CRISIS RESPONSE SYSTEM STANDARDS

GBRICS PARTNERSHIP
GREATER BALTIMORE REGIONAL INTEGRATED CRISIS SYSTEM

INTRODUCTION

The Greater Baltimore Regional Integrated Crisis System (GBRICS) Partnership is a public-private partnership that invests $45 million over five years in behavioral health infrastructure and services in Baltimore City and Baltimore, Carroll, and Howard Counties. The overall goal is to reduce unnecessary Emergency Department (ED) use and police interaction for people in need of immediate access to behavioral health care. The GBRICS Partnership was developed by a broad coalition of 17 hospitals, four Local Behavioral Health Authorities, and many behavioral health experts and community leaders across the four local jurisdictions.

By building upon the strengths of the current behavioral health system, the GBRICS Partnership intends to achieve its goal by implementing the following components for the region:

Principles for Community Engagement

1. **Comprehensive Call Center:** Create a regional, integrated hotline that is supported with infrastructure for real-time bed and appointment capacity and referrals tracking, coordinated dispatching of mobile crisis response plus dashboard reporting.

2. **Mobile Response Teams (MRT) Services:** Expand capacity and set regional standards following national best practices.

3. **Open Access Services:** Support behavioral health providers to offer same day walk-in/virtual services for people in immediate need of behavioral health care.

4. **Community Engagement & Outreach:** Support culture change to increase awareness and use of the hotline as an alternative to calling 911 or using the ED.

A major task of the GBRICS Partnership in Year One (2021) of the project was to engage stakeholders in developing regional Mobile Response Team (MRT) standards. These standards will be applied to the MRT services that are funded through GBRICS and to the extent possible by locally funded contracts for crisis services. Through the process of creating the MRT standards, the stakeholders realized there was a need for standards for the entire crisis system in addition to specific standards for MRTs (the Comprehensive Call Center, which is part of the GBRICS project, will follow National Suicide Prevention Hotline standards[1]). This document includes both crisis system standards and MRT standards.

[1]Best Practices: Lifeline (suicidepreventionlifeline.org)

Purpose of the standards

The establishment of standards provides an opportunity to create greater consistency with the implementation of crisis services across the region, an expectation of quality for these services, and better accountability. The standards were created to serve the following purposes:

- Create a structure for accountability and performance monitoring of the entire crisis system, whether grant funded or funded through the state's Medicaid program.
- Serve as the basis for evaluating competitive bids for MRT services and auditing individual MRT providers.
- Provide specific guidance on the implementation of the clinician/peer model of MRTs, which is a new model for most jurisdictions in the region.
- Support high-quality MRT services that can operate across jurisdictional boundaries.
- Serve as a starting point for the state to build from in creating consistency in crisis services across Maryland, which is needed to seek reimbursement from third party payors like Medicaid.

How the standards were developed

Behavioral Health System Baltimore (BHSB), a non-profit that serves as the Local Behavioral Health Authority for Baltimore City and the Regional Administrative Manager for the GBRICS Partnership, convened a MRT Work Group whose primary task was the development of the Crisis Response System Standards contained in this document. The MRT Work Group met over the course of six months in 2021 and consisted of over 50 individuals representing community members, people with lived experience, representatives from service providers in each of the jurisdictions, and staff representing local jurisdictions including the Local Behavioral Health Authorities.

The standards were developed through the following steps:

- **Creating shared understanding.** The first step for the Work Group was to develop a shared understanding of the service values on which the standards will be based.
- **Best practice research.** The primary sources for the draft standards that the Work Group discussed were The Roadmap to the Ideal Crisis System (Group for the Advancement of Psychiatry, 2021) and the National Guidelines for Behavioral Health Crisis Care Best Practice Tool Kit (SAMHSA, 2020). The definition of a "Medicaid Qualifying Community-based Mobile Crisis Intervention" from Section 9813 of the American Rescue Plan are also incorporated into the standards[2]. The complete bibliography of all sources used in the development of the standards is at the end of this document.
- **An Environmental Scan of current mobile response/crisis services.** The Work Group conducted an environmental scan to provide a landscape review of how mobile response/crisis services operate across the four-jurisdiction region. The scan involved a survey tool that was administered to mobile response/crisis service providers in the region. The Work Group looked at a draft national environmental scan questionnaire developed by Preston Looper and Matthew Goldman (Crisis Talk, 2021) and modified the draft scan to meet the unique needs of the region. The results of the scan were discussed at Work Group meetings to inform the development of the standards.
- **Writing of draft standards.** BHSB synthesized information from the research, environmental scan, and input from the Work Group to craft the draft Crisis Services Standards document, which was shared with the Work Group. In fall of 2021, BHSB staff presented the draft standards to the GBRICS Community Engagement Committee (comprised of over 50 community members) and the GBRICS Council for feed back and revised the standards accordingly.
- C**oordinate with the Behavioral Health Administration.** The GBRICS Partnership collaborated closely with the Behavioral Health Administration (BHA) throughout the development process for the standards. BHSB will collaborate with BHA on implementation of the standards once they are final.

[2] Section 9813 of the American Rescue Plan

CRISIS SYSTEM STANDARDS

The Crisis System Standards were developed to identify system-level expectations for the continuum of crisis services. The implementation of the system standards will be supported by Local Behavioral Health Authorities (LBHAs), the system managers for the public behavioral health system.

Crisis Care Continuum Description

1. Available 24 hours a day, every day of the year.[3]
2. Is integrated, serving people with mental health and substance use concerns.
3. Serves all levels of acuity. People in crisis at all levels of risk for violence to self or others are served by the continuum through a formal risk assessment.
4. Responds to all ages in a developmentally appropriate way.
5. Has capacity to serve people with concomitant need: intellectual and developmental disabilities (IDD), physical illness, LGBTQ, English as a second language, Deaf/hard of hearing, immigrant/refugees, domestic violence (DV), homelessness, and criminal justice involvement.
6. The crisis system is integrated with the broader behavioral health system so that individuals with lower acuity needs can be connected directly to ongoing care, reserving more intensive crisis services for those with higher acuity needs.

System Accountability

1. Has an established set of system and program performance metrics and ensure they are measured and reviewed regularly.
2. Implements a regular, system-wide performance review process to identify system breakdowns and access barriers, conduct collaborative problem-solving to address the identified challenges and improve consumer care, and ensure that residents are served in an equitable and developmentally appropriate manner. Consumers and family members of consumers will be involved in the system-wide performance review process.
3. Collaborative review process to analyze aggregate data on emergency petitions, conduct case reviews, and review sentinel events to look for inequities and opportunities for system improvements.
4. Ensures there are regular contract audits and programmatic monitoring processes.
5. Ensures there is a consumer quality oversight process to assess the satisfaction of individuals and families with the services they've received to improve quality of care. Also ensures there is an opportunity for referral sources and other system partners, such as law enforcement and hospitals, to give feedback on the quality of care.

Collaboration

1. Strong relationships with relevant community partners, including medical and behavioral health providers (including higher levels of care)[4], street outreach teams, peer workers, consumer and family groups, primary care providers, community health centers, crisis respite, Fire/EMS and managed care organizations.[5]
2. Strong partnership with law enforcement and 911 to promote criminal justice system diversion,

[3]Language is from: State Option to Provide Qualifying Community-Based Mobile Crisis Intervention, Section 9813 of the American Rescue Plan
[4]Ibid.
[5]Ibid.

including Memorandum of Understanding when appropriate. Law enforcement consultation for threat assessments.

3. Strong partnership with local hospitals to promote diversion and ongoing connection to behavioral health services in the community for people being discharged from the ED or hospital.
4. Strong partnership with the schools, including Memorandum of Understanding when appropriate.
5. Strong partnerships with existing street outreach/homeless outreach/harm reduction teams.

MOBILE RESPONSE TEAM STANDARDS

The Mobile Response Team Standards were developed to be applied to MRT programs. MRT programs will be contractually obligated to apply these standards to their service delivery. LBHAs will monitor and support programs to implement the standards and conduct audits annually.

Definition

According to the federal Substance Abuse and Mental Health Services Administration and the Maryland Behavioral Health Administration, a MRT "is a community-based service that provides face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis. The immediate goal is to de-escalate the individual's behavioral health crisis, but also assists with continuity of care by providing support that continues past the crisis period."[6]

Mobile Response Teams must meet the service definition for Mobile Crisis Intervention, CTP code H2011- HT: "Services are delivered in the community, home, school or other community-based environments and are face-to-face with the individual and/or family providing appropriate crisis intervention strategies. The person in crisis must be present for a majority of the service delivery duration. Crisis intervention services shall be available 24 hours a day, seven days a week, wherever the need presents. The service requires the availability of a licensed practitioner who will screen and triage all calls to recommend crisis intervention care dispatch through an accredited hotline."[7]

Service Competencies

1. Universal competencies: welcoming, hopeful, safe, trauma-informed, timely, culturally affirming.
2. Competency in information sharing, including coordination of care and information sharing in a life-threatening emergency. Maintains the privacy and confidentiality of patient information consistent with Federal and State requirements.[8]
3. Consumers are asked about Wellness Recovery Action Plan (WRAP) crisis plans and psychiatric advanced directives.
4. MRTs will respond to calls for service within one hour, 90% of the time.
5. Integrated assessment tools for the whole continuum.
6. Maximizing trust and minimizing restraint.
7. Suicide risk screening and intervention, including postvention in the aftermath of a completed or attempted suicide.

[6] Effectiveness, Cost-Effectiveness, and Funding Strategies for Behavioral Health Crisis Services (samhsa.gov)
[7] NASMHPD, 2022. RIInternational_CrisisCodingDocuments_v15hk (crisisnow.com)
[8] Section 9813 of the American Rescue Plan

8. Violence risk screening/threat assessment.
9. Substance use disorder triage and screening.
10. Mobile crisis teams should have the capability to make referrals to outpatient care. Follow-up should occur within 72 hours and until the person is connected to ongoing care (up to 3 months). Follow-up should include: review of safety plans, confirmation of appointment completion or other linkages, and discussion of barriers to seeking care, such as transportation or finances.

Staffing

1. At least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law.[9]
2. Other professionals or paraprofessionals with appropriate expertise in behavioral health crisis response, including nurses, social workers, peer support specialists. [10]
3. Nurses on staff for medical clearance.
4. Access to consultation by a behavioral health prescriber either in person or through Telehealth.
5. The crisis system will provide access to consultation for crisis providers throughout the continuum by a Board-Certified Behavioral Analyst for crisis involving consumers with Intellectual or Developmental Disabilities
6. Expertise on staff or consultation available in the following areas: Child and adolescent, geriatric, trauma in formed care, cultural competence, immigrants/refugees, Medically Assisted Treatment, eating disorders, forensic.
7. Peer support throughout the continuum.
    a. Peers on staff who reflect the community served: young adult peers, older adult peers, family/caregiver peers, LGBTQ peers, peers with shared culture.
    b. Peers report directly to a Lead Peer (not a clinician) and are provided the opportunity to work with peer-led organizations for support.
    c. There is a paid pathway for peers to become Certified Peer Recovery Specialists (CPRS) if the certification is required for reimbursement of services.
8. Human Resources policies support addressing secondary trauma through promoting regular check-ins with supervisors and proactive monitoring for burn-out or secondary trauma.
9. Supervisors available during all shifts to support staff and resolve consumer/community complaints.

Practice Guidelines

MRT Programs need to apply the following practice guidelines:

1. Effectively engaging with families and other collateral support people during a crisis.
    a. All staff are trained to regard family members and collateral support people as priority customers in crisis situations. Staff demonstrate competency in routine engagement of all people who provide collateral support to the client, know how to gather information in the absence of a signed disclosure and show consistent positive regard for family members and other collaterals.
    b. Disposition is never complete without involvement of support people and provision for their ongoing needs. Families should also receive ongoing supports following an acute crisis. This should include:
        i. Invitation to be part of treatment interventions, problem-solving and disposition planning.
        ii. Psychoeducation from the crisis response team, including answering family questions, as well as connection with community resources including the National Alliance on Mental Illness (NAMI).

[9] Ibid.
[10] Ibid.

c. Staff are expected to continually revisit initial denials of consent of inclusion of family members and other support people to emphasize the importance of family and collateral contact participation in crisis services planning.

2. Information sharing with families and other community, natural and professional supports.
   a. All confidentiality regulations permit communication with collateral support people without release when such communication is necessary for assessment and intervention in a potentially harmful crisis or life-threatening emergency. Communication with collateral contacts is an expectation.
   b. Even in the absence of a life-threatening emergency, crisis providers can facilitate the receipt of information from collateral contacts, even without permission to disclose information.
   c. Guidelines are developed to ensure the confidentiality of adolescent health records in compliance with state and federal laws (e.g., 21st Century Cures Act and Health Insurance Portability and Accountability Act)
3. Criteria for emergency petitions.
   a. Criteria for emergency petitions with a formal assessment for deciding whether an emergency petition is needed.
      i. Guidelines need to consider relevant state laws
      ii. Mobile Response Teams should identify natural support systems and engage them in attempts to resolve the crisis.
      iii. MRTs must use interventions to resolve contributing factors that may have initially indicated the need for EP (e.g., interpersonal conflict, access to means of suicide, availability of natural and formal supports, lack resources such as housing or food).
      iv. Consumers should be engaged in shared decision making and encouraged to engage in voluntary treatment
      v. MRTs should notify consumers of their rights
      vi. When necessary, emergency petitions can be used proactively to prevent tragedy.
   b. Emergency petitions require supervisory review and tracking.
   c. Training on this guideline should include peers and family members who can talk about lived experience with emergency petitions.
4. Working with children, youth and families:
   a. Dedicated MRTs for children, youth and families (for children/young adults under 25), with intensive training for these teams.
   b. Close coordination with individual schools, school systems, child welfare and juvenile justice systems, as well as higher education institutions for young adults. Coordination includes providing clear information to entities about what the agency and child/young adult/family can expect when engaging an MRT.
   c. Incorporate Family Support Peer Specialists and Youth Peers into the teams (clinician and peer model).
   d. Provide follow-up services: first follow-up no later than 72 hours and second follow-up within 2 weeks.
   e. Establish a low-barrier process for dispatching MRTs for children and young adults based on a standardized assessment.
   f. Send a MRT to every call from individual schools or school system.
5. Additional practice guidelines will need to be developed for the following:
   a. Use of WRAP crisis plans and psychiatric advanced directives.
   b. Standards for follow-up care, with enhanced follow-up services for vulnerable groups such as children, youth, older adults, and people with Intellectual or Developmental Disabilities or other cognitive disabilities, including linking to intensive case management services when indicated.
   c. Harm reduction services (for example, distributing naloxone) are provided to people who need it.
   d. Transporting consumers.

e. Guidelines for working with consumers with:
    i. co-occurring mental illness and substance use disorder
    ii. co-occurring medical illness, including geriatric care
    iii. cognitive disabilities (Intellectual/Developmental Disabilities, Traumatic Brain Injury, Dementia), including de-escalation strategies for people with cognitive impairment
    iv. People with hearing, visual or physical disabilities.
    v. LGBTQ consumers
    vi. Veterans
f. Reporting abuse and neglect of children and vulnerable adults
g. Extreme Risk Protective Orders (petitioning for people found to be dangerous to themselves or others from temporarily purchasing or possessing firearms).
h. Language access:
    i. Cultural/linguistic/immigrant capacity. Services provided by multilingual staff in the primary languages in the community, with 24-hour language line access for languages not served by staff.
    ii. Capability to serve Deaf/Hard of Hearing people through the use of clinicians or peers who are fluent in ASL, use of a Deaf Interpreter, video relay system or video remote interpreting, and/or speech-to-text/captioning services. Respect for communication preferences and acknowledge the spectrum of language use and variation in hearing and literacy levels.

Training

Consumers and family members of consumers participate in developing and presenting training.
Onboarding and annual training in:

1. Trauma-informed care, de-escalation strategies, and harm reduction.[11]
2. Recognizing medical emergencies (for non-medical staff).
3. Self-care.
4. Cultural humility and anti-racism.
5. Training on the standards (including services for special populations) listed above.

[11] Ibid.

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