervention.		
3J	Violence risk screening/threat assessment.		
3K	Medical triage and screening.		
3L	Substance use disorder triage and screening.		
3M	Application of civil commitment (inpatient/output).		
3N	Practice guidelines: multidisciplinary crisis teamwork, including role of peers.		
3O	Practice guidelines: non-medical crisis intervention.		
3P	Practice guidelines: crisis psychopharmacology.		
3Q	Practice guidelines: co-occurring substance use disorder/ medication-assisted treatment startup.		
3R	Practice guidelines: co-occurring medical illness.		
3S	Practice guidelines for youth/families/guardians.		
3T	Practice guidelines for older adults/caregivers.		
3U	Practice guidelines for cognitive disabilities.		
3V	Workflows within the crisis continuum.		
3W	Post-crisis continuity, critical time intervention.		
3X	Pre-/post-crisis planning with community providers.		
3Y	Coordination of Care with Community Systems		
	Section III Total:	/ 125 (total points possible)	
	Grand Total:	/ 380 (total points possible)	

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