Recommendations for Care Response for Behavioral Health Crises in Cuyahoga County

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for:

EXECUTIVE SUMMARY

Recent events in Cuyahoga County, Ohio and elsewhere in the United States have demonstrated that a police-centric response to behavioral health (BH) crises too frequently leads to untoward outcomes such as needless hospitalizations, arrests, and even injury or death to individuals experiencing a crisis, as was the case with George Floyd in Minnesota and Tanisha Anderson and Maalik Roquemore in Cleveland. These events have led many communities, states, and the nation to evaluate community behavioral health crisis response and to strive for a comprehensive and integrated response system that is safer and better meets the needs of individuals in crisis.

One of the crucial, but underdeveloped, components of such a crisis system is Care Response. Care Response is a program where the first responders assisting individuals experiencing a behavioral health crisis are unarmed behavioral health practitioners, usually including a peer support person (individual with personal lived experience of mental illness or addiction). They are directed to a person in crisis by dispatch services that have special training to determine that this kind of response is appropriate for the situation and is safe for both the Care Response providers and the person in need of services.

Communities that have implemented Care Response services have reported excellent results. They have found reduced need for police-response to behavioral health crisis situations which permit police to engage in other community-safety activities, reduced psychiatric hospitalizations, reduced crime in the areas covered by Care Response, safer situations for all involved, and increased engagement in behavioral health services by served clients following the crisis. Care Response is also cost-effective, with overall system savings several-fold higher than the cost of the program itself.

Community surveys have indicated that people in Cuyahoga County are supportive of matching the type of crisis response to the type of crisis, including behavioral health response to behavioral health crisis. Surveys done by existing programs elsewhere generally find high levels of satisfaction among those who have received unarmed community response crisis services, their families, and local police.

For maximum impact, it is critical that Care Response services are integrated into a comprehensive behavioral health crisis care system which itself is integrated into the broader behavioral health system. The "Crisis Now" model championed by the Substance Abuse and Mental Health Services Administration (SAMHSA) breaks this into three basic components:

- Someone to talk to (telephone crisis services—frequently through 988)
- Someone to respond (community- based services like Care Response)
- A place to go (facility-based crisis services)

Efforts are underway in Cuyahoga County and Cleveland in all these areas, including the expansion and further development of 988, increased crisis intervention training (CIT) for police, development of "co-response" teams composed of a police officer accompanied by a mental health professional, and development of a diversion center to avoid needless incarceration of individuals with mental illness and substance use disorders.

For several years, various groups and organizations in Cuyahoga County have been investigating Care Response as an alternative to current behavioral health response processes. In October of 2022, R Strategy Group, with the support of local foundations and in collaboration with the Cuyahoga County Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board, convened a working group of local advocates (many of whom had been actively working on this topic previously) and outside consultants to evaluate the feasibility of implementing Care Response services in Cuyahoga County. Since then, extensive research has been done, including interviews with local leaders and advocates, discussion with Care Response programs in Ohio and nationally, research of existing professional literature, and review of media reports related to Care Response. Additionally, several focus groups were held to supplement the input and wisdom gained from previous community engagement work conducted by local organizations and advocates. Working group members provided input through the research phase and recommendations were made based upon the research and discussion.

Based upon this research, **we strongly recommend that the Cuyahoga County ADAMHS Board implement Care Response as part of its continuing work to expand and enhance a comprehensive and integrated behavioral health crisis care system**. It is our suggestion that this begin on a pilot basis in a circumscribed area of the county that is in significant need of such services and is traditionally underserved. Prior to the implementation of services, we suggest a "lead-in" period to work extensively with partners across the crisis continuum and assure good collaboration and integration, especially with members of the community served. This period should also be used to establish protocols and guidelines and develop or enhance a data management system for program assessment and accountability. The recommendations are extensive and found in the full report, which follows. A summary of the recommendations is in Appendix 10 of this report.

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TABLE OF CONTENTS

EXECUTIVE SUMMARY 1
OVERVIEW OF CRISIS RESPONSE 4
BEST PRACTICES FOR COMMUNITY CRISIS SYSTEMS 6
- Someone to talk to: 7
- Someone to respond: 7
- A place to go: 7

SOMEONE TO RESPOND—TYPES OF COMMUNITY BEHAVIORAL HEALTH CRISIS REPSONSE 9
FUNDAMENTALS OF A CARE RESPONSE PROGRAM 11
OUTCOMES IN MOBILE CRISIS RESPONSE 14
COMMUNITY ACCEPTANCE OF MOBILE CRISIS 16
CHALLENGES OF MOBILE CRISIS TEAMS 17
SUMMARY OF RESEARCH 17
RECOMMENDATIONS FOR CARE RESPONSE IMPLEMENTATION 19
SUMMARY 33
REFERENCES 34
APPENDICES 40
CUYAHOGA COUNTY CARE RESPONSE WORKING GROUP 52

OVERVIEW OF CRISIS RESPONSE

The United States has a well-developed emergency medical response system. Beginning in the 1960s, it was observed that having specifically trained and credentialled staff responding to medical emergencies in the community improved medical care and clinical outcomes. Almost everyone in our country knows to call 911 in the event of a medical emergency and expects that within minutes, a fully equipped medical response vehicle with trained staff will present to the site, and on arrival the person experiencing the emergency will be assessed, stabilized in the community to the degree possible, and if necessary, transported to a medical facility which has more medical capability than the emergency medical system vehicle and staff. The design of response to fires or criminal activity is similar to the emergency medical response system (Rafla-Yuan, et al., 2021). Regrettably. and despite best efforts, gaps and inefficiencies in the emergency response system still exist in some parts of our country.

This response system has also been the default system for individuals in behavioral health crisis, and has frequently served them poorly, sometimes even leading to injury or death. Individuals in behavioral health crises have unique needs that are better dealt with utilizing the specific expertise of a behavioral health clinician, just as individuals with other medical needs are best served by responders with specific medical expertise. Although medical and police responders are generally well-intended and some have had additional training in behavioral health, they lack the specific expertise of individuals who have advanced training and are licensed in a behavioral health field, or that of peers who have lived experience in the behavioral health system and understand first-hand how the crisis response impacts underserved and frequently marginalized individuals. Additionally, when law enforcement responds, they present to the scene in squad cars, frequently with sirens and flashing lights, and are invariably armed. Even without use of a weapon, such a presentation can lead to individuals in crisis misinterpreting the nature of the response, feeling intimidated, and experiencing a trauma response. This can create undesired outcomes, such as individuals in crisis and their families choosing to not access services for fear of the response type, behavioral health crises that go unresolved in the community, unnecessary transport to emergency facilities, incarcerations, and even injuries or death, especially in individuals of color and gender diverse individuals (Rafla-Yuan, et al, 2021; McCleod, et al, 2020; Turan, 2022).

Individuals surveyed recently in Cleveland have stated a clear preference that those responding to crises should have the correct training and expertise to address the type of situation that was of concern, namely, police for safety threats, firefighters for fire, medical responders for general medical illness needs, and behavioral health providers for behavioral health needs. Overall positivity and safety indicators rose when this specialization was seen in first responses. Multiple individuals surveyed underscored that the expertise of the responder is one of the primary factors in their sense of how a crisis is handled and what outcome is produced (Schleiffer and van Lier, 2022).

Successful implementation of programs where behavioral health providers respond to behavioral health crises in numerous communities across Ohio and the country demonstrate that Care Response is an important part of an integrated and comprehensive crisis response system, and research demonstrates that when Care Response is part of the behavioral health continuum, communities benefit in many ways Government agencies (SAMSHA, 2020; Ohio MHAS, 2023; Bureau of Justice Assistance, 2019), professional organizations (NASMHPD-- Pinals, 2020; Group for Advancement for Psychiatry, 2021), academic institutions (Center for Police Research and Policy, 2021), policy advisory groups (VERA—Watson et al., 2019; Beck et al., 2020, Beck et al, 2022; The Council of State Governments, 2021; Policy Matters Ohio--van Lier, 2022) and advocacy groups (Mental Health America, 2017) have developed resources to aid communities in developing, expanding, or reconfiguring behavioral health crisis response. Specific interventions for these crises (including Care Response) provide numerous advantages to individuals and communities where they reside (Table 1).

TABLE 1. BENEFITS OF GOOD CRISIS CARE (SAMSHA, 2020)	
• An effective strategy for suicide prevention • An approach that better aligns care to the unique needs of the individual • A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis • A key element to reduce psychiatric hospital bed overuse	• An essential resource to eliminate psychiatric boarding in emergency departments • A viable solution to the drains on law enforcement resources in the community • Crucial to reducing the fragmentation of mental health care.

Federal, state, and local government have all initiated efforts to enhance crisis care. On a federal level, the Substance Abuse and Mental Health Services Administration (SAMSHA) developed an implementation toolkit based on the recommendations of national thought-leaders in crisis response (SAMHSA, 2020). Communities implementing services based on this toolkit may be eligible for funding from the Centers for Medicare and Medicaid Services (CMS) to provide seed money for start-up and compensation for clinical care rendered (CMS, 2021). Other federal funding has been provided for the development, expansion, and operation of crisis call lines (988) and behavioral health crisis care for adolescents. SAMSHA now requires that five (5) percent of all federal mental health block grant funding be earmarked for crisis services (SAMSHA, 2023).

In Ohio, the Department of Mental Health and Addiction Services (Ohio MHAS) engaged national, Ohio and local experts and stakeholders to develop a state plan for a comprehensive community crisis response system, including Care Response. This plan conforms with the recommendations in the SAMHSA toolkit, but in many ways goes beyond them to lay the foundation for a crisis system tailored to Ohio's mental health and cultural landscape (Ohio MHAS, 2023). The FY 2024-2025 budget proposed by Ohio Governor Mike DeWine has

earmarked $46.5M to support 988 operations and an additional $40M of flexible funding for locally identified crisis needs.

Locally, Cuyahoga County has been a pioneer in the integration of psychiatric emergency services, establishing a hotline, integrated community-based crisis programming, and a mobile crisis response team (Guo, 2001), as well as a crisis stabilization center and a psychiatric emergency department. Recent additions include police-provider co-response teams utilized as a second level of support behind standard patrol teams, and development of a diversion center to avoid needless incarceration for individuals with mental illness and/or substance use disorders engaged by law enforcement (Casanova, 2022).

In addition to government activities, numerous professional organizations and advocacy groups have demonstrated support for a comprehensive and integrated crisis care system. The National Council for Mental Well-Being and the National Association of State Mental Health Program Directors (NASMHPD) have both developed crisis service implementation toolkits, and the National Alliance on Mental Illness (NAMI) and Mental Health America (MHA) have demonstrated support for an integrated and comprehensive crisis care system. NAMI also has specific resources for Mobile Crisis Teams (Weslowski, 2022).

Community philanthropic support is also significant in Ohio. Peg's Foundation in Hudson, Ohio supports communities around the state as they develop their own crisis response systems by providing both technical assistance and material support in their "Clear Pathways" initiative. In Cuyahoga County, the Cleveland Foundation, the George Gund Foundation and the Mount Sinai Foundation have all provided funding for this research and to gather community input on the need for Care Response in Cleveland and Cuyahoga County. Furthermore, multiple government leaders have voiced support for expanded crisis services and Care Response including Senator Sherrod Brown, Representative Shontel Brown, Cuyahoga County Executive Chris Ronayne, and Cleveland Mayor Justin Bibb. Numerous local organizations have also advocated for Care Response, including Magnolia Clubhouse, Policy Matters Ohio, and REACH (Responding with Empathy, Access, and Community Healing). In essence, there is a groundswell of support for an integrated and comprehensive crisis system that includes Care Response in America's communities, including Cuyahoga County, and it is now increasingly seen as a best practice in community behavioral health.

BEST PRACTICES FOR COMMUNITY CRISIS SYSTEMS

The toolkit published by SAMSHA in 2020 established "best practices" for an integrated crisis system. Although other toolkits have been developed, the core components differ only modestly from the SAMHSA document. There are three (3) major structural components to the ideal crisis system, which function under essential care principles and practices that are "baked-in" to the entire continuum (Figure 1).

FIGURE 1. COMPONENTS OF AN INTEGRATED BEHAVIORAL CRISIS REPSONSE SYSTEM (SAMHSA, 2020)

		Essential Characteristics of All Crisis Care Components:
	Someone to talk to	• Address recovery needs • Significant role for peers • Trauma-informed care • Safety and security for staff and those in crisis • Law enforcement and emergency medical services collaboration
	Someone to respond	
	A place to go	

Someone to talk to:

In 2022, "988" was implemented as the national behavioral health emergency call number, analogous to 911 as the intake number for responses relating to medical emergencies, fires, or law enforcement situations. While implementation is ongoing, this provides an opportunity to standardize dispatch and response processes across the country and replace what previously was a patchwork of numbers in different locations with different providers.

Someone to respond:

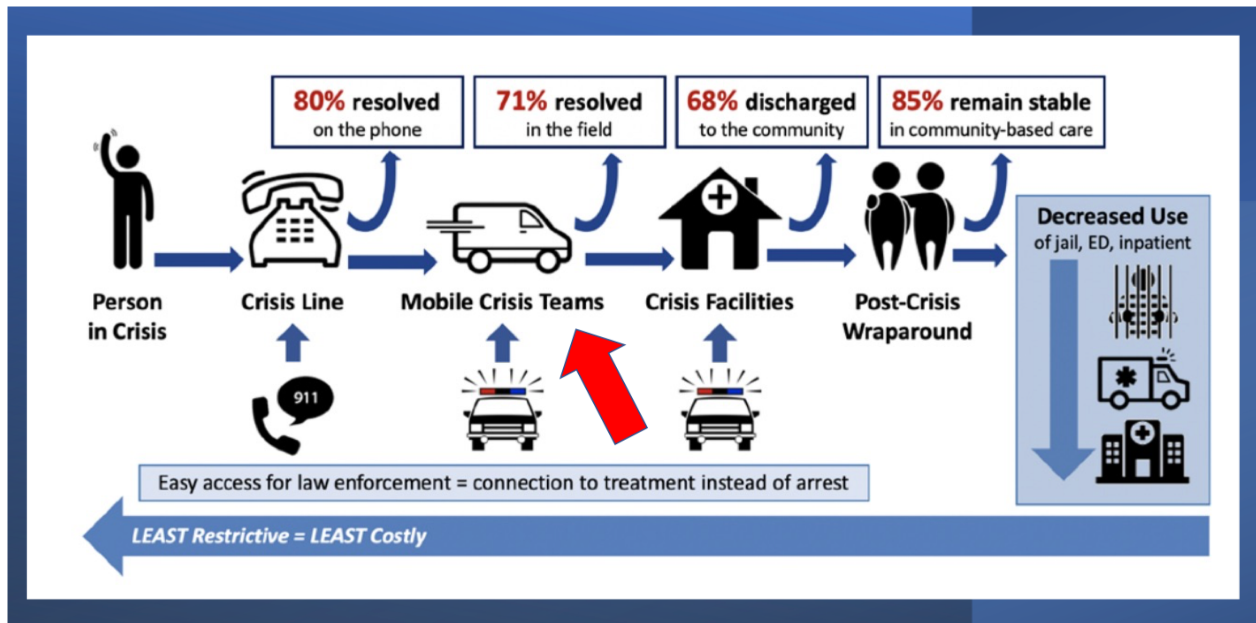
In the United States, the default response to a behavioral health crisis is frequently law enforcement. An increasing number of communities are implementing programs where unarmed behavioral health professionals respond either with police or instead of police and positive results are being seen. Care Response fits into this sector, as well as other forms of community response, both armed and unarmed. Unless noted otherwise in this document, both "Care Response" and "Mobile Crisis" will refer to *unarmed* behavioral response teams.

A place to go:

If crisis situations cannot be resolved in the community, the needs of the individual can frequently be met in a crisis facility with a stay of less than 24 hours. In the current system, such individuals are often transported to hospital emergency departments. Emergency departments vary greatly in their capacity to provide stabilizing behavioral health interventions which can lead to unnecessary hospital admission or discharges to the community without resolving the crisis.

When effectively implemented and integrated, comprehensive Care Response and mobile crisis services resolve many events in the community, decreasing the need for clinical services that are more intensive, more costly, and more disruptive to a person's life such as hospitalization (Figure 2)

FIGURE 2. OUTCOMES IN A COMPREHENSIVE AND INTEGRATED CRISIS CARE SYSTEM (Balfour, 2022)



The outcomes listed for each phase of crisis response in Figure 2 suggest that in aggregate, 90% of all community behavioral health crisis situations can be resolved in the community without transportation to a crisis facility or emergency department. These results reflect outcomes in a well-developed, well-funded and fully operational integrated crisis system, but results may vary among different geographic regions due to different operational aspects, even in those areas with mature crisis programs. Although the "resolved" percentage in each phase may vary somewhat by location, overall resource savings and reduced life disruption can be anticipated in any area where integrated and comprehensive services are implemented.

Despite the recommendations and growing evidence of the importance and effectiveness of a comprehensive and integrated crisis system, only 6% of all entities offering behavioral health crisis services in the United States meet all best practices recommended in the SAMSHA toolkit. The most common area of deficiency is in the mobile crisis response, which is offered less than 25% of the time (Burns, et al., 2023).

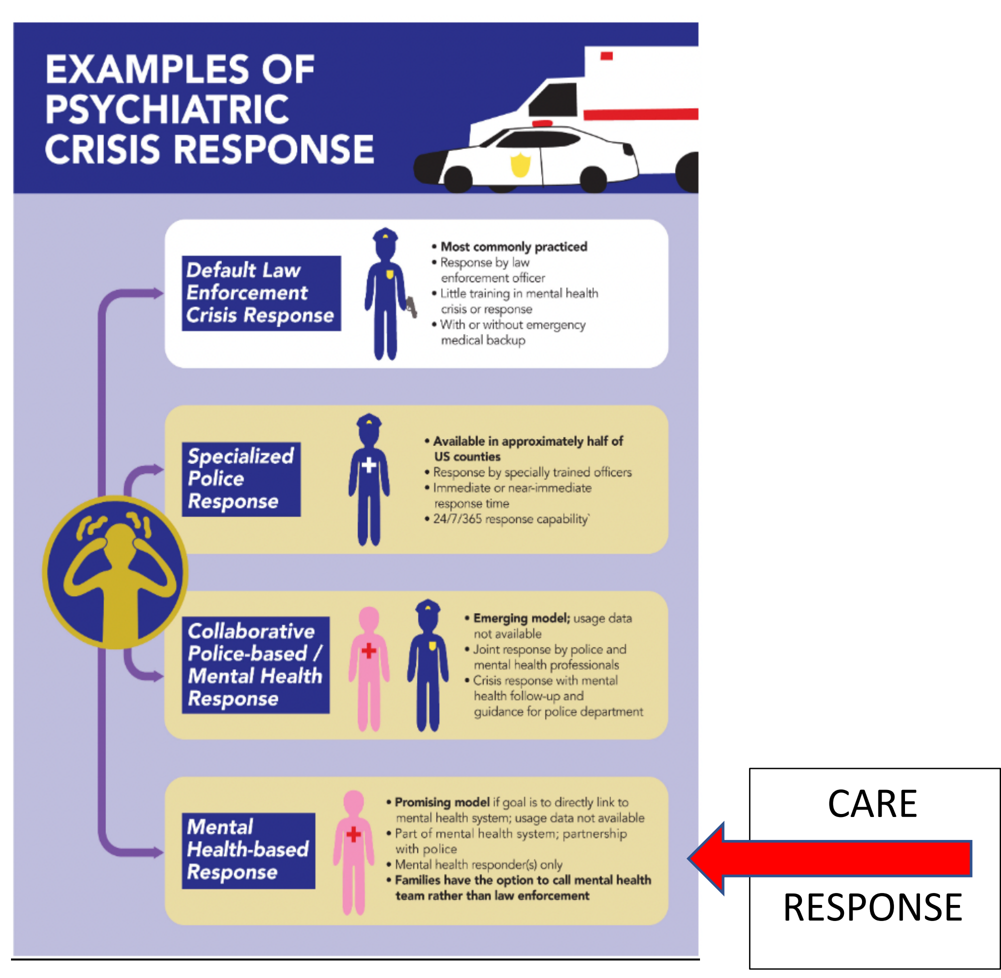
The components of a comprehensive system including "Someone to talk to," "Someone to respond," and "A place to go" all exist in Cuyahoga County and are under regular review to improve services and reach more individuals in need (Hussey et al., 2018). **The focus of this**

report is to make recommendations for "someone to respond," and serve an increased number of individuals experiencing lower-risk behavioral health crisis situations in the county. This form of response is not to supplant other response services that already exist, but rather to supplement and augment them. For best results, all components of the behavioral health crisis system, the law enforcement system, the medical care system, the social service system and the broader (non-crisis) behavioral health system must work in concert.

SOMEONE TO RESPOND—TYPES OF COMMUNITY BEHAVIORAL HEALTH CRISIS REPSONSE

Multiple types of community behavioral health crisis response exist (Figure 3) each of which has advantages and drawbacks in different circumstances. The availability of each type of response varies based upon a variety of factors such as availability of staff, funding for services and community receptivity to various forms of response.

FIGURE 3. EXISTING TYPES OF COMMUNITY PSYCHIATRIC CRISIS RESPONSE (Modified from Pinals, 2020)



All are important components of the crisis care system and highlight the need for cross-system collaboration. For example, if "someone to talk to" to is unable to resolve a crisis telephonically, they need to assure that the correct form of "someone to respond" is dispatched in any given situation. Further, there needs to be collaboration and cooperation among different responder types in the field to assure that the client's needs are best met by those responding and that the safety of the client, the responders and the community are maintained. Also, if a community responder determines that client's needs are best met in a facility ("a place to go"), there should be strong handoffs to assure continuity of care and the facility should be the one that best meets the needs of the client. Many communities have developed trainings and protocols to address these issues, although there is local variation due to the unique characteristics of each region.

Within Cuyahoga County, all four forms of community response listed in Figure 3 exist to varying degrees. The "Default Law Enforcement Crisis Response," dispatched by 911, has been the traditional first response and remains the only rapid response that is available twenty-four hours a day, seven days a week (24/7). "Specialized Police Response" is increasingly available and refers to officers who have Crisis Intervention Team training (CIT), which consists of both classroom instruction and field training with mental health professionals working in the community. Since 2020, 847 officers have been trained across the 75 police jurisdictions in Cuyahoga County, bringing the total number of officers trained in the county total to slightly over 2000 (Criminal Justice Coordinating Center of Excellence, communicated March 3, 2023). In 2022 there were nearly 5,000 CIT incidents in Cleveland alone (a slight increase from 2021), although not all were responded to by CIT officers (MHRAC, 2022; MHRAC, 2023). While CIT officers are frequently available and can be requested by callers or by non-CIT officers in the field, they are not always available 24/7.

In 2021, the City of Cleveland established a pilot program for "Collaborative Police-based/Mental Health Response" or "Co-Response" which is coordinated by the Cleveland Division of Police (CDP) and the Cleveland Department of Health. In this program, a CDP
CIT officer and a behavioral health professional are dispatched following a request from other officers who have already responded. Five teams were established initially, with another five to be added as a result of increased funding allocated from American Rescue Plan Act (ARPA) funds. Services have been well-received (Casanova, 2023). They are available 8AM-5PM Monday-Friday as of March 1, 2023. Other communities in Cuyahoga County have also implemented co-response teams or are investigating doing so.

Mental Health-Based Response ("mobile crisis") has existed in Cuyahoga County since 1996, with services rendered through Frontline Service. Behavioral health professionals respond to requests for community presence from callers to 988 and are currently dispatched only through this number. The 988 clinicians will contact 911 if behavioral-health only response is not appropriate or additional support is required. Services are designed to be available 24/7 with prompt response time, although response may be delayed due to staffing shortages (which are ubiquitous throughout the behavioral health system). Most responses for adults are to a hospital setting (54%), with the remainder to homes (32%), offices (12%), or community sites (2%). In

2022, there were 1472 mobile crisis contacts, which is down from a peak of 2259 in 2018. It is anticipated that the number of contacts will increase in subsequent years due the institution of the 988-crisis line and the waning influence of COVID. (Frontline data, communicated 3/9/2023). Even at its 2018 peak utilization, the number of in-community responses is significantly lower than the 24,000 contacts provided by the CAHOOTS (Crisis Assistance Helping Out On The Streets) Care Response program in Eugene, Oregon, a city of 175,000 (Beck et al. 2020), highlighting the magnitude of potential unmet need in Cuyahoga County.

A specific mobile crisis service for youth up to age 21 and their families is provided by Bellefaire JCB. This Mobile Response Stabilization Service (MRSS) provides crisis assessment and care in the community (e.g., home, school) with a goal of response within 60 minutes of initial contact. The MRSS staff may continue to follow with the patient/family for up to six weeks after the initial call. Services are not yet available 24/7, but plans are in place for this to occur.

Certified Community Behavioral Health Centers (CCBHCs) are required to provide a comprehensive range of services to enrolled clients, one of which is 24/7 mobile crisis response. As of April 1, 2023, there are fifteen CCBHCs in Ohio and two in Cuyahoga County, although they do not yet offer full 24/7 mobile crisis services. Ohio Medicaid has recently been awarded funding to expand CCBHCs in the state, which will provide expanded and prospective funding to them contingent upon them meeting all core functions, including mobile crisis. It is unclear whether they will need to provide these services directly or will be able to provide them through affiliation. This will merit following to determine how this will fit into the overall system of crisis response in the county and whether this programming will result in any added capacity to Cuyahoga County's crisis services continuum.

FUNDAMENTALS OF A CARE RESPONSE PROGRAM

All types of response to behavioral health crises are needed, but the experience of many communities and an evolving research base has demonstrated that Care Response is both effective and desirable. The pioneer of this approach is the CAHOOTS program in Eugene, Oregon. Established in 1994, CAHOOTS consists of a medic and a crisis worker responding to almost all behavioral health crisis calls in Eugene 24/7. In 2019, CAHOOTS was involved with approximately 24,000 calls with only 311 (1.3%) requiring law enforcement involvement (Beck et al., 2020).

Many other communities in the United States have implemented Care Response programs in recent years, including larger communities that are demographically similar to Cleveland and Cuyahoga County (Table 2). Although the specific responder types differ among communities, the basics of the program are consistent: an unarmed response to the site where the crisis is occurring that relies primarily on behavioral health expertise and is designed to only involve police when requested by Care Responders. Responders always include trained crisis workers who are either licensed behavioral health professionals or supervised by licensed providers, and frequently include peer support specialists. Others involved may include community health

workers, emergency medical technicians, nurses, paramedics, and others depending on the goals of the program and preferences of the community.

TABLE 2. EXAMPLES OF COMMUNITIES WITH EXISITING OR DEVELOPING CARE RESPONSE PROGRAMS	
Eugene, OR	Cincinnati, OH
Baltimore, MD	New Orleans, LA
San Francisco, CA	Columbus, OH
Seattle, WA	Dallas, TX
Denver, CO	Sacramento, CA
Portland, OR	Harris Co, TX
Olympia, WA	Dayton, OH
Phoenix, AZ	Chicago, IL
Salt Lake City, UT	Nashville, TN
Charlotte, NC	Albuquerque, NM
St. Petersburg, FL	New Haven, CT
San Diego, CA	Durham, NC
Minneapolis, MN	Detroit, MI

Many of the fundamentals of a Care Response Program encompass the fundamentals of good care rendered anywhere in the behavioral health system—caring and well-trained clinicians providing up-to-date and evidence-based services to those in need. The care should be timely, coordinated with other care that the person might be receiving and tailored to their specific symptoms, life circumstance, historical background, and culture. However, as with all care, there are other factors that must be included to best meet the needs of the person receiving services and be accepted in the community. Essential functions that are specifically expected for mobile crisis teams are found in Table 3

TABLE 3. ESSENTIAL FUNCTIONS OF MOBILE CRISIS TEAMS (SAMHSA, 2020)	
Triage and Screening	• Assesses risk of person in crisis and appropriate level of response
Assessment	• Suicide risk • Strengths and resources • Precipitating factors • Present connections with mental health resources
De-escalation and Support	• Engage to de-escalate crisis • Attempt to avoid higher level of care, if possible and safe

Peer Support	• Promote engagement
	  ○ Person in crisis
	  ○ Family and support persons
	• Promote care after crisis resolved

Coordination with Medical and Behavioral Health Services	• Connect to resolve crisis and prevent future crises
Crisis Planning and Follow-up	• Create crisis plan • Create safety plan • Conduct follow-up visits to assure linkage occurs

In consideration of the increasing demand for mobile crisis services, The Centers for Medicare and Medicaid Services (CMS) have established criteria for programs to receive enhanced reimbursement in states which apply for and receive such funding (Ohio has not applied—this is separate from the CCBHC funding mentioned previously) (CMS, 2021). These are not required to operate a Care Response team, but they do point to future direction of funding and standards of care linked to certain funding streams.

Specifically, these criteria indicate that programs should be mindful to include underserved communities of color and should integrate services with all other community crisis care components. They must meet the needs of a diverse population, including those with language barriers, those who are deaf or hard-of-hearing and those with disabilities. Services must be provided by a multi-disciplinary team with at least one person licensed to diagnose (CMS, 2021).

Basic service requirements from CMS are as follows:

- Help individuals experiencing a crisis event experience relief quickly and resolve the situation when possible
- Meet the person in crisis where the crisis is occurring, or where they are comfortable

- Provide care and support while avoiding unnecessary law enforcement involvement, emergency department use and hospitalization
- Connect individuals with facility-based care when needed, with warm handoffs and coordination of transportation
- 24/7 availability
- Rapid response

The more specific criteria for service provision are robust and emphasize the need for services to be comprehensive to best meet the needs of diverse individuals and achieve the desired outcomes for both the individual and the community. Requirements may be found in Table 4.

TABLE 4. SERVICE REQUIREMENTS FOR ENHANCED MOBILE CRISIS REIMBURSEMENT (CMS, 2021)	

Required:
• Screening and assessment
• Stabilization and de-escalation
• Coordination with and referral to:
  ○ Health services
  ○ Social services
  ○ Supports
  ○ Behavioral health services
(In real-time, when possible)
	Desired characteristics:
	• Safety planning
	• Medication availability (RN, APN, MD/DO)
	• Naloxone availability
	• Harm reduction supplies
	• Telehealth to bridge services
	• Warm hand-offs
	• Defined relationships with other partners

While it may be difficult to meet all these criteria at the launch of Care Response services in Cuyahoga County, using them as a benchmark for progress over the several years following implementation should be considered to assure that the services are the most impactful to the largest number of individuals and are eligible to receive maximum reimbursement.

OUTCOMES IN MOBILE CRISIS RESPONSE

Although mobile crisis teams (MCTs) have existed in the United States and elsewhere for several decades, rigorous scientific outcome research is limited. There are multiple reasons for this. First, inconsistencies in funding have meant that programs are sometimes unable to sustain continuous service over the long-term, and the resulting variability in program content and hours makes them poor subjects for outcome research. Further, it is only in recent years that standards for MCTs have become more generally agreed-upon, leading to variability across MCTs and difficulty in generalizing outcomes reported by individual sites. Additionally, most mobile crisis programs in the United States have been launched in the past several years and are only now maturing to the point where significant scientifically driven research can be done.
Despite this, many programs have been collecting data to assess outcomes and aid in program planning and modification. Studies of community behavioral health outcomes are often done

naturalistically (based on the “natural” setting and circumstances where treatment occurs) rather than in a scientifically controlled process. These reports have found that mobile crisis is associated with public benefit (such as reduced hospitalization, reduced likelihood of traumatic events or re-traumatization, and cost savings), and programs are generally well-received, accessed and trusted in communities where they are implemented.

In an early evaluation of MCT effects on hospitalization, Scott (2000) found a 37% reduction in hospitalization among those receiving MCT services compared to usual police intervention. Similarly, in a study conducted in Cuyahoga County, Guo et al. (2001) found a 33% reduction in hospitalizations for those receiving MCT vs. hospital emergency room crisis services. This same group (Dyches, et. al, 2002) found that those receiving MCT services were also 20% more likely to access community mental health services than those receiving hospital-based crisis services, though the utilization rate was still low at 45%. This rate was affirmed in another more recent study, also utilizing the Cuyahoga County population (Kim and Kim, 2017) where 44% followed up within 30 days post MCT intervention. MCTs have also been an effective tool to enhance linkage to outpatient treatment following presentation to an emergency department with suicidal ideation, with individuals linked to MCTs more than twice as likely to link compared to standard referral approaches (Currier, et al., 2009).

Denver implemented a Care Response MCT program (STAR—Support Team Assistance Response) in 2020. Based on the CAHOOTS model, the program was implemented in downtown Denver in an area that is rapidly becoming gentrified, leading to the displacement of residents who are poor, disaffected, and frequently are experiencing symptoms of mental illness and/or drug use disorders. Although at the time of the study, the program was small in scope (10AM-6PM Monday-Friday) and targeted to a very specific setting, pilot-phase research indicated a decrease of 1376 criminal offenses (34%) compared to the six months prior to program initiation. The reduction in crime also was noted during the hours that the STAR team was not available. The authors attribute this to proactive intervention by the STAR team in identifying and assisting individuals who they determined might need services and were not in crisis during the time that they patrol the area. (Dee and Pyne, 2022).

Programs also report overall system financial savings with mobile crisis implementation. Scott (2000) found that costs for an MCT intervention were 23% lower than traditional police intervention. CAHOOTS, with a budget of approximately $2 million, is estimated to save $14 million in ambulance and emergency room costs and an additional $8.5 million in public safety costs (White Bird Clinic, 2020). Other studies have found substantial cost savings for an entire integrated crisis response system which includes MCT, although they are unable to specifically carve-out the impact of only the MCT /Care Response component. For instance, Maricopa County (AZ) found that a $100M investment in the crisis system created potential reduction of $260M in inpatient costs (Pinals, 2020) and Minneapolis/St. Paul found a return of $2.16 for every dollar invested in crisis services (Leite-Bennett and Diaz, 2013).

A crisis resource need calculator has been developed to assist communities in understanding potential costs associated with delivering care to individuals requiring in-person crisis care in

various scenarios (Appendix 1). Using the Crisis Now Basic Crisis Care Calculator, in a scenario where Cuyahoga County enhances existing services to include a robust community Care Response program and complementary services, it estimates that investments of $40.3M in crisis care a (including $3.7M in Care Response) would result in overall system cost savings of $81M, almost entirely due to a reduction in inpatient utilization ($104M reduction) and emergency department costs ($18M reduction). Another crisis care calculator predicts even greater overall cost savings.

This is somewhat deceiving, as many of the crisis care components recommended in these calculators already exist in Cuyahoga County. Although substantial net cost savings are likely, they should not be expected to be of the magnitude suggested by the calculator. Additionally, the cost savings projected are not likely to return to the probable funders of Care Response. The reduced costs instead would be to the advantage of 3rd party payers and hospital systems. Accordingly, engaging those entities which are likely to reap most financial benefit from Care Response and comprehensive crisis services should be considered.

COMMUNITY ACCEPTANCE OF MOBILE CRISIS

Outcome studies have found a high level of satisfaction in communities served by mobile crisis. Scott (2000) found the consumers of services provided an average rating of 27.4 out of 32 on the Consumer Satisfaction Questionnaire with families reporting similar satisfaction (27.7/32). Among police in the area served (Dekalb County, GA), 75% of officers reported being very satisfied or mostly satisfied with MCT services, with 19% neutral and only 6% mostly or very dissatisfied.

Other sites have also found high levels of law enforcement satisfaction. A survey of police officers in Austin, TX, found 85% felt collaboration with MCTs was helpful to the department and 89% as beneficial to the community. However, such praise is not universal, as in Knoxville, TN, with only 7% of officers felt that MCTs were effective in decreasing police time spent on behavioral health crisis calls, although the majority felt that MCTs were of overall benefit to the community and effective in responding to people with mental health conditions. This discrepancy highlights variability in program characteristics, and points to the importance of dialogue between crisis providers and law enforcement on a continuing basis (Center for Police Research and Policy, 2020).

Local community surveys done both as part of this project and previously indicate that many community members are optimistic about the potential of Care Response, though cautiously so. Responses were often predicated on experiences with first responders, some of which were favorable and others which were clearly not. Common themes included a hesitancy of historically marginalized individuals to reach out to law enforcement for assistance due to fear of harassment or violence (and with that a desire to reduce law enforcement involvement in issues and incidents not related to public safety), a distrust of medical and certain other professionals, and a frustration with not being well-informed about existing behavioral health services and

programs. There was a consistent theme of a need for ongoing community input into the planning, implementation, and evaluation of the existing crisis systems, and importantly, continued input into future programming, including Care Response. However, generally those surveyed felt favorably about a trained, specialized, professional, and culturally competent team responding to behavioral health crises.

CHALLENGES OF MOBILE CRISIS TEAMS

Community surveys and research generally indicate the desirability of Care Response/MCTs, but consumers, service providers, and law enforcement also express concerns about existing mobile crisis teams and their ability to add capacity to first response programming. Concerns about MCTs include:

- Lengthy response times
- Lack of 24/7 availability
- Lack of community knowledge of crisis services, including how to access service
- Communication among crisis providers, emergency departments, law enforcement
- Reticence of some community members to access services due to:
    - Prior experiences with police-centric behavioral health crisis response
    - Prior experiences in behavioral health system
- Safety of MCT providers

These concerns demonstrate challenges with both current services and future expansion of services, highlighting the need for better communication and trust-building with the community and effective collaboration among community members, crisis care providers, police, and others. Some of these issues were identified in the 2018 report on Cuyahoga County Crisis Services by the Begun Center (Hussey et al., 2018), though they are common and identified elsewhere (Bailey et al., 2018)

SUMMARY OF RESEARCH

Care Response teams are increasingly present in communities around the United States. These teams provide expert and timely behavioral health services in the community setting and contribute to safe resolution of crises that could otherwise lead to unnecessary hospitalizations, emergency department visits, incarcerations, injuries and even death. They are associated with high levels of client satisfaction, community benefit, and a reduction in overall healthcare costs. **Accordingly, we recommend that Cuyahoga County establish a robust Care Response program as a component of an overall integrated crisis response system and to do so in collaboration with individuals receiving and individuals providing behavioral health services, public safety, and the community to make crisis response safer, non-traumatizing, and effective in meeting the needs of diverse individuals and the community as a whole.**

RECOMMENDATIONS FOR CARE RESPONSE IMPLEMENTATION

Based upon existing research and experience of communities across the nation, we recommend that Cuyahoga County implement a community-based, unarmed Care Response program that will be rapidly available and staffed by behavioral health professionals and peers.

The Care Response program should be designed to meet the needs of individuals experiencing crises at the site of the crisis or another location where they feel comfortable and should augment existing services, such as the current mobile crisis team, co-response programs, and CIT response. Implementation should occur in partnership with the community served, including recipients of services and their families. It is hoped that such services will eventually be available county-wide and at all hours.

These recommendations are based upon review of current literature on mobile crisis response, interviews with experts in the field and local stakeholders, and focus groups with community members. It is recognized that these recommendations propose a "best case" scenario for implementation. These recommendations may need to be revised, implemented in stages, partially implemented, or not implemented based on fiscal realities, resources available, and community preferences.

Recommendation #1: Care Response services should commence with a pilot program in one or more geographic regions of the county, with plan to expand based upon the learnings of the pilot program.

- The pilot program provides an opportunity to implement on a small scale and receive input to identify and resolve weaknesses before broad implementation. This could be done utilizing the "Plan-Do-Study-Act" (PDSA) process improvement cycle which is demonstrated to improve the efficiency and outcomes of new processes (IHI/AHRQ, 2009; Appendix 2). This approach allows the program to adapt and innovate promptly based upon qualitative and quantitative data (including community feedback) during the pilot period, leading to a model that should be more easily implemented elsewhere in the county when expansion occurs. This also speaks of the importance of data acquisition, analysis, and transparency, and continued community surveying during the pilot project and beyond.

- We recommend that a similar PDSA process occur in each region as Care Response expands, as each area has its own unique qualities that must be considered. Engaging each community in this process also increases likelihood that the added programs best meet the needs of each particular area.

Recommendation #2: Entity or entities implementing care response should be selected through a competitive process by responding to a Request for Proposal (RFP) to find the vendor(s) with the greatest likelihood of success in addressing the complexities of Care Response.

- The applicant pool could be quite diverse. Behavioral health agencies or organizations, municipalities, and hospital systems are a few of the potential applicant types, all of which bring important, but different, expertise to this process. Applicants from consortiums of groups should also be considered, as collaboration among multiple partners is essential for success. Important characteristics to consider for applicants may be found in Table 5.

TABLE 5. IMPORTANT CONSIDERATIONS FOR CARE RESPONSE RFP APPLICANTS
• Experience • History of service to marginalized communities • History of community collaboration • Regard in community among general public and recipients of services • History of implementing promising practices and innovative programs • Demonstrated commitment to trauma-informed, culturally affirming and linguistically competent services • Demonstrated ability to establish strong working relationships with community partners • Ability to receive reimbursement for services

Recommendation #3: The specific pilot region(s) may either be determined in advance by the funder or may be proposed by the applicants themselves.

- The area(s) for the pilot should be areas of high need, either as determined by behavioral health call volume OR disproportionately low volume in view of population demographics. The demographics of the pilot area should encompass a significant number of individuals who are underserved in the behavioral health system by virtue of race, ethnicity, socioeconomic status, and sexual orientation.

- Racial disparities in psychiatric care in the United States are well-documented and include reduced access to psychotropic medication, fewer outpatient appointments and increased likelihood of involuntary treatments (Fiscella et al., 2017; Cook et al., 2017; Smith et al., 2022). Black adults are also more likely to receive behavioral health treatment through an emergency department, which is likely a reflection of insufficient and inequitable access to routine and expected treatments (Peters et al., 2023). Reticence to request crisis response described by Cleveland residents who fear the response they receive may be violent, demeaning, or impersonal may also be a

component (Schleiffer and van Lier, 2022). Accordingly, partnering with underserved communities in a Care Response pilot is likely to fill a gap that can improve linkage to non-emergent care, to decrease costly and unnecessary emergency department visits and prevent coercive interventions.

- Other factors to consider in selection of a pilot area or areas include community interest and support of the pilot project, and support of other partners (agencies, law enforcement, residential crisis facilities, hospitals, and dispatch services). It would be highly desirable for the pilot area to have an uncomplicated dispatch landscape (911) to facilitate integration of 911, 988 and Care Response.

- A summary of suggested characteristics of a pilot region may be found in Table 6.

TABLE 6. SUGGESTED CHARACTERISTICS OF CARE RESPONSE PILOT AREA

• Demographics reflect significant population of underserved individuals by virtue of:
  ○ Race
  ○ Ethnicity
  ○ Socioeconomic status
  ○ Sexual orientation
• Area of high need
  ○ High volume of calls relating to MH/SUD issues
  OR
  ○ Disproportionately low calls and service utilization in view of demographics
• Area with more adverse outcomes in interactions between served individuals and current responders
• Interest and support of proposed pilot community
• Support of partner agencies:
  ○ Behavioral health agencies
  ○ Behavioral health crisis facilities
  ○ Hospitals
  ○ Law enforcement
  ○ Dispatch services
  ○ Other community behavioral health crisis responders, if present (e.g., co-response programs)
  ○ Social service agencies
• Uncomplicated dispatch landscape (single 911)
• Sufficient population size to generate meaningful number of encounters to assess program effectiveness and inform future expansion

Recommendation #4: The model of Care Response implemented in the pilot region(s) should meet the basic criteria for mobile crisis defined in Table 3.

- There are multiple models of Care Response services implemented in communities in the United States. The two most common are a behavioral health-only response, usually consisting of a licensed behavioral health provider and a peer support specialist, or a behavioral health/medical response, usually consisting of a licensed behavioral health provider and a medical professional such an emergency medical technician (EMT) or a nurse. Each has its own unique advantages.

- There is currently no consensus and no persuasive research that suggests the superiority either model. However, Care Response programs implemented elsewhere, including in Ohio, have trended toward a behavioral health-only response, and costs of implementation of this model are likely to be lower than the behavioral health/medical response. Additionally, it is desirable to have a single model implemented throughout the county to provide continuity in the crisis response network, promote shared data and learnings, and facilitate collaboration both within and across jurisdictions. For these reasons, Cuyahoga County should strongly consider focusing on the behavioral health-only model.

- Regardless of model chosen, community responders should have ready access to supervisory support from a licensed independent behavioral health practitioner and have other consultation available from individuals with licensure and expertise in specialty areas such as:

    - Person-centered assessment and planning
    - Geriatrics
    - Intellectual and developmental disabilities
    - Trauma
    - Child and adolescent
    - LGBTQ issues
    - Cultural issues
    - Immigrant populations
    - Psychotropic medications and medications for opioid use disorder (MOUD)
    - Forensic issues
    - Medical clearance

- Many behavioral health crisis situations are either caused by or exacerbated by situational stressors. Addressing these stressors alone can often resolve the crisis and avoid further interventions that place the person in crisis in a “patient role” and can lead to a hospitalization that is not needed and fails to resolve the root of the crisis situation (Drake and Bond, 2021). In any model chosen, the Care Responders should have the resources to assist individuals and resolve crisis-precipitating events, such as need for

shelter, food, and medical care. Availability of such interventions was highly valued by individuals recently surveyed in Cleveland (Table 7) (Schleiffer and van Lier, 2022).

TABLE 7. SERVICES AND SUPPORTS FROM CARE REPSONSE SUGGESTED BY COMMUNITY MEMBERS (SCHLEIFFER AND VAN LIER, 2022)
• Access to medical care • Access to homelessness resources • Food, with diabetic-friendly options • Water • Transportation • Blankets • Hygiene supplies • First-aid supplies. • Narcan, Naloxone, test strips for drugs, etc.

Recommendation #5: The pilot period should consist of six months of "lead-in" following award to complete necessary preparatory work, followed by 12 months of actual service provision.

- Prior to implementation of services, a great deal of work will need to be completed including:
    - Engaging and enhancing relationships with the community in the selected pilot region(s) to build trust and establish a collaborative working relationship
    - Hiring of staff
    - Preparing staff for service provision:
        - Training in delivery of Care Response services
        - Establishing and verifying competencies
        - Developing process of triage, assessment, and documentation of services
    - Clarifying relationships, responsibilities, and protocols with other partners in the crisis continuum:
        - Dispatch
        - Law enforcement
        - Emergency medical services (If not part of the Care Response team)
        - Crisis facilities
        - Behavioral health agencies and hospitals (including emergency departments and inpatient facilities)
        - Other mobile crisis teams (MRSS and potentially CCBHCs)
    - Enhancement of data collection and a process and schedule for reporting and interpreting data.

Recommendation #6: The community of the pilot region(s) should be engaged as a partner in the development, implementation, and assessment of the pilot.

- The Cuyahoga County Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) Board has existing relationships with community groups to advise on the implementation of behavioral health programs and policies. Community surveying through RSG and by community partners including the Center for Community Solutions, Policy Matters Ohio and REACH all confirm the community's expectation that they have a significant role in the design, implementation and assessment of Care Response services.

- We recommend that an advisory group be formed specifically for the Care Response pilot and that the pilot community be strongly represented in such a group. This is an essential feature of trauma-informed services and is especially important since many individuals in a behavioral health crisis and the communities where they reside have experienced trauma, sometimes because of a crisis response itself. This group would serve as the "eyes and ears" of the community in the region of service provision, helping to identify community reaction to the service and ideally, serving as ambassador to the pilot community or communities. They should have access to program data and their input solicited and incorporated into program development and modifications. It is suggested that members be offered financial compensation for their insights and time commitment to this initiative.

Recommendation #7: Staffing of the Care Response team should reflect the characteristics of the community served to the greatest extent possible.

- Numerous studies indicate that people prefer to receive services from providers who are reflective of their community (Ma, et al., 2019) and that such providers are more readily trusted and achieve better outcomes. Accordingly, RFP respondents and the eventual awardee of the grant should recruit service providers from the pilot area or similar areas of the county inclusive of licensed or certified staff, peer supporters and other community partners who may have ability to provide Care Response services. This process will need repeating as the program expands beyond the pilot region(s), as each area will have its own unique composition.

- Developing and maintaining an adequate workforce is a chronic issue in behavioral health, and Care Response is likely to face the same issues. Workforce development is likely to be a persistent issue and could compromise the ability to offer the desired state of 24/7 services in the near term. On a positive note, if staffing issues lead to less than the desired "round-the-clock" services, this provides an opportunity for more intense analysis and program refinement before broader implementation, even in the pilot region. Based upon local preferences and staff availability, consideration could also be given to providing telehealth assistance during the hours when the program is not able to provide on-site services.

- Ideally, care response will not only be a service provided in the pilot area but will be a program where people known to the residents are responding (enhancing trust), where the program presents employment opportunities for some community members, and where the community experiences genuine partnership with those providing services.

- Further recommendations for workforce development may be found in Appendix 3.

Recommendation #8: Staff safety and wellness must be a priority.

- Concerns have been raised about the safety of behavioral health practitioners responding to community crisis calls without police involvement. MCTs around the country have found that police involvement is needed very infrequently. In the CAHOOTS program, police back-up was requested in less than 2% of all team interactions (Shapiro, 2020). In Cleveland, only 4% of all CIT incidents involved a weapon in each of the past two years (MHRAC 2022, MHRAC 2023). Based upon the success in other communities, establishing protocols to assist dispatch in sending the right type of response to a situation will be essential, designating Care Response as the first responder in most behavioral health crises, and utilizing police only if necessary or specifically requested. This should be continuously monitored during the pilot and protocols modified based on experiences of staff, individuals and families served, and law enforcement.

- Staff wellness and avoiding "burnout" is also essential. The Care Responders should have supervisors available to assist with difficult situations in the community, and regular mentorship sessions to deal with work-related stress and facilitate professional development. Resiliency training, adequate compensation, reasonable hours, and paid time off also help to address self-care needs and enhance retention of staff in high stress fields such as this. Formal interventions that are person-centered and trauma-informed such as employee assistance programs (EAP) and behavioral healthcare should be available and easily accessed, if needed.

Recommendation #9: A training curriculum should be developed from currently available resources, with adaption to meet Cuyahoga County and pilot area needs. Modifications and additions should be based upon input of local experts, inclusive of pilot-area residents, consumers of services, and family members. Consideration should be given to obtaining technical assistance to facilitate this process.

- Many communities have developed training curricula for MCTs and have indicated a willingness to share materials. The existing Cuyahoga County MCT also has training materials and experience in this area. As a result, it should be unnecessary to develop a curriculum *de novo.* The plan should provide for both initial and continuing training of staff and should extend to all Care Response providers and 911/988 staff who dispatch Care Response staff to crisis situations. The training plan should address the local

healthcare system, local and neighborhood culture, and state and local processes, policies, regulations, and laws. Additional trainings requested by local community members include understanding special populations, de-escalation, active listening, and trainings that combat internal bias (Appendix 4) (Schleiffer and van Lier, 2022).

- Examples of available resources for development of service competencies and clinical best practices for MCTs have been developed by the Greater Baltimore Region Integrated Crisis System (GBRICS, 2023), the Group for Advancement of Psychiatry (2021), and Ghelani (2022), among others. GIBRICS service competencies and practice guidelines may be found in Appendices 5 and 6. Moreover, the greater Baltimore area and Cuyahoga County have similar histories, demographics and community needs and may present a tremendous opportunity for peer-to-peer learning that could benefit both communities.

- Additionally, during local community research those surveyed indicated desire for a community education campaign that provides information and resources on the benefits of a Care Response program. The campaign should utilize a variety of media tools, such as social media, print materials, and community events, to reach as many people as possible. This campaign should be designed to engage community members in meaningful dialogue on behavioral health issues and crisis response and focus on trust building. Consideration should also be given to training of pilot community members in Mental Health First Aid so they can better assist fellow-community members who may be experiencing difficulties before the Care Response team arrives.

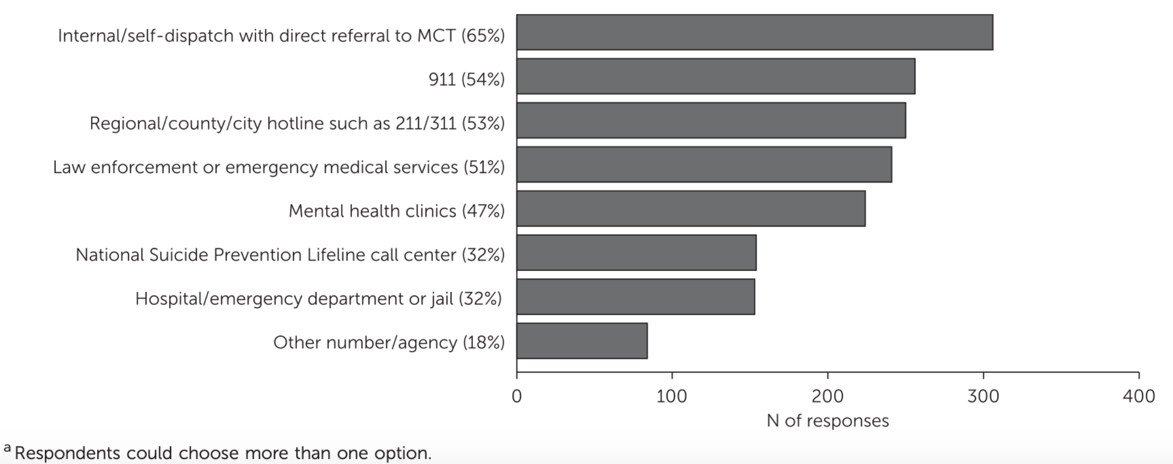
Recommendation #10: Staff will utilize standardized tools for assessment and assistance in determining disposition of clients.

- Consistency in practice advised by the best available knowledge is essential for best outcomes. One component is utilizing standardized tools for assessment, which also helps assure that all important areas are addressed in meeting the unique needs of the client. Additionally, a tool to assist with client placement helps to provide consistency in this area which is helpful for the client, Care Response staff, and any facility where the client may receive subsequent care. The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) is an example of such a placement tool (AACP, 2010). Clinicians may use such tools to establish a framework and provide general guidance, but still need to apply clinical judgement and decision-making to assure that client needs are met.

Recommendation #11: Interface with 911 and 988, dispatch criteria and responsibilities of respective partners should be defined prior to implementation of services.

- Recent literature has identified the patchwork of methods to access mobile crisis nationally, highlighting that such a fragmented system is likely to be confusing for individuals attempting to access MCTs (Odes et al., 2023; Figure 4).

FIGURE 4. PHONE NUMBER OR AGENCY THAT COMMUNITY MEMBERS COULD CALL TO DEPLOY A MOBILE CRISIS TEAM (MCT) IN RESPONDENT'S PROGRAMS (N=5474) (ODES ET AL., 2023)



[a] Respondents could choose more than one option.

- To address this issue, it is essential that responsibilities be delineated between all those receiving emergency behavioral health calls. This will involve significant dialogue among those groups, the Care Response leadership, the Care Response providers, law enforcement and the community. It would be advantageous for the pilot area(s) to have an uncomplicated 911 system so the process would be more straightforward and encourage effective communication involving 911 and 988 to assure that first responders dispatched are the ones best suited to meet the need of the person in crisis. A "no wrong number" approach would be ideal, so the person requesting assistance does not need to know the "right" number to call to receive help and is not shuttled between different numbers.

- Other areas (Cincinnati, specifically) have had success in building an effective and integrated system. Consideration may be given to procuring technical assistance specifically for this purpose, with this project funded separately from the core Care Response RFP. Frequent dialogue and data analysis of dispatch should continue throughout the pilot program and beyond, utilizing its own PDSA process.

Recommendation #12: Discussion should be held, and clarity provided about appropriate disposition of clients who require facility-based crisis care.

- The most recent MHRAC report (MHRAC 2023, covering calendar year 2022) lists sixteen (16) different facility destinations following CIT incidents, with emergency departments being the most common. Community partners should discuss the most appropriate disposition for clients served by Care Response, which should be client specific. Decisions should be based upon individual clinical factors and best service to the client. Following implementation, data-informed communication should continue regularly to assure that collaborative interaction continues, misunderstandings are dealt with and resolved, established referral criteria meet client needs and services provided by existing crisis facilities achieve desired outcomes. If data reveals otherwise, partners should collaborate on revision.

Recommendation #13: The Care Response pilot should be data-driven. Process measures, means of collecting data, entities responsible for data collection and interpretation, and reporting process should be determined prior to implementation of services and with the active involvement of community advisory members. An outside vendor may be considered for data expertise, management, and reporting.

- Innovations that result in better user experiences, better outcomes, and more efficient use of resources have high potential for overall impact (Johnson et al., 2022). The acquisition of meaningful data and transparency of the data is essential to determine program success, identify and monitor areas for improvement, and promote accountability and public trust. It is frequently helpful to have an outside entity carry responsibility for the data to demonstrate objectivity. This is not common among MCTs in the US, as much of the data is self-obtained and self-reported by programs. If fiscally possible, utilizing an outside vendor demonstrates objectivity which is generally well-received by the public and potential funders.

Recommendation #14: A data dashboard which is available to anyone should be created and posted online.

- A publicly available Care Response data dashboard creates transparency. Additionally, individuals who may not otherwise have had ready access to the data can review it and make suggestions for programmatic approaches. Such dashboards have been developed in multiple communities, including Cincinnati and Durham, NC. NOTE: protected and identifiable healthcare information cannot be shared outside of those who are rendering care who need to know the information.

Recommendation #15: Quality measures should be selected to determine compliance in executing the pilot.

- Regular reviews of the program help determine if the plan of service is being followed, and all components are implemented. It is not expected that a pilot will meet all national standards when services are launched, but assessing fidelity of the program compared to national standards helps guide program development to move toward the ideal state. Fidelity standards have been developed for overall crisis system structure (Group for Advancement for Psychiatry, 2021) with sub-components for mobile crisis. A crisis response team-specific fidelity scale has also been developed (Lloyd-Evans et al., 2016) (Appendix 7).

- Measures of success/quality measures should be considered prior to implementation. To avoid an overwhelming amount of data, a minimum data set should be considered with the determining factor being "what do we need to know?" instead of "what would we like to know?" Data sets should consist of both quantitative and qualitative information. Measures of success as defined by the community should be included.

- Satisfaction data are essential and should be considered from numerous sources:

  - Clients receiving services
  - Families of clients
  - Members of the pilot community
  - Staff rendering services
  - Law enforcement
  - Crisis facilities/hospitals
  - Behavioral health agencies

- Community surveying should continue throughout the pilot and into program expansion beyond the pilot.
- Many other potential quality measures could be considered Table 8).

TABLE 8. EXAMPLE QUALITY MEASURES FOR MOBILE CRISIS TEAMS (Adapted from Group for Advancement for Psychiatry, 2021)
• Percent of crisis customers who have welcoming, hopeful customer experience • Percent of crisis calls that are resolved without police involvement • Percent of mobile crisis team encounters resolved in the field • Percent of individuals discharged safely to non-hospital settings • Percent of individuals who receive crisis follow-up within 48 hours of initial contact • Percent of families engaged collaboratively in the crisis intervention process • Percent of crisis encounters resolved successfully within two hours

Recommendation #16: Care Response programs should seek multiple funding streams to support the pilot project and promote long-term fiscal viability.

- The funding landscape for crisis services in general is evolving rapidly and is likely to change in upcoming years. Experts in the field recommend "braiding" funding to diversify revenue stream (Pinals, 2020). Monitoring for newly available funding streams is encouraged to assure that opportunities are not missed (van Lier, 2022).

- Billing for services provided is one funding stream. Currently, many crisis services, including mobile crisis, can be billed to third party payers such as Medicaid. Unfortunately, this alone is not sufficient to support the desired state of 24/7 service access, and not all client needs will fit into a traditional insurance-covered paradigm.

- Additionally, many individuals needing service do not have healthcare coverage, some plans do not cover crisis care in any meaningful way, and most payers only reimburse for time spent in the provision of service. Although reimbursement for clinical care is not adequate to support all Care Response services as currently configured, it is an important source of revenue and respondents to the RFP should be able to bill for services to supplement any other funding.

- CMS has made a funding opportunity available that will enhance funding and more completely support 24/7 mobile crisis availability beyond direct billing for services (CMS, 2021). There are specific criteria for services to receive this form of payment (Table 4) and the state must apply to participate in this program for qualifying providers and regions to receive it. This has not yet occurred in Ohio. Ideally, Care Response programs would be designed to meet the qualifying criteria upon launch, but this is not likely to occur for the reasons listed earlier. It is recommended that the awarded provider(s) and the funders stay abreast of this opportunity and set a goal to qualify for this funding, assuming it becomes available.

- At this point, the main source of funding is likely to be governmental, including local Health and Human Services levy funds, designated components of federal mental health block grant, state general revenue allocation, and "one time" funds. Other sources may merit pursuit. Specifically, models indicate that the cost savings of mobile crisis and an integrated crisis response system occur because of decreased emergency room visits and decreased hospitalizations (SAMHSA, 2020; Appendix 1). The beneficiaries of this are hospital systems in the first case and third-party payers in the second. Accordingly, seeking financial investment from each of these sources may be considered. Finally, philanthropic organizations have supported research into Care Response and crisis service expansion in Cuyahoga County and elsewhere in Ohio. Pursuing their interest in continuing involvement is suggested.

Recommendation #17: Respondents to the RFP should prepare a budget that will meet promising practice standards established by SAMHSA and includes a plan for billing for services as one source of revenue beyond grant funding.

- The prepared budget should address the foundational ethics of Care Response including a significant role for peers, competitive wages and benefits for all staff and sufficient training and supervision to assure competency in providing services.

- As a pilot program, it will be important to understand to what degree billings and collections from third party payers can offset grant funding to inform planning for further expansion in the county.

Recommendation #18: The funder(s) should consider budgeting as much as $1.65 M for an 18-month pilot program.

- Budget assumptions were made in determining potential overall pilot program costs. The recommendation for this pilot is a six-month lead-in followed by a 12-month service implementation period. Goals for the six-month lead in:

    - Develop and implement a training program
    - Develop or enhance a data management system
    - Hire staff
    - Address 911/988 interface
    - Procure equipment and necessary materials

- Two different budget scenarios were developed, each case utilizing a behavioral health-only Care Response model.

    - In scenario 1 (Appendix 8) the team provides services ten (10) hours daily, 7 days/wk. Staff consists of two teams of one licensed behavioral health professional and one peer support specialist, supervised by a licensed independent behavioral health professional who serves as clinical director, community liaison and lead trainer.

        - This scenario results in estimated expenses of $727,000 for the six-month lead-in and $932,000 in the twelve-month implementation period. Total estimated expenses for the entire eighteen-month pilot amount to $1.65M

    - Scenario 2 (Appendix 9) presents a more limited-service capacity upon launch (8 hours/day, 5 days/week). Staff consists of a single team of one licensed behavioral health professional and one peer support specialist, supervised by a licensed

independent behavioral health professional who serves as clinical director, community liaison and lead trainer.

  - This scenario results in estimated expenses of $544 000 for the six-month lead-in and $748,000 in the twelve-month implementation period. Total estimated expenses for the entire eighteen-month pilot amount to $1.29M.

- Although overall costs are higher in scenario one, economies of scale are evident when comparing budget scenarios. Costs per team decrease from $748,000/team for a single team (Scenario 2) to $464,000/team with 2 teams (Scenario 1).

- The figure of $464,000/team in scenario 1 corresponds reasonably well with the Crisis Now Basic Calculator figures in Appendix 1, which suggests that at full implementation nine (9) total teams would be required for a population of 1,250,000 (2020 Cuyahoga County population) at a cost of $3.7M for all teams, or $411,000/single team.

- Budget estimates for program expansion will become clearer based upon real budget experiences in the pilot and will need to be modified. Some of the "lead-in" costs of a programming in additional areas could be reduced or eliminated such as training program development and data system procurement. Other costs would not be reduced (automobiles, computers, communication devices, supplies). In other areas, new costs may be incurred (MCT program director, HR staff, IT staff, additional billing staff, etc.). In general, however, the overall costs/team are likely to be reduced based upon overall economy of scale.

- The funder may wish to consider separate RFPs for subsections of the program, such as a training vendor and a data vendor. Additionally, certain expenditures (such as data and training), may be less than estimated due to systems which are already in place, or by sharing costs with other partners such as Cleveland Public Health or law enforcement agencies.

Recommendation #19: The system should begin planning for expansion of services early in the pilot period.

- While the pilot is ongoing, discussions may begin about what areas may be best suited for additional teams. The results of the pilot will help the ADAMHS Board and its partners decide whether to expand the existing pilot to cover more hours within the initial geographic region(s), or to expand to cover more areas without an increase in availability. Some communities have found that the initially determined pilot area did not have sufficient demand for their pilot MCT, and expanded the region to cover a larger area as the pilot was proceeding.

- In planning for program expansion, many of the same things recommended for the pilot would be needed in each new region covered. The pilot will yield important information regarding the utilization of services and true program costs, permitting more specific planning for the eventual number of teams needed and financial prognosis for funding those teams.

A "quick view" summary of these recommendations may be found in Appendix 10.

SUMMARY

Cuyahoga County has long been a leader in community behavioral health services in Ohio and nationally, developing a mobile crisis team, diversion center, crisis stabilization unit and coordination of services. Behavioral health crisis services currently do not fully meet the needs of individuals experiencing a crisis and at times are unsafe. **Implementing a Care Response program in Cuyahoga County to augment existing services is an import addition to the crisis continuum to provide specific and safe care to those experiencing a behavioral health crisis and achieve better outcomes for clients and families served and the community as a whole.**

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APPENDICES

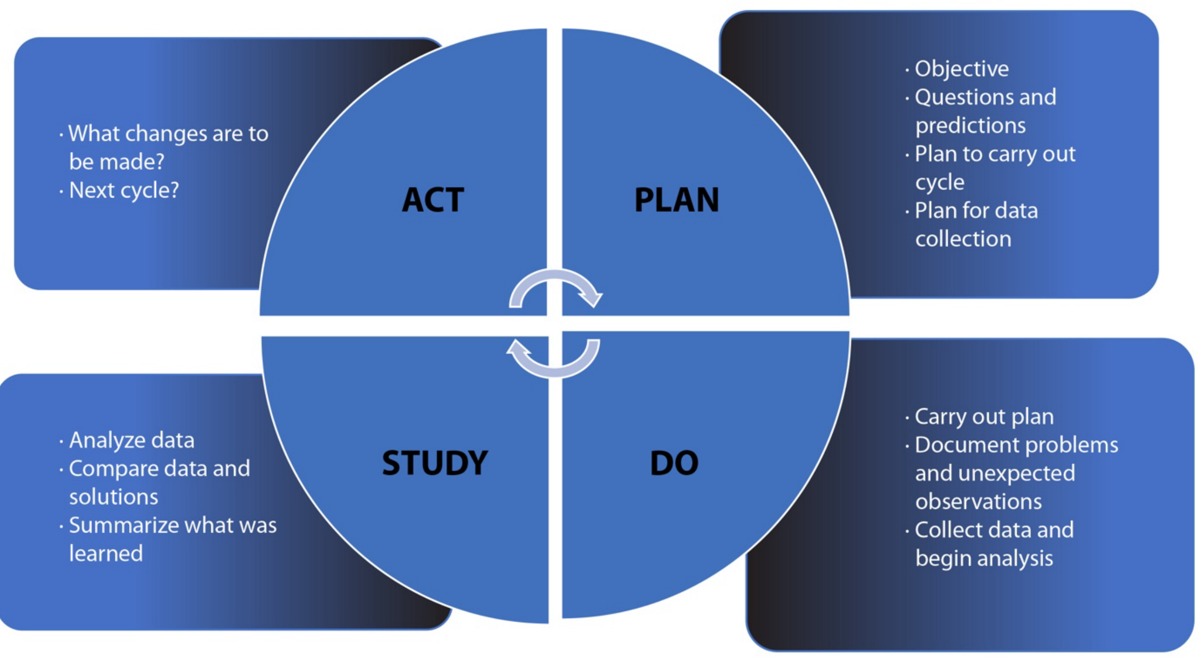
APPENDIX 1. PROJECTIONS FOR CRISIS SYSTEM COSTS IN CRISIS NOW SYSTEM

(Basic Crisis Care Calculator)

Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	Crisis Now
# of Crisis Episodes Annually *(200/100,000 Monthly)*	30,000	30,000
# Initially Served by Acute Inpatient	20,400	4,200
# Referred to Acute Inpatient From Crisis Facility	-	1,670
Total # of Episodes in Acute Inpatient	20,400	5,870
# of Acute Inpatient Beds Needed	**497**	**143**
Total Cost of Acute Inpatient Beds	**$ 145,066,667**	**$ 41,738,667**
# Referred to Crisis Bed From Stabilization Chair	-	6,678
# of Crisis Beds Needed	**-**	**51**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 14,840,000**
# Initially Served by Crisis Stabilization Facility	-	16,200
# Referred to Crisis Facility by Mobile Team	-	2,880
Total # of Episodes in Crisis Facility	-	19,080
# of Crisis Observation Chairs Needed	**-**	**60**
Total Cost of Crisis Facility Beds / Chairs	**$ -**	**$ 21,805,714**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**9**
Total # of Episodes with Mobile Team	-	9,600
Total Cost of Mobile Teams	**$ -**	**$ 3,682,192**
# of Unique Individuals Served	**20,400**	**30,000**
TOTAL Inpatient and Crisis Cost	**$ 145,066,667**	**$ 82,066,573**
ED Costs ($1,233 Per Acute Admit)	**$ 25,153,200**	**$ 7,237,094**
TOTAL Cost	**$ 170,219,867**	**$ 89,303,666**
TOTAL Change in Cost	**$ (80,916,200)**	**-48%**

Population Census	**1,250,000**
ALOS of Acute Inpatient	**8**
Avg. Cost of Acute Bed/Day	**$ 800**

APPENDIX 2. THE PDSA IMPROVEMENT CYCLE
(Institute for Healthcare Improvement)



APPENDIX 3. APPROACHES TO CONSIDER IN WORKFORCE DEVELOPMENT

Basic Principles:

- Workforce should approximate the population served.
- Recruit within the service area for individuals who may already be able to provide services.
- Consider sign-on bonuses.
- Consider retention bonuses to be provided at specific intervals (e.g., 3 months, 6 months, 12 months and then annually)
- Expand the workforce by helping others in the service area develop skills and as needed, certification and licensure to provide services. Specifically:
    - Peer support:
        - Identify individuals who may already be certified peer support specialists.
        - Identify individuals with lived experience with an interest in becoming certified and support them to obtain training and ultimately certification (including financial support) with a service commitment to Care Response to reciprocate to for the assistance.
    - Licensed staff:
        - Identify individuals who may already have licensure or are close to obtaining licensure.
        - Help in obtaining licensure for those with degrees who may need supervised clinical experience or need to take an examination.
        - Provide financial support with a service commitment to Care Response to reciprocate for the assistance.
    - Identify individuals with interest in becoming BH providers. Provide educational support during their education and training with service commitment to reciprocate for the assistance.
    - Survey staff: Hire and train community members to administer surveys/collect data as part of the program assessment activities.
- Offer incentive pay for above usual and customary pay for individuals providing care response services, especially those who may be working non-traditional hours.
- Offer the Crisis Response team as a training site for individuals obtaining a BH certification or licensure. This is an effective way to help them understand the system better and can serve as a recruitment tool.
- Broadly train community members in Mental Health First Aid to become “citizen providers.” This is analogous to training community members in CPR and first aid to temporize a situation until professional assistance arrives. This also increases community ownership of improving behavioral health within the area. NOTE: THESE INDIVIDUALS WOULD NOT BE “CARE RESPONDERS,” *PER SE.*
- Funding: Funding of different aspects varies from quite inexpensive (Mental Health First Aid), to very expensive (scholarships and loan payback). The less expensive components may be funded through the Care Response funding. Funding for other components may be pursued through other sources:
    - MHAS workforce development funding through state general budget (Still in process)
    - Philanthropic sources that fund workforce initiatives.

APPENDIX 4. CARE REPSONSE TEAM TRAININGS SUGGESTED BY CLEVELAND COMMUNITY MEMBERS (SCHLIEFFER AND VAN LIER, 2022)

- Wide range of skills and competencies, including:
    - Mental health
    - Interpersonal skills
    - Trauma-informed care
    - Youth
    - LGBTQ
    - Homelessness
- Active listening
- Anti-internal bias
- Relationship building
- Interpersonal skills
- Conflict resolution or mediation
- Trauma-informed competency
- Racial equity competency
- Physical health care/medical skills
- Homeless community competency
- Knowledge of social services, local resources, or wraparound care options

APPENDIX 5. MOBILE CRISIS REPSONSE SERVICE COMPETENCIES (GBRICS, 2022)

Universal Competencies:

- Welcoming
- Hopeful
- Safe
- Trauma-informed
- Timely
- Culturally-affirming

Specific Competencies:

- Information sharing including coordination of care and sharing of information in emergencies consistent with federal and state privacy laws and best clinical practice
- Consumers are asked about crisis plans and advanced directives
- Respond to calls within one hour 90% of the time
- Integrated assessment tools
- Maximize trust and avoid coercive interventions
- Suicide risk screening/threat assessment
- SUD screening and triage
- Ability to make referrals to outpatient care
    - Follow-up within 72 hours and continuing until connected to ongoing care

APPENDIX 6. MOBILE CRISIS RESPONSE PRACTICE GUIDELINES (GBRICS, 2022)

- Effectively engage families and other support persons during a crisis
- Information sharing with families and other community, natural and professional supports consistent with state and federal law
- Try to avoid involuntary detention by using engagement skills, de-escalation, resolving inciting factors and involving respected others (training should involve persons involuntarily detained and families)
- Dedicated MRT for children, youth, and families (*Exists in Cuyahoga County)*
- Crisis plans and advance directives
- Standards for follow-up care
- Harm reduction services
- Transporting consumers
- Guidelines for:
  - Co-occurring MI and SUD
  - Co-occurring medical issues/geriatric
  - Clients with cognitive impairment: ID/DD, TBI, dementia
  - People with hearing, visual or communication issues or physical issues
  - LGBTQ consumers
  - Veterans
- Requirements and methods for reporting abuse and neglect
- Management of firearms-related issues
- Language access
  - Multi-lingual staff and availability of language line
  - Staff trained in ASL and availability of interpreter, video relay, etc.
  - Respect for consumer's communication preferences
- Training in:
  - Trauma-informed care and de-escalation strategies
  - Harm reduction
  - Recognizing medical emergencies
  - Self-care
  - Cultural humility and anti-racism
  - Training on all standards

APPENDIX 7. FIDEILTY SCALE FOR MENTAL HEALTH CRISIS RESOLUTION TEAMS (Lloyd-Evans, et al., 2016)

	#	Item	Median score	Range
Referrals and Access	1	The CRT responds quickly to new referrals	2	1–5
	2	The CRT is easily accessible to all eligible referrers	4	**2–5**
	3	The CRT accepts referrals from all sources	3	1–5
	4	The CRT will consider working with anyone who would otherwise be admitted to adult acute psychiatric hospital	4	**2–5**
	5	The CRT provides a 24 h, 7 day a week service	4	1–5
	6	The CRT has a fully implemented "gatekeeping" role, assessing all patients before admission to acute psychiatric wards and deciding whether they are suitable for home treatment.	4	1–5
	7	The CRT facilitates early discharge from hospital	3	1–5
	8	The CRT provides explanation and direction to other services for service users, carers and referrers regarding referrals which are not accepted	4	1–5
	9	The CRT responds to requests for help from service users and carers whom the CRT is currently supporting	3	1–5
	10	The CRT is a distinct service which only provides crisis assessment and brief home treatment	4	1–5
Content and delivery of Care	11	The CRT assertively engages and comprehensively assesses all service users accepted for CRT support	4	1–5
	12	The CRT provides clear information to service users and families about treatment plans and visits	3	1–5
	13	The CRT closely involves and works with families and wider social networks in supporting service users	3	1–5
	14	The CRT assesses carers' needs and offers carers emotional and practical support	2	1–5
	15	The CRT reviews, prescribes and delivers medication for all service users when needed	5	**2–5**
	16	The CRT promotes service users' and carers' understanding of illness and medication and addresses concerns about medication	2	**1–4**
	17	The CRT provides psychological interventions	1	1–5
	18	The CRT considers and addresses service users' physical health needs	2	1–5
	19	The CRT helps service users with social and practical problems	5	1–5
	20	The CRT provides individualised care	3	1–5
	21	CRT staff visits are long enough to discuss service users' and families' concerns	3	1–5
	22	The CRT prioritises good therapeutic relationships between staff and service users and carers	2	1–5
	23	The CRT offers service users choice regarding location, timing and types of support	4	1–5
	24	The CRT helps plan service users' and service responses to future crises	1	**1–4**
	25	The CRT plans aftercare with all service users	3	1–5
	26	The CRT prioritises acceptability to service users in how CRT care is ended	3	1–5
Staffing and team procedures	27	The CRT has adequate staffing levels	5	1–5
	28	The CRT has a psychiatrist or psychiatrists in the CRT team, with adequate staffing levels	5	1–5
	29	The CRT is a full multi–disciplinary staff team	2	1–5
	30	The CRT provides a thorough induction programme for new staff and ongoing training and supervision in core competencies for CRT staff	3	1–5
	31	The CRT has comprehensive risk assessment and risk management procedures, including procedures for safeguarding children and vulnerable adults living with CRT service users	2	1–5
	32	The CRT has systems to ensure the safety of CRT staff members	5	1 5
	33	The CRT has effective record keeping and communication procedures to promote teamwork and information sharing between CRT staff	4	1–5
	34	The CRT works effectively with other community services	3	1–5
	35	The CRT takes account of equality and diversity in all aspects of service provision	4	1–5
	36	The CRT has systems to provide consistency of staff and support to a service user during a period of CRT care	2	1–5
Timing and location of care	37	The CRT can access a range of crisis services to help provide an alternative to hospital admission for service users experiencing mental health crisis	1	1–5
	38	The CRT provides frequent visits to service users	2	1–5
	39	The CRT mostly assesses and supports service users in their home	5	**2–5**

***Range scores of less than 1-5 are presented in bold**

APPENDIX 8. BUDGET ASSUMPTIONS FOR CARE RESPONSE PILOT PROGRAM
(Scenario 1: Services 10 hr/day, 7 days/week—2 teams required)

Expense type	Amount		Notes
	6-month lead-in	12-month implementation	
Clinical Director/lead trainer (1)	$87,500	$175,000	Licensed Independent Practitioner—supervises and trains staff, liaisons with partners and community
Licensed BH professional (2)	$57,500 (3 months)	$230,000	Provides direct service 40 hrs/week
Peer support Specialist (2)	$50,000 (3 mo)	$200,000	Provides direct service 40 hrs/week
Advisory panel (8)	$9,600 2meetings/mo	$9600 1 meeting/month	$25/hour
Community research assistants (2)	$20,000	$80,000	$30/hour 20 hours/week
Community Training	$4000	$4000	Mental Health First Aid training for 100 community members each year
Travel	$20,000	$5,000	To existing MCT programs for observation and training
Vehicles (2)	$100,000	0	
Equipment	$50,000	$25,000	Radios, phones, computers
Fuel and vehicle maintenance	$2500	$10,000	
Supplies	$10,000 (initial procurement)	$20,000	Naloxone, Harm reduction kits, medical supplies, bus passes, housing vouchers, food, water, clothing
Development of training plan	$100,000 (includes payment to community trainers)	$30,000	May be separate RFP to different vendor. Includes development of plan for 911/988 interface and dispatch
Data plan and analysis	$100,000	$100,000	May be separate RFP. To different vendor
Communications and outreach	$30,000	$20,000	
Sign-on bonus	$10,000	$4,000	$2000/employee hired
Retention bonus	$6,000	$20,000	$1000 at 3 and 6 months of employment $2000 at 12 months
Contingency	$70,000	$100,000	
TOTAL	$727,100	$932,600	

APPENDIX 9. BUDGET ASSUMPTIONS FOR CARE RESPONSE PILOT PROGRAM

(Scenario 2: Services 8 hr/day, 5 days/week—1 team required)

Expense type	Amount		Notes
	6-month lead-in	12-month implementation	
Clinical Director/lead trainer (1)	$87,500	$175,000	Licensed Independent Practitioner—supervises and trains staff, liaisons with partners and community
Licensed BH professional (1)	$28,750 (3 months)	$115,000	Provides direct service 40 hrs/week
Peer support Specialist (1)	$25,000 (3 mo)	$100,000	Provides direct service 40 hrs/week
Advisory panel (8)	$9,600 2meetings/mo	$9600 1 meeting/month	$25/hour
Community research assistants (2)	$20,000	$80,000	$30/hour 20 hours/week
Community Training	$4000	$4000	Mental Health First Aid training for 100 community members each year
Travel	$15,000	$3,500	To existing MCT programs for observation and training
Vehicles (1)	$50,000	0	
Equipment	$50,000	$15,000	Radios, phones, computers
Fuel and vehicle maintenance	$2500	$5,000	
Supplies	$10,000 (initial procurement)	$20,000	Naloxone, Harm reduction kits, medical supplies, bus passes, housing vouchers, food, water, clothing
Development of training plan	$100,000 (includes payment to community trainers)	$30,000	May be separate RFP to different vendor. Includes development of plan for 911/988 interface and dispatch
Data plan and analysis	$100,000	$100,000	May be separate RFP. To different vendor
Communications and outreach	$30,000	$20,000	
Sign-on bonus	$6,000	$2,000	$2000/employee hired
Retention bonus	$6,000	$8,000	$1000 at 3 and 6 months of employment $2000 at 12 months
Contingency	$50,000	$70,000	
TOTAL	$544,350	$748,100	

APPENDIX 10. SUMMARY OF RECOMMENDATIONS ON MOBILE CARE RESPONSE FOR BEHAVIORAL HEALTH CRISES IN CUYAHOGA COUNTY

Recommendation #1: Care Response services should commence with a pilot program in one or more geographic regions of the county, with plan to expand based upon the learnings of the pilot program.

Recommendation #2: Entity or entities implementing care response should be selected through a competitive process by responding to a Request for Proposals (RFP) to find the vendor(s) with the greatest likelihood of success in addressing the complexities of Care Response.

Recommendation #3: The specific pilot region(s) may either be determined in advance by the funder or may be proposed by the applicants themselves.

Recommendation #4: The model of care response implemented in the pilot region(s) should meet the basic criteria for mobile crisis.

Recommendation #5: The pilot period should consist of six months of "lead-in" following award to complete necessary preparatory work, followed by 12 months of actual service provision.

Recommendation #6: The community of the pilot region(s) should be engaged as a partner in the development, implementation, and assessment of the pilot

Recommendation #7: Staffing of the Care Response team should reflect the characteristics of the community served to the greatest extent possible.

Recommendation #8: Staff safety and wellness must be a priority.

Recommendation #9: A training curriculum should be developed from currently available resources, with adaption to meet Cuyahoga County and pilot area needs. Modifications and additions should be based upon input of local experts, inclusive of pilot area residents, consumers of services, and family members. Consideration should be given to obtaining technical assistance to facilitate this process.

Recommendation #10: Staff will utilize standardized tools for assessment and assistance in determining disposition of clients.

Recommendation #11: Interface with 911 and 988, dispatch criteria and responsibilities of respective partners should be defined prior to implementation of services

Recommendation #12: Discussion should be held, and clarity provided about appropriate disposition of clients who require facility-based crisis care.

Recommendation #13: The Care Response pilot should be data-driven. Process measures, means of collecting data, entities responsible for data collection and interpretation, and reporting process should be determined prior to implementation of services with active involvement of community advisory members. An outside vendor may be considered for data expertise and management.

Recommendation #14: A data dashboard which is available to anyone should be created and posted online.

Recommendation #15: Quality measures should be selected to determine compliance in executing the pilot.

Recommendation #16: Care Response sponsor(s) should seek multiple funding streams to support the pilot project and promote long-term fiscal viability.

Recommendation #17: Respondents to the RFP should prepare a budget that meets promising practice standards and includes a plan for billing for services as a source of revenue beyond grant funding.

Recommendation #18: The funder(s) should consider budgeting as much as $1.65 M for an 18-month pilot program.

Recommendation #19: The system should begin planning for expansion of services early in the pilot period.

CUYAHOGA COUNTY CARE RESPONSE WORKING GROUP

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