Mobile Crisis for Peers & Other Qualified Behavioral Health Professionals

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Overview of State of Nevada Needs Assessment (Mercer)

Nevada is committed to building a Behavioral Health Crisis Care Response System (CCRS)
that is supportive of the unique qualities of its local communities and that is responsive to the needs of its residents in crisis.

The state strives to serve individuals experiencing a behavioral health crisis in a timely, evidence-based, and trauma-informed manner.

This report focuses on the importance of mobile crisis intervention services as one component of the state's vision for the CCRS.

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Overview of State of Nevada Needs Assessment (Mercer)

Following an October 2019 Summit to engage stakeholders in learning about components of a Crisis Care Response System (CCRS), and in response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) release of its "National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit," the state brought stakeholders together for a seven-week immersion series on Nevada's CCRS to assess the state's assets and gaps.

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Overview of State of Nevada Needs Assessment (Mercer)

Leveraging the SAMHSA National Guidelines, participants learned about the four key components of an effective crisis response system, which include the following.

- A crisis call center hub
- Mobile crisis teams
- Facility-based crisis stabilization programs
- Essential principles and practices

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Overview of State of Nevada Needs Assessment (Mercer)

Another important milestone in Nevada's journey to establish a CCRS and to strengthen mobile crisis intervention services infrastructure was the passing of **Senate Bill 390 (SB390)**
in 2021.

This legislation established a telecommunications fee cap and crisis response account to fund crisis call center operations and technology, mobile crisis and crisis stabilization services and defined requirements for mobile crisis teams.

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Overview of State of Nevada Needs Assessment (Mercer)

This report summarizes Mercer's findings from targeted research and offers recommendations to further support Nevada in developing a sustainable, statewide mobile crisis intervention system that is responsive to the needs of local communities and consistent with best and promising practices. Guiding questions utilized to help develop the recommendations contained in this report center on the following:

- What constitutes an allowable, Medicaid-reimbursable mobile crisis response?
- What are the additional requirements that must be met in order for a mobile crisis response to qualify for the time-limited enhanced FMAP associated with Section 1947?
- What are the best practice components of an effective mobile crisis response?
- How can DHCFP and DPBH partner to ensure mobile crisis intervention services are available to all Nevadans?

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Overview of State of Nevada Needs Assessment (Mercer)

The remainder of this report discusses the methodology, background, and key findings and recommendations for Nevada in its development of mobile crisis intervention services under Section 1947 and SB390. Moreover, each recommendation addresses the core requirements detailed in Section 1947 and SB390, including: provider qualifications, training requirements, access and service standards, broad financing options, and state oversight and monitoring considerations.

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Overview of State of Nevada Needs Assessment (Mercer)

Mercer’s research included review of the following:

- An array of background materials specific to Nevada as well as national best practices related to behavioral health crisis systems.
- Nevada's current mobile crisis service capacity and operations, as well as limitations and barriers to expanding mobile crisis services consistent with Nevada’s vision and incompliance with federal and state requirements.
- Nevada’s Medicaid State Plan and existing waiver authorities.
- Medicaid billing for crisis intervention services, including crisis services provided by Certified Community Behavioral Health Centers (CCBHCs).

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Senate Bill 390

Passed in 2021, SB390 was an integral milestone in Nevada's journey to establish a statewide crisis response system16.This legislation established a telecommunications fee cap and crisis response account to fund 988 operations and technology, and mobile crisis and crisis stabilization services, as authorized by 47 U.S.C. 251a.

SB390 defined requirements for three types of mobile crisis teams, which include:

1. Persons professionally qualified in the field of behavioral health and providers of peer recovery support services

2. A provider of EMS that includes persons professionally qualified in the field of behavioral health and providers of peer recovery support services

3. A LE agency that includes LE officers, persons professionally qualified in the field of psychiatric mental health and providers of peer recovery support services. SB390 also gave DPBH broad authority to adopt regulations pertaining to the qualifications of providers and to determine communication and information sharing practices when responding to a behavioral health crisis.

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Senate Bill 390

Since the completion of the 2020 Statewide Assets and Gaps Analysis, and subsequent passage of SB390 and Section 1947, Mercer evaluated the extent to which existing mobile crisis services align with the new federal and state requirements. This report details finding from that analysis and provides recommendations to ensure that future services comport with those requirements.

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Certified Community Behavioral Health Centers (CCBHCs)

9 Core Services

- Crisis Behavioral Health Services
- Screening, Assessment & Diagnosis
- Person-Centered Treatment Planning
- Outpatient Behavioral Health Services & Medication Management
- Primary Care Screening and Monitoring
- Target Case Management
- Psychiatric Rehabilitation
- Peer Support Services
- Community Based Outpatient Behavioral Health Services for Members of the Armed Forces and Veterans

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Certified Community Behavioral Health Centers (CCBHCs) Required Evidence Based Practices

- Assertive Community Treatment Teams (encompassing the 9 core services as clinically needed)
- Screening Tools
- Assessment Tools
- Risk Severity Tools
- ASAM, LOCUS, and CASII Utilization Management Tools
- Direct EBP Interventions

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Crisis Services, Meeting Needs, Saving Lives

&

National Guidelines for Crisis Care – A Best Practice Toolkit

Advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts.

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National Association of State Mental Health Program Directors (NASMHPD)
Substance Abuse and Mental Health Services Administration (SAMHSA)

What are Crisis Services?

Crisis services are for anyone, anywhere and anytime.

Examples of crisis level safety net services seen in our communities and around the country include:

- **911** accepting all calls and dispatching support based on the assessed need of the caller,
- **Law enforcement, fire or ambulance personnel** dispatched to wherever the need is in the community, and
- **Hospital emergency departments** serving everyone that comes through their doors from all referral sources.

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Historical approach to Mental Health Crises

- **Short-term & Short-sighted**
- **Escalating costs due to:**
  - Overdependence on hospitalizations
  - Over utilization of expensive services and supports (e.g., psychiatric inpatient assets)
  - Hospital readmissions
- **Overuse of law enforcement**

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Consequences of a Broken System

(1) High rates of incarceration for individuals with mental health challenges,

(2) Crowding of emergency departments that experience lost opportunity costs with their beds,

(3) Higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available,

(4) Human tragedies due to lack of access and appropriate care

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Core Services to Mental Health Crisis Care

The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

Regional Crisis Call Center: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat).

Crisis Mobile Team Response: Available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner.

Crisis Receiving and Stabilization Facilities: Providing short-term(under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

These services are for *anyone, anywhere and anytime.*

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Essential Functions & Qualities of Mobile Crisis Teams

National Guidelines for Crisis Care – A Best Practice Toolkit

Essential Functions:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Essential Qualities:

- Safety and security for staff and those in crisis;
- "Suicide Safer" care;
- Trauma-informed care;
- Recovery needs & significant use of peers; *and*
- Law enforcement and emergency medical services collaboration

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Peer Support

National Guidelines for Crisis Care – A Best Practice Toolkit

- For community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services.
- Peers should not reduplicate the role of behavioral health professionals, but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis.
- They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

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Significant Role of Peers

National Guidelines for Crisis Care – A Best Practice Toolkit

Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a ***safe and effective*** program mechanism for assessing and reducing suicide risk for persons in crisis.

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Peer Support

Peer Support Services in Crisis Care – SAMHSA Advisory June 2022

Peer support workers demonstrate that recovery is possible and act as an advocate for the individual.

Inclusion of peer support workers on your Mobile Crisis Team can help improve outcomes, such as:

- Reducing trauma and agitation
- Increasing trust
- Reducing hospitalizations and emergency department usage
- Reducing recurrence of symptoms
- Decreasing recidivism.

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Peer Support Specialists

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*
- *Develop support and supervision that aligns with the needs of your program's team members.*
- *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

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Designated Mobile Crisis Teams

- **DMCTs are a new Medicaid reimbursable specialty type, scheduled to be effective after pending CMS approval.**

- While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher level of care is needed through an in-person response for the individual's acute/emergent episode of crisis.

- An assessment, including the evaluation of suicidality, is required to be delivered by a qualified and/or licensed behavioral health professional.

- The resulting intervention and stabilization of the crisis by the DMCT includes care coordination (through active engagement and "warm hand-off") and follow-up by providers.

- Care coordination is inclusive of coordinated transportation to other locations when recipients are determined to need facility-based care.

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Designated Mobile Crisis Teams

At the time of this webinar ***DMCT enrollment Criteria has not been finalized***; however, the following proposed criteria are likely to be included as the official requirements from Medicaid:

1. Staffing
2. Provider Training
3. Services – Screening
4. Services – Assessment
5. Services – Crisis & Safety Plans
6. Services – Psychiatric Advance Directives
7. Services – Harm Reduction
8. Services – Coordination of Care
9. Services – Privacy & Confidentiality
10. Access
11. Payment Operations
12. Reporting Requirements

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Designated Mobile Crisis Teams

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Essential Functions & Qualities of Mobile Crisis Teams

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- Crisis planning and follow-up.

Essential Qualities:

- Safety and security for staff and those in crisis;
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- Trauma-informed care;
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- Law enforcement and emergency medical services collaboration

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*DMCT Criteria: Staffing Requirements

Mobile crisis services are provided by a **Multidisciplinary Team** comprised of the following:

Led by:

At least one behavioral health professional who is authorized to conduct an assessment in accordance with Nevada scope of practice requirements, including:

- Physicians
- Physician assistants
- Licensed practitioners/Qualified mental health professionals (**QMHPs**):
  - Licensed psychologists
  - Licensed marriage and family therapists (LMFTs)
  - Licensed clinical social workers (LCSWs)
  - Licensed clinical professional counselors (CPCs)
  - Advanced practice registered nurses (APRNs)
  - Interns (under the supervision of a licensed clinician)
- Qualified mental health associates (**QMHAs**) working under the 24/7/365 supervision of a physician, physician assistant, or licensed practitioner/QMHP

Other members of the team may include:

- QMHAs
- Qualified behavioral aides (**QBAs**)
- **Peer supporters**
- Substance use disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), and/or certified alcohol and drug counselor (CADCs)

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Staffing Requirements

Regarding **Peer-to-Peer Support Services**, it is the intent of policy that the DMCT include one team member who is a peer and recovery support services provider, to the greatest extent possible, as Peer Supporters will become mandatory team service providers, certified by DHHS and enrolled with Nevada Medicaid (per SB 390), by July 1, 2026.

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*Proposed criteria – not finalized at time of webinar

Medicaid Definitions

Qualified Behavioral Aide - QBA

- An individual who has an educational background of a high-school diploma or General Education Development (GED) equivalent; and
- Has been determined competent by the overseeing Clinical Supervisor, to provide Rehabilitative Mental Health (RMH) services.
- A QBA must have the documented competencies to assist in the provision of individual and group rehabilitative services,
- Delivered under the Clinical Supervision of an Independent Behavioral Health Professional who may be enrolled as a Qualified Mental Health Professional (QMHP) and the Direct Supervision of a QMHP or Qualified Mental Health Associate (QMHA); the supervising professional(s) assume(s) responsibility for their supervisees and shall maintain documentation on this supervision in accordance with MSM 403.2A Supervision Standards.

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Medicaid Definitions

Qualified Behavioral Aide - QBA

- **QBAs** must also have experience and/or training in the provision of services to individuals diagnosed with mental and/or behavioral health disorders, and have the ability to:
  - Read, write, and follow written and oral instructions; *and*
  - Perform RMH services as prescribed on the rehabilitative treatment plan; *and*
  - Identify emergency situations and respond appropriately; *and*
  - Communicate effectively with recipient and recipient's support system; *and*
  - Document services provided according to Chapter 400 Documentation requirements; *and*
  - Maintain recipient confidentiality.

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Medicaid Definitions

Qualified Behavioral Aide - QBA

- For **QBAs** who will also function as **Peer-to-Peer Service Specialists**,
  - Peer Supporter cannot be the legal guardian or spouse of the recipient.
  - The primary role of the Peer Supporter is to model skills based on lived experience to help individuals meet their rehabilitative goals.
- Services are delivered under Clinical Supervision provided by an independently licensed QMHP-level mental health professional, LCSW, LMFT, or LCPC; this supervision shall be provided and documented at least monthly by the supervising professional.

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Medicaid Definitions

Qualified Mental Health Associate - QMHA

Meets the following documented minimum qualifications:

- Professional licensure as a Registered Nurse (RN) issued by the Nevada State Board of Nursing; **and/or**
- Official documentation of a Bachelor's degree in Human Services from an accredited college or university with additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements; **or**
- Official documentation of an Associate's degree in Human Services from an accredited college or university and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated through four years of relevant professional experience by proof of past or current enrollment as a Nevada Medicaid provider delivering direct services to individuals with behavioral health disorders; **or**
- Official documentation of a Bachelor's degree from an accredited college or university in a field other than Human Services and additional understanding of outpatient treatment services, rehabilitative treatment services, and case file documentation requirements, demonstrated by four years of relevant professional experience by proof of resume.

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Medicaid Definitions

Qualified Mental Health Associate - QMHA

A QMHA with experience and training will demonstrate the ability to:

- Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise; and
- Identify presenting problem(s); and
- Participate in treatment plan development and implementation; and
- Coordinate treatment; and
- Provide parenting skills training; and
- Facilitate discharge plans; and
- Effectively provide verbal and written communication on behalf of the recipient to all involved parties.

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Medicaid Definitions

Qualified Mental Health Associate - QMHA

A **QMHA** delivers services under the Clinical and Direct Supervision of a mental health provider(s) within the appropriate scope of practice; the Supervisor(s) assume(s) responsibility for their supervisees and shall maintain documentation on supervision in accordance with MSM 403.2A Supervision Standards.

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Medicaid Definitions

Qualified Mental Health Professional - QMHP

Meets the qualifications of a QMHA and also meets the following documented minimum qualifications:

- Holds any of the following independent licensure with educational degrees:
  - Licensed Psychiatrist or Licensed Physician, M.D., Osteopath, D.O., with clinical experience in behavioral health treatment.
  - Licensed Physician's Assistance with clinical experience in behavioral health treatment.
  - Doctorate degree in Psychology and Licensed Psychologist.
  - Advanced Practice Registered Nurse (APRN) with a focus in psychiatric mental health.
  - Graduate degree in Social Work and licensed as a Clinical Social Worker.
  - Graduate degree in Counseling and Licensed as a Marriage & Family Therapist or as a Clinical Professional Counselor.

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Medicaid Definitions

- There are additional Medicaid requirements related to enrollment for QMHP, QMHA, and QBA.

- Please refer to Medicaid Chapter 400

https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C400/Chapter400/

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*DMCT Criteria: Staffing Requirements

Mobile crisis teams have policies and clinical supervision procedures in place, including a ***staffing plan*** that identifies the supervisory structure and the employees and positions within the agency, and must ensure:

- Case records are kept updated
- Protocols on when/how to engage the on-call clinician are updated
- QMHAs discuss the case with their supervisor in person or via phone, and shall document the time and outcome of that supervisory discussion
- The supervisor reviews and co-signs the QMHAs' documented screening within 24 hours or next business day
- Documentation of supervisory contacts, including date of supervisor review, date of observation, log of indirect supervision contacts (e.g., paperwork reviewed), and date, agenda, and action plan for conferences with supervisee
- QMHAs have the necessary training, competencies, and skills to conduct mental health screens.

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Provider Training

Mobile crisis providers have developed a staff training and competency plan to be reviewed annually. The training plan includes all required trainings and other core competencies defined by the state.

The training plan should indicate all of the following:

- That all team members must receive annual refresher trainings on required training topics,
- That all team members must pass post-tests on each topic to demonstrate competency in the topic.
- That each topic is covered in a separate training module dedicated to the specific topic.

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*DMCT Criteria: Provider Training

All mobile crisis team members are trained in the following areas prior to participating in a mobile response:

- **Safety/Risk screening:**
  - Adapt to cultural and linguistic needs of individuals during the screening process – **All Staff**
  - Select the appropriate screening tool – **QMHA -> QMHP staff**
  - Engage with supportive family system and collateral contacts – **All Staff**
  - Interpret screening tool results – **QMHA -> QMHP staff**
- **Stabilization/Verbal de-escalation techniques – All Staff**
- **Harm reduction strategies for individuals with SUD:**
  - Use of naloxone in the field – **All Staff**
  - How to educate individuals at risk (and their supportive family system) about naloxone use – **All Staff**
  - How to educate individuals about harm reduction techniques and resources – **All Staff**
- **Crisis/Safety planning – All staff; however, some interventions may require QMHA -> QMHP staff**
- **Privacy and Confidentiality policies and procedures – All Staff**
- **Use of telehealth equipment – All Staff**
- **Electronic Health Record – All Staff**
- **Trauma-Informed Care – All Staff**

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Screening

Mobile crisis teams have policies and procedures in place to ensure consistent screening of all individuals and documentation of all screenings and screening findings

Mobile crisis teams must have policies and procedures in place indicating that only QMHPs and QMHAs, who have continuous access to a QMHP for consultation, may conduct screenings.

Mobile crisis teams have selected screening tools that include adopted tools for evaluation of risk, violence, and suicidality.

Screening tools include the State-required Columbia Suicide Screening Tool (Columbia) and other tools that meet State requirements.

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*Proposed criteria – not finalized at time of webinar

Safety / Risk Screening

Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

- Occurs over the telephone (crisis call hub) with the initial crisis call and ***again*** on site with the mobile team.
- Determines the level of risk faced by the individual in crisis.
- Assesses the most appropriate response to meet the need.

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Safety / Risk Screening

Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

EMS or police intervention should only be used when the nature of the crisis indicates that these services are required. EMS or police intervention is ***not*** the preferred approach unless appropriately indicated.

- **For example, if the person in crisis poses an imminent threat of harm, coordination with emergency responders *is* appropriate.**

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Safety / Risk Screening

Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of screening both over the phone and by the mobile crisis team.

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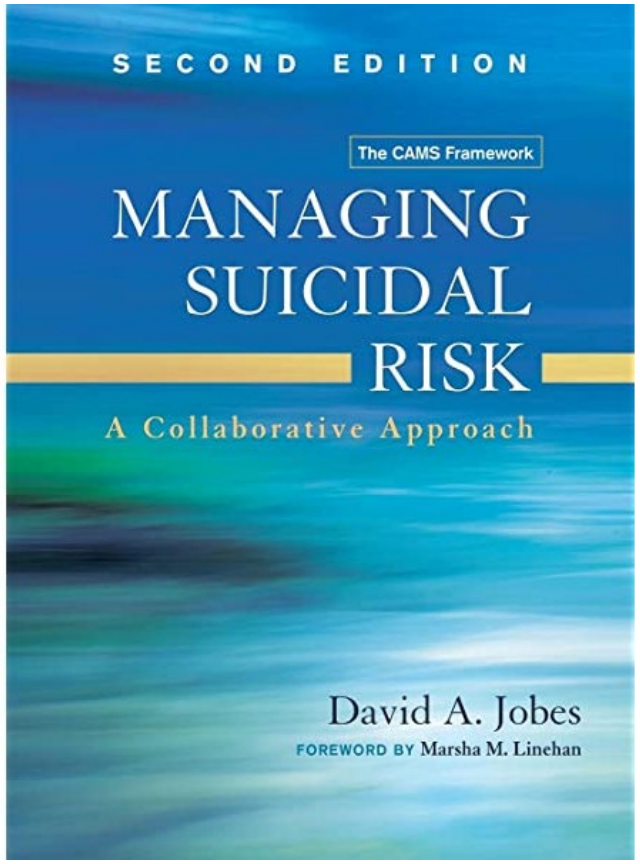
Screening for Suicidality



Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		**High Risk**

988 SUICIDE & CRISIS LIFELINE

If **YES** to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is **YES**, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

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CAMS

Columbia Suicide Severity Rating Scale

Screening for Suicidality

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - ☐ "Yes" to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 7/1/2020

ASQ

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

SAFE-T

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Screening for Suicidality

C-SSRS & SAFE-T Protocol Combo

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) Lifetime/Recent

Step 1: Identify Risk Factors

C-SSCS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	Month	Lifetime (Worst)
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*		
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*		
4) **Suicidal Intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*		
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	3 Months	Lifetime

Activating Events:
- ☐ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone

Treatment History:
- ☐ Previous psychiatric diagnosis and treatments
- ☐ Hopeless or dissatisfied with treatment
- ☐ Non-compliant with treatment
- ☐ Not receiving treatment
- ☐ Insomnia

Other:
- ☐ _____
- ☐ _____
- ☐ _____

Clinical Status:
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Mixed affect episode (e.g. Bipolar)
- ☐ Command Hallucinations to hurt self
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Highly impulsive behavior
- ☐ Substance abuse or dependence
- ☐ Agitation or severe anxiety
- ☐ Perceived burden on family or others
- ☐ Homicidal Ideation
- ☐ Aggressive behavior towards others
- ☐ Refuses or feels unable to agree to safety plan
- ☐ Sexual abuse (lifetime)
- ☐ Family history of suicide

☐ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:
- ☐ Fear of death or dying due to pain and suffering
- ☐ Identifies reasons for living
- ☐ _____
- ☐ _____

External:
- ☐ Belief that suicide is immoral; high spirituality
- ☐ Responsibility to family or others; living with family
- ☐ Supportive social network of family or friends
- ☐ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior – skip if questions 1-5 are all no)

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation identified above)	Month	Lifetime (Worst)
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous		
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply		
Total Score		

Notes:

Behaviors:
- ☐ Preparatory Acts (e.g., buying pills, purchasing a gun, giving things away, writing a suicide note)
- ☐ Aborted/self-interrupted attempts,
- ☐ Interrupted attempts and
- ☐ Actual attempts

☐ **Assess for the presence of non-suicidal self-injurious behavior** (e.g. cutting, hair pulling, cuticle biting, skin picking) particularly among adolescents and young adults, and especially among those with a history of mood or externalizing disorders

☐ **For Youths:** ask parents/guardian about evidence of suicidal thoughts, plans or behaviors and changes in mood, behaviors or disposition

☐ **Assess for homicidal ideation, plan behavior and intent** particularly in:
- ☐ character disordered males dealing with separation, especially if paranoid, or impulsivity disorders

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."
From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Risk ☐ Suicidal ideation with intent or intent with plan **in past month** (C-SSRS Suicidal Ideation #4 or #5) **Or** ☐ Suicidal behavior **within past 3 months** (C-SSRS Suicidal Behavior)	☐ **Initiate local psychiatric admission process** ☐ **Stay with patient until transfer to higher level of care is complete** ☐ **Follow-up and document outcome of emergency psychiatric evaluation**
Moderate Risk ☐ Suicidal ideation with method **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) **Or** ☐ Multiple risk factors and few protective factors	☐ **Use clinical judgement to determine if further evaluation is necessary** ☐ **Outpatient Referral**
Low Risk ☐ Wish to die or suicidal thoughts (C-SSRS Suicidal Ideation #1 and/or #2) **no method, plan, intent or behavior** **Or** ☐ Suicidal ideation more than 1 month ago (C-SSRS screen #1-5) **Or** ☐ Modifiable risk factors and strong protective factors **Or** ☐ No reported history of Suicidal Ideation or Behavior	☐ **Outpatient Referral**

Step 5: Document Level of Risk, Rationale for Risk Assignment, Intervention and Structured Follow Up Plan (to be developed)

Risk Level :

[ ] High Risk [ ] Moderate Risk [ ] Low Risk Suicidal

Clinical Note:
- ☐ Your Clinical Observation
- ☐ Relevant Mental Status Information
- ☐ Methods of Suicide Risk Evaluation
- ☐ Brief Evaluation Summary
  - ☐ Warning Signs
  - ☐ Risk Indicators
  - ☐ Protective Factors
  - ☐ Access to Lethal Means
  - ☐ Collateral Sources Used and Relevant Information Obtained
  - ☐ Specific Assessment Data to Support Risk Determination
  - ☐ Rationale for Actions Taken and Not Taken
- ☐ Provision of Crisis Line 1-800-273-TALK(8255)
- ☐ Implementation of Safety Plan (if Applicable)

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https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.healthcare.english

Screening for Suicidality

PHQ-9 (PHQ-A) & ASQ Combo

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead?	YES	NO
(2) In the past few weeks, have you felt that you or your family would be better off if you were dead?	YES	NO
(3) In the past week, have you been having thoughts about killing yourself?	YES	NO
(4) Have you ever tried to kill yourself?	YES	NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now?	YES	NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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Safety / Risk Screening

In some cases, screening(s) and an assessment may have already occurred prior to mobile deployment. In these cases, it is **Best Practice** to

- Reduce duplicative screening and assessments, and
- Access and review existing medical records/treatment information when available to support crisis intervention activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).

However, it is also best practice to **VALIDATE** the findings from previous screenings and/or assessments.

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Safety / Risk Screening

Adapt to cultural and linguistic needs of individuals

All Staff need to be trained on how to adapt and engage with the person in crisis based on that person's cultural and linguistic needs.

Ultimately these trainings and methods will be decided upon by your agency; however, the following is an example of what this could look like…

https://destinationsinternational.org/blog/what-cultural-competency-and-why-it-matters-your-business

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Safety / Risk Screening

Adapt to cultural and linguistic needs of individuals

Example of meeting cultural competency

988 Cultural Competency Training:

There are ongoing efforts to improve cultural competency training for 988 Lifeline crisis counselors. Some examples of related improvements to 988 are that:

- Spanish-speaking crisis counselors are answering calls, texts, and chats in Spanish.
- LGBTQI+ trained crisis counselors answer calls, texts, and chats in a specialized LGBTQI+ youth and young adult service.
- The 988lifeline.org website has improved information related to mental health wellness in the Black community.
- The 988 Lifeline has specific tools for crisis counselors, such as Spanish-language clinical guidance resources, Deaf and Hard of Hearing best practices for callers/chat visitors, an LGBTQI+ guidance document, and an American Indian/Alaskan Native tip sheet.

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https://www.samhsa.gov/find-help/988/faqs

988 SUICIDE & CRISIS LIFELINE

GET HELP | LEARN | GET INVOLVED | PROVIDERS & PROFESSIONALS

988 CHAT

En Español | For Deaf & Hard of Hearing

Anyone could be struggling with suicide. Find more specific resources below.

A CURRENT EVENT:
The Lifeline and 988

A CURRENT EVENT:
Coping During Community Unrest

A CURRENT EVENT:
Emotional Wellbeing During COVID-19

Individuals with Neurodivergence

Black Mental Health

Maternal Mental Health

Youth

Disaster Survivors

Native American, Indian, Indigenous, & Alaska Natives

Veterans

Loss Survivors

LGBTQ+

Attempt Survivors

Deaf, Hard of Hearing, Hearing Loss

988 SUICIDE & CRISIS LIFELINE

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https://988lifeline.org/

Safety / Risk Screening

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https://www.thetrevorproject.org/survey-2022/

THE TREVOR PROJECT

2022 National Survey on LGBTQ Youth Mental Health

Key Findings

45% of LGBTQ youth seriously considered attempting suicide in the past year.

Nearly 1 in 5 transgender and nonbinary youth attempted suicide and LGBTQ youth of color reported higher rates than their white peers.

Share:

LGBTQ youth who felt high social support from their family reported attempting suicide at **less than half the rate** of those who felt low or moderate social support.

Share:

Fewer than 1 in 3 transgender and nonbinary youth found their home to be gender-affirming.

Share:

LGBTQ youth who found their school to be LGBTQ-affirming reported **lower rates of attempting suicide.**

Share:

60% of LGBTQ youth who wanted mental health care in the past year were not able to get it.

Share:

LGBTQ youth who live in a community that is accepting of LGBTQ people reported **significantly lower rates of attempting suicide** than those who do not.

Share:

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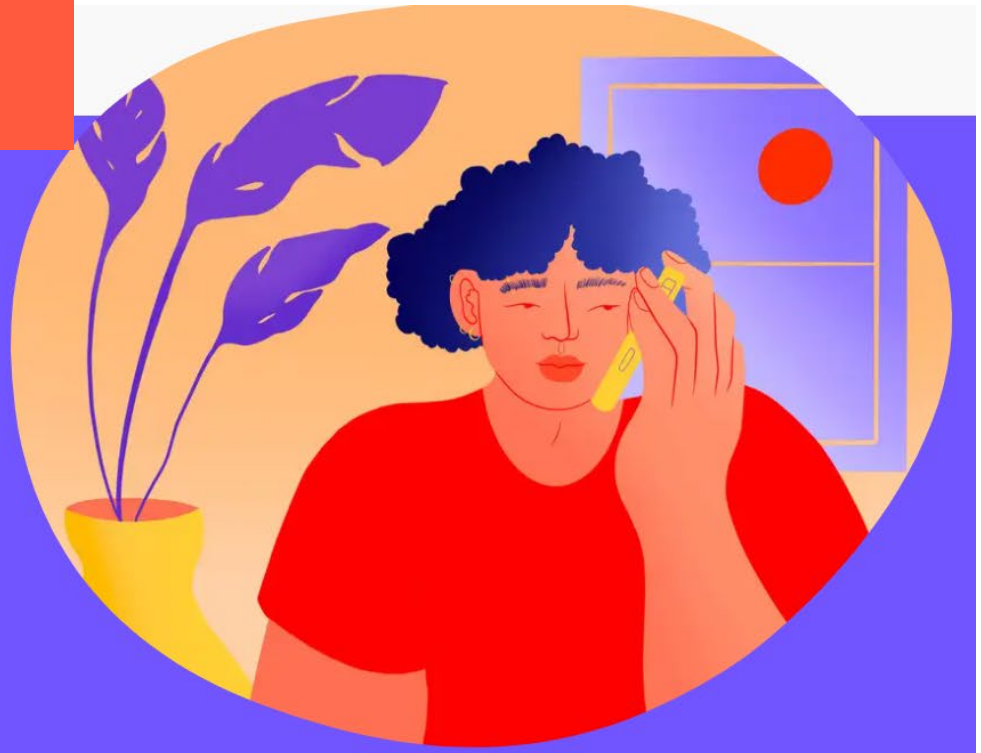
https://www.thetrevorproject.org/survey-2022/

Safety / Risk Screening

THE TREVOR PROJECT

Mental Health & Suicide Risk

LGBTQ youth are not inherently prone to suicide risk because of their sexual orientation or gender identity but rather placed at higher risk because of how they are mistreated and stigmatized in society.



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https://www.thetrevorproject.org/survey-2022/

Safety / Risk Screening

Adapt to cultural and linguistic needs of individuals

Example of meeting linguistic needs

988

The 988 Lifeline provides live crisis center call, text, and chat services in English and Spanish and uses Language Line Solutions to provide caller translation services in more than 240 additional languages.

The Lifeline currently serves TTY users either through their preferred relay service or by dialing 711 then 1-800-273-8255. Lifeline also offers services through chat and text. Lifeline is in the process of expanding to video phone service to better serve deaf or hard of hearing individuals seeking help through the Lifeline/988.

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https://www.samhsa.gov/find-help/988/faqs

Safety / Risk Screening

Adapt to cultural and linguistic needs of individuals

There are also digit resources to assist in meeting the linguist and cultural needs of those you serve in crisis.

Phqscreeners.com

- Access screening tools such as PHQ (4, 8, 9, 15, SADS, etc) and GAD- 7
- Any of the above screening tool can be downloaded from a vast menu of different languages.

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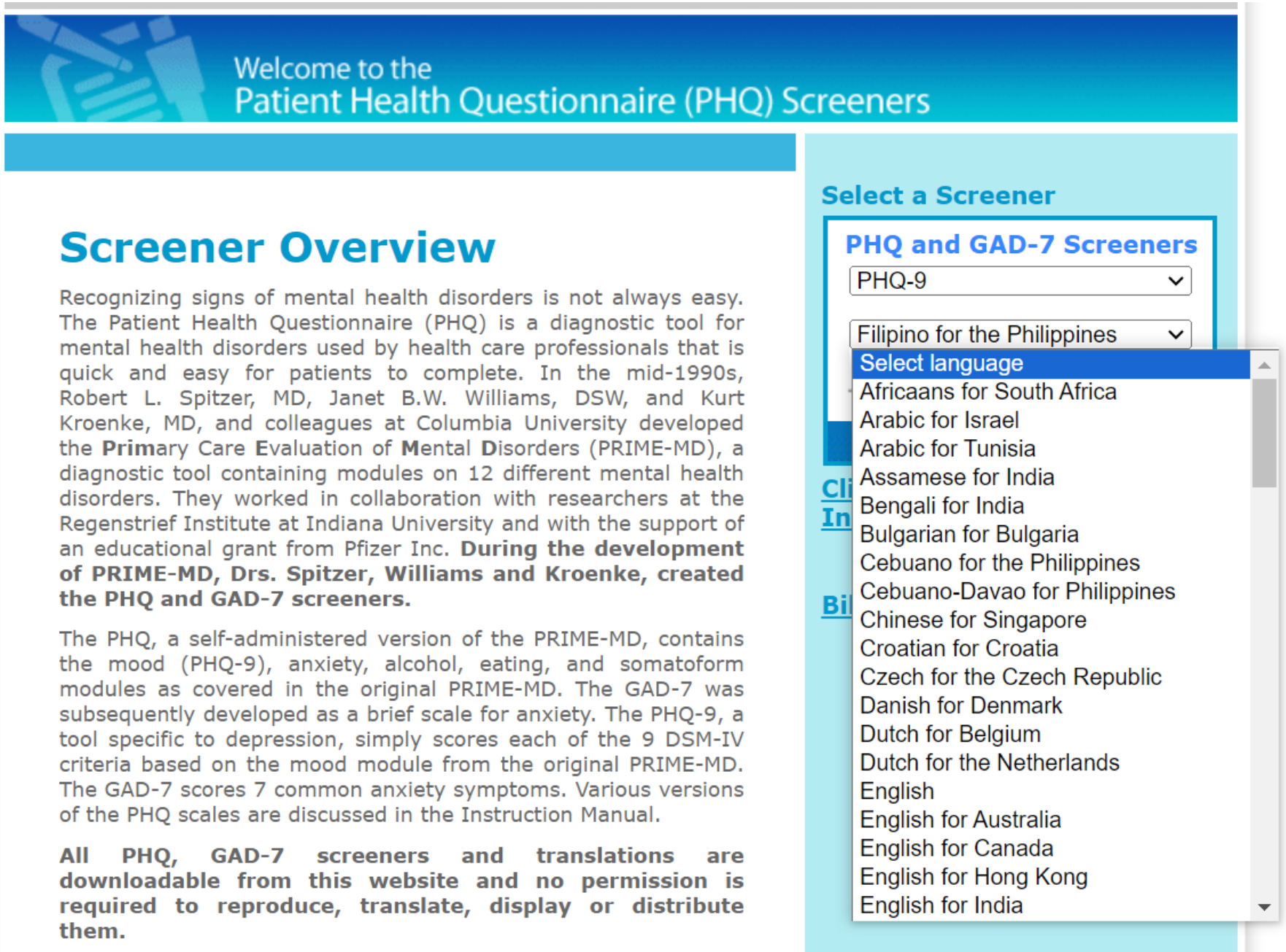

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https://www.phqscreeners.com/select-screener

Safety / Risk Screening

Adapt to cultural and linguistic needs of individuals

There are also digit resources to assist in meeting the linguist and cultural needs of those you serve in crisis.

- The Columbia-Suicide Severity Rating Scale (C-SSRS) is available in **more than 140 country-specific languages**. Many of these translations have been linguistically validated.
- You can obtain a Spanish translation of the scale directly from the website, and then request any other of the 140 country-specific translations from the website.

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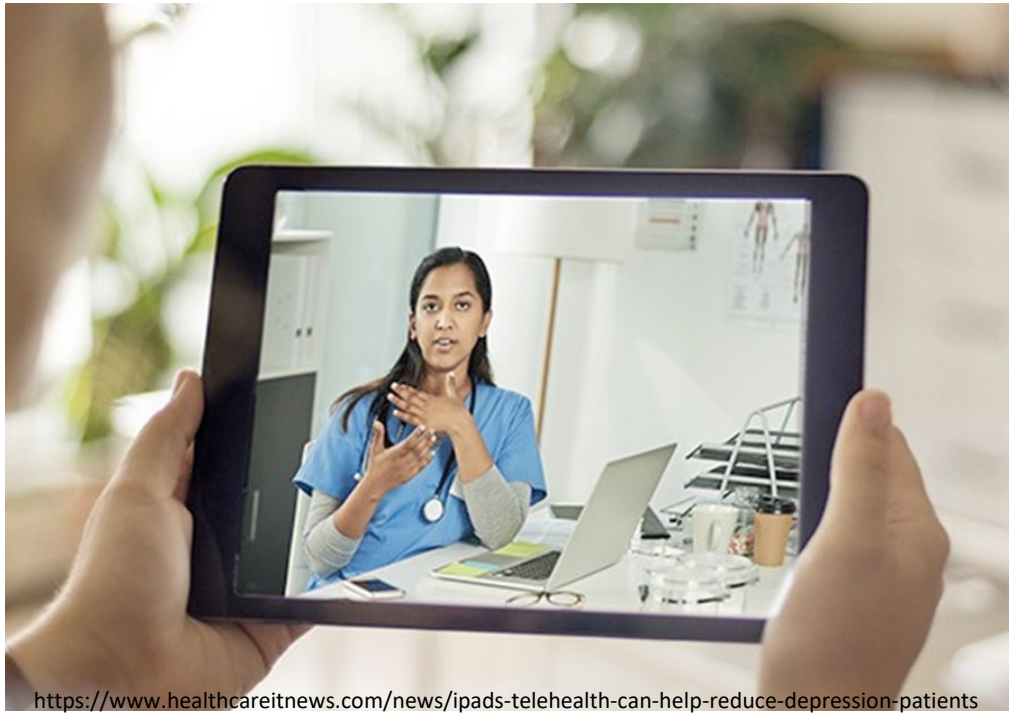
https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/translations/

Safety / Risk Screening

Selecting and Interpreting the Appropriate Screening Tool(s)

- Can only be selected by a **QMHP** or **QMHA** **under the direct 2/7/365 supervision of a QMHP**.
- If team is not led by a **QMHP**, then the lead **QMHA** needs to have adequate work experience history and training history to be able to confidently and competently choose the screening tools. **The QMHA needs continuous access to a QMHP for on-the-spot consultation.**
- Even if suicidal ideation is not described in the initial crisis call, a suicide screen should always be utilized at some point during the crisis intervention.
- Don't forget to screen for potential substance use issues, with tools like the SBIRT (Screening, Brief Intervention, Referral for Treatment).



https://www.healthcareitnews.com/news/ipads-telehealth-can-help-reduce-depression-patients

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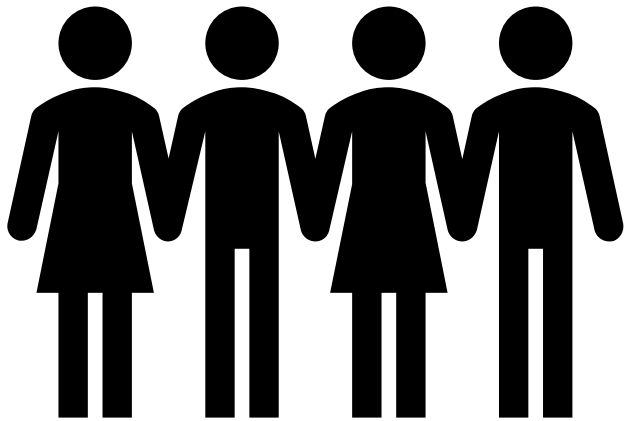
Safety / Risk Screening

Selecting and Interpreting the Appropriate Screening Tool(s)



Triage & Screening

National Guidelines for Crisis Care – A Best Practice Toolkit

Another part of the mobile team triage and screening process will be to ensure that the most appropriate services are being utilized.

- For example, the behavior of a person in crisis may result from a physical condition or reaction that then triggers a mental or behavioral response.
- Physical, mental and behavioral health conditions can affect a person at the same time, so it is crucial to determine if the person in crisis describes a serious medical condition.

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Safety / Risk Screening

Additional Questions you can ask during triage and screening:

- Do you have any weapons on you?
- Are you hearing voices or seeing things that others cannot see?
- Have you been drinking, or have you taken any drugs?
- Do you have a behavioral or mental health condition that we should know about?
- Are you so angry about what's happened that you have considered hurting someone else?

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Safety / Risk Screening

Engage with Supportive Family System and Collateral Contacts

All Staff need to be trained to engage with collateral informants.

- Collaterals or collateral informants, are the people other than the person in crisis that may have helpful and relevant information to provide during the screening, assessment and coordination of care process.
- Often the collateral informants will be a part of the person in crisis' family system or significant others.
- It is important to be mindful of Privacy and Confidentiality when engaging with collateral informants.

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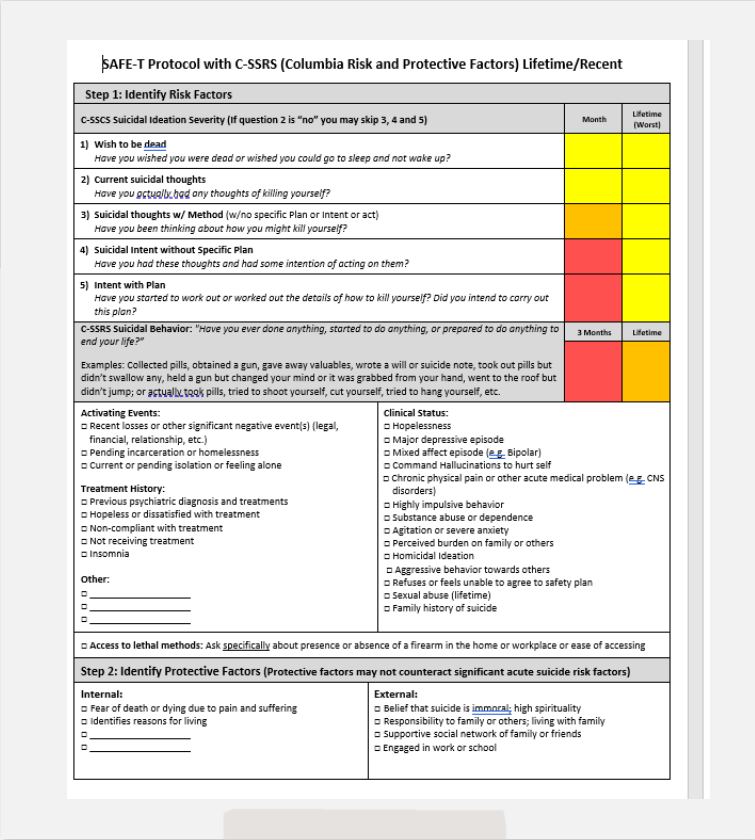
Safety / Risk Screening

Engage with Supportive Family System and Collateral Contacts



SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) Lifetime/Recent

Step 1: Identify Risk Factors

C-SSCS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	Month	Lifetime (Worst)
1) **Wish to be dead** *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) **Current suicidal thoughts** *Have you actually had any thoughts of killing yourself?*		
3) **Suicidal thoughts w/ Method** (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*		
4) **Suicidal Intent without Specific Plan** *Have you had these thoughts and had some intention of acting on them?*		
5) **Intent with Plan** *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
C-SSRS Suicidal Behavior: *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	3 Months	Lifetime

Activating Events:
- ☐ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)
- ☐ Pending incarceration or homelessness
- ☐ Current or pending isolation or feeling alone

Treatment History:
- ☐ Previous psychiatric diagnosis and treatments
- ☐ Hopeless or dissatisfied with treatment
- ☐ Non-compliant with treatment
- ☐ Not receiving treatment
- ☐ Insomnia

Other:
- ☐ _____
- ☐ _____
- ☐ _____

Clinical Status:
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Mixed affect episode (e.g. Bipolar)
- ☐ Command Hallucinations to hurt self
- ☐ Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- ☐ Highly impulsive behavior
- ☐ Substance abuse or dependence
- ☐ Agitation or severe anxiety
- ☐ Perceived burden on family or others
- ☐ Homicidal Ideation
- ☐ Aggressive behavior towards others
- ☐ Refuses or feels unable to agree to safety plan
- ☐ Sexual abuse (lifetime)
- ☐ Family history of suicide

☐ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or workplace or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:
- ☐ Fear of death or dying due to pain and suffering
- ☐ Identifies reasons for living
- ☐ _____
- ☐ _____

External:
- ☐ Belief that suicide is immoral; high spirituality
- ☐ Responsibility to family or others; living with family
- ☐ Supportive social network of family or friends
- ☐ Engaged in work or school

- It is considered **Best Practice** to have an individual in crisis be represented in screening/assessment, crisis planning, and follow-up by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning, especially when working with children and youth.
- Additionally, DMCT's will require that mobile crisis teams establish protocols to allow family members and other collateral contacts to represent an individual in crisis, and to follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM 100.

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Safety / Risk Screening

Summary

- **All staff** need to have training related to Safety / Risk screening; however, the screening itself will be completed and interpreted by a **QMHP** or **QMHA** with continuous, in-real-time, **QMHP supervision.**
- It's important to understand the cultural and linguistic needs of those you will be serving, and to be prepared to adapt to these needs on the spot.
- Even if suicidal ideation is not expressed as a current concern from the intake call, it is imperative that the safety and risk screening process includes screening for suicidal ideation.
- There are many evidenced based tools that we can choose from; however, it is important to realize that the best tool for a given situation may be our own professional expertise. ***It is essential to understand the human element, and to build genuine rapport with the person you are trying to help.***

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Stabilization / Verbal De-escalation

- **All staff** require training on Stabilization and verbal de-escalation.
- Techniques shall be culturally competent, including when and how to adjust response based on the circumstances of the individual in crisis, the site of the crisis response, and the severity of the situation.

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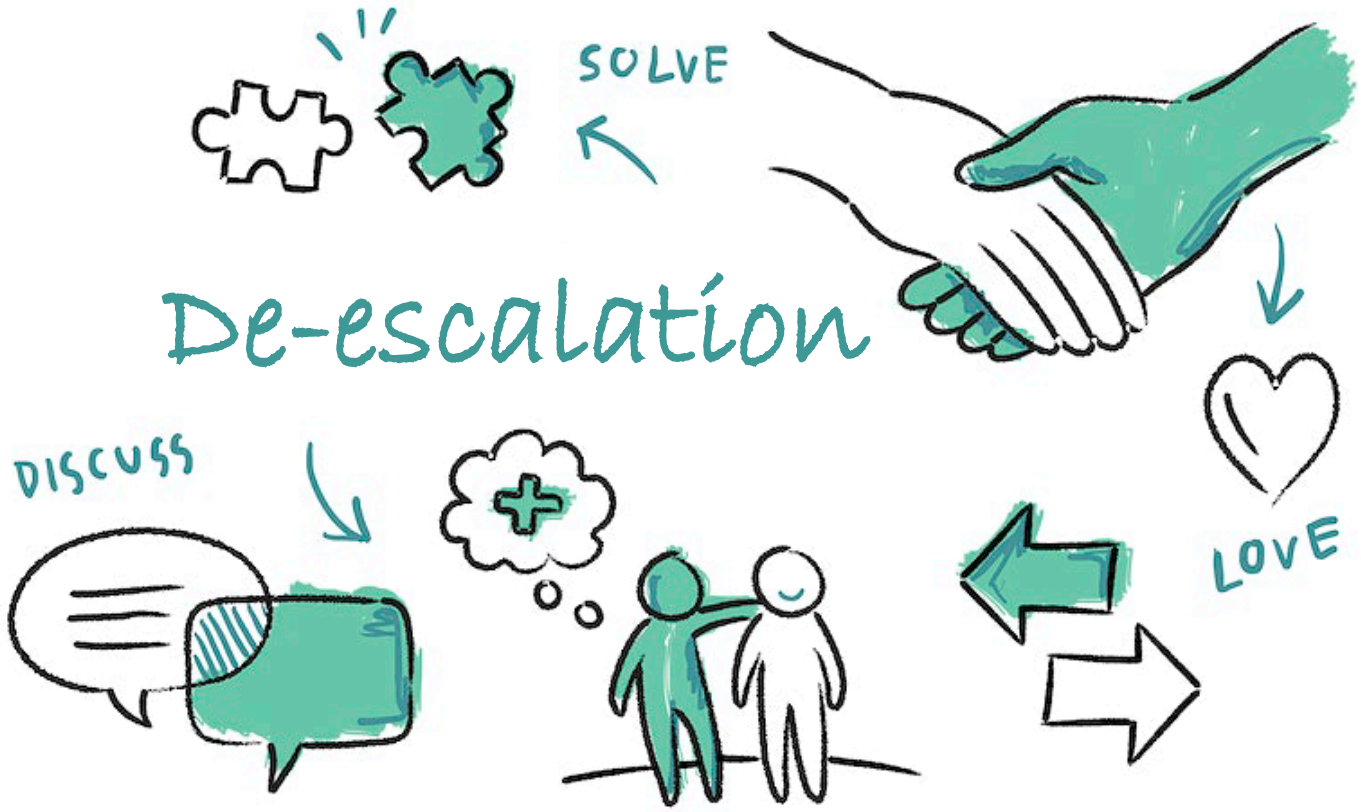
Image: https://foxintegratedhealthcare.com/neuropathy/4-ways-stress-anxiety-are-causing-your-neuropathy/

De-escalation and Resolution

National Guidelines for Crisis Care – A Best Practice Toolkit



- Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis.
- The goal is not just to determine a needed level of care to which the individual should be referred, but to

Resolve the situation so a higher level of care is not necessary.

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TIP: **PICS has a Verbal De-escalation 101 webinar available at casatlearning.org**

Stabilization / Verbal De-escalation

- Talk to the person, not the action, when communicating with an individual experiencing a mental health or substance use crisis.
- De-escalation can support and protect everyone involved during the mental health crisis.
- De-escalation can assist in building a positive connection with the individual in crisis, which can aid in their recovery journey.
- De-escalation will not work on every individual. Always attend to your own safety first.

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TIP: **PICS has a Verbal De-escalation 101 webinar available at casatlearning.org**

VERBAL DE-ESCALATION

Safe Space

Ensure the environment is safe: Have team backup and clear the area of potential weapons.

Respect personal space by remaining at least 2 arms lengths away.

Maintain safe body language: Remain calm and keep an open body posture.

Use Simple Language

Be concise, using short sentences and simple language.

Use a calm, low tone of voice.

Speak slowly to be easily understood.

Build a Collaborative Relationship

Listen carefully to understand what provoked the agitation.

Identify the individual's wants and feelings.

Agree as much as possible with the truth, the underlying principle, or the odds.

Provide genuine EMPATHY & VALIDATION throughout the entire intervention.

Do Set Limits

Set limits to ensure safety and maintain a collaborative relationship.

Continue to speak slowly and use simple language.

Inform the individual of potential consequences for crossing boundaries.

Uphold Optimism & Unveil Choices

Provide optimism by offering choices.

Agitation may prevent the individual from "seeing" all their options.

Having choices can be empowering!

Evaluate Effectiveness

Evaluate the ongoing situation to decide if a different intervention is needed.

Mobilize help if necessary.

Debrief with your team to reflect on the outcome of the verbal de-escalation intervention.

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CASAT Center for the Application of Substance Abuse Technologies UNIVERSITY OF NEVADA, RENO

Citation: Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, J., Zeller, S. L., Wilson, M. P., Rifai, M. A., & Ng, A. T. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. The Western Journal of Emergency Medicine, 13(1), 17–25. https://doi.org/10.5811/westjem.2011.9.6864

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https://smchd.org/2018/12/what-is-harm-reduction/

Harm Reduction Strategies

Harm reduction is a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives (Harm Reduction, 2023).

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Harm Reduction Strategies

- **All staff** require training on harm reduction strategies for individuals with substance use disorders.
- **All staff** should be trained on
  - How to use Naloxone in the field
  - How to educate individuals at risk (or their supportive family system) about Naloxone.
  - How to educate individuals about harm reduction techniques and resource.
- DMCTs will be require to carry harm reduction supplies with them, such as Fentanyl test strips, in addition to Naloxone kits.

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Harm Reduction Strategies

- SAMHSA's Opioid Overdose Toolkit for additional training
  - https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Crisis & Safety Planning

Crisis Planning & Follow-up

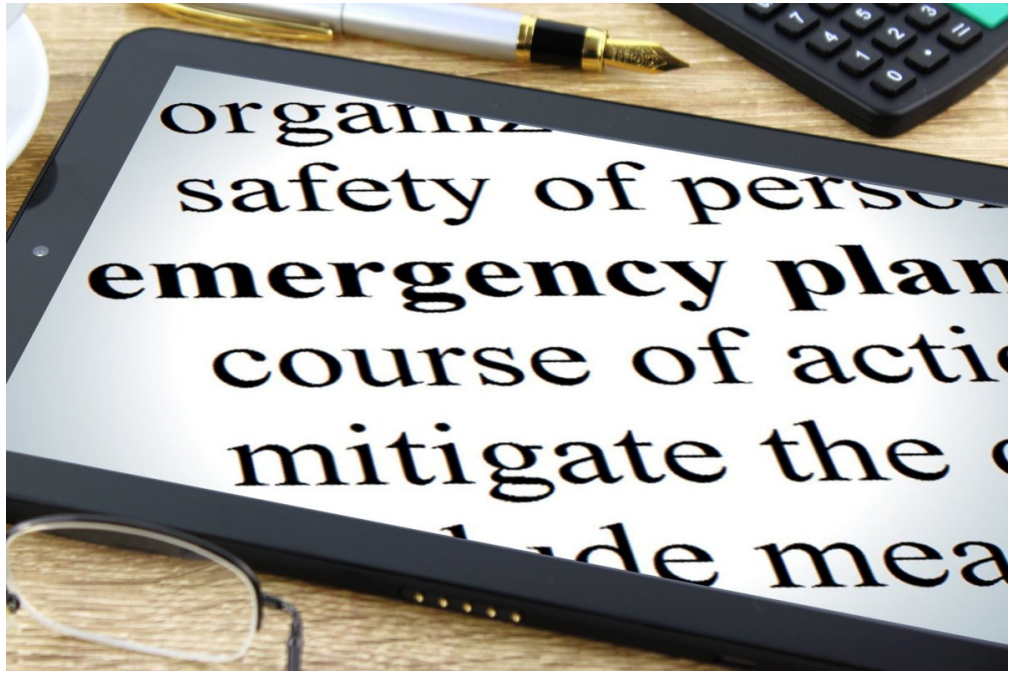
National Guidelines for Crisis Care –
A Best Practice Toolkit

- During a mobile crisis intervention, the Behavioral Health Professional and peer support professional should engage the individual in a crisis planning process; resulting in the creation or update of a range of planning tools including a safety plan.
- When indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Crisis & Safety Planning

- **All staff** require training on Crisis and Safety Planning. however, some interventions may require QMHA -> QMHP staff intervention.
- Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record.
- As part of the crisis and safety planning, DMCTs must **either** complete an assessment indicating individual is able stay in current placement/location **or** coordinate the transfer of the individual to an appropriate higher level of care.
- **Best Practice** is to co-create a safety/crisis plan, when applicable.



PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Zero Suicide / Safer Suicide Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members.*
- *Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services.*
- *Incorporate suicide risk screening, assessment and planning into the crisis provider's practices.*
- *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider.*
- *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

ZERO SUICIDE

https://zerosuicide.edc.org/

Trauma-Informed Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Trauma-informed care is *urgently* important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; *especially those with trauma histories*.

An established resource for further understanding trauma-informed care is provided by **SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57)**. It includes the following guiding principles:

- Safety;
- Trustworthiness and transparency;
- Peer support and mutual self-help;
- Collaboration and mutuality;
- Empowerment, voice and choice; *and*
- Ensuring cultural, historical and gender considerations inform the care provided.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Trauma-Informed Care

National Guidelines for Crisis Care – A Best Practice Toolkit

Implementation Guidance

- *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
- *Apply assessment tools that evaluate the level of trauma experienced by the individual served by the crisis program and create action steps based on those assessments.*

Assessment examples:

- **Life Events Checklist for DSM-5 (LEC-5)**
- **Adverse Childhood Experiences (ACEs)**

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Trauma-Informed Care

- **All staff** require training on Trauma-Informed Care within 90 days of employment.

PICS
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Trauma-Informed Care

CASAT Learning Resources

#1 Trauma Informed Crisis Response for Paraprofessionals Learning Series (8 weeks)

Presenter: Bianca McCall

This training will provide insight for interacting with individuals and communities experiencing a mental health crisis and identifying the appropriate referral resources. Provided is an overview of Trauma Informed Care (TIC), the different types of traumas, and the continuum of mental, emotional, behavioral, and cognitive trauma reactions after a crisis.

- Will satisfy the PRSS Crisis Endorsement Training requirement.
- The series runs from Sept 27-Nov 15
- 25 CEUs

https://www.casatlearning.org/component/eventbooking/webinars/tic-parapro-event?Itemid=762

#2 ACES/Trauma Informed Care webinar

Presenter: Fabricia Prado - master trainer for ACE Interface

https://www.aceinterface.com/

Event details TBA, but likely to occur in October or November 2023

Check casatlearning.org for more details

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Privacy & Confidentiality

- **All Staff** need to be trained on Privacy and Confidentiality.

- There are Federal and State Regulations on Confidentiality.
  - Federal Regulations include 42 C.F.R. Part 2 and 45 C.F.R. Parts 160, 162, and 164 (HIPAA).
  - State Regulations may include those found Chapter 629 of NRS and Medicaid Policy. If you belong to a state certifying or licensing board, your professional code of ethics may also be codified into state law (e.g. NAC 641A.252, Code of Ethics for MFT & CPC).

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Privacy & Confidentiality

42 C.F.R. Part 2

Are you a Part 2 Program?

- Do you receive funding related to SUD services?
- Do you receive federal assistance in any form?

If Yes to the above, then the following applies:

- Valid consent signed by the client
- Business Associative Agreement and/or Qualified Services Agreement

PICS
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Privacy & Confidentiality

42 C.F.R. Part 2

Continued:

- Exceptions to the general rule:
  - Internal Communications
  - Medical Emergency (mobile crisis would apply)
  - Reporting Child Abuse and Neglect
  - Reporting to Law Enforcement related to crimes (limitations apply)
  - Research
  - Vital Statistics
  - Valid Court Order (Subpoena in and of itself are not sufficient)

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Privacy & Confidentiality

HIPAA 45 C.F.R. Parts 160, 162, and 164

Are you a Health Insurance Portability and Accountability ACT (HIPAA) Program?

Two Questions:

- Are you a healthcare provider?
- Do you transmit client Patient Protected Health Information (PHI) electronically?

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Privacy & Confidentiality

State Laws and Mandated Reporting

How do you comply with Part 2 and HIPAA related to limitation on reporting serious crimes or threats of serious crimes?

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Privacy & Confidentiality

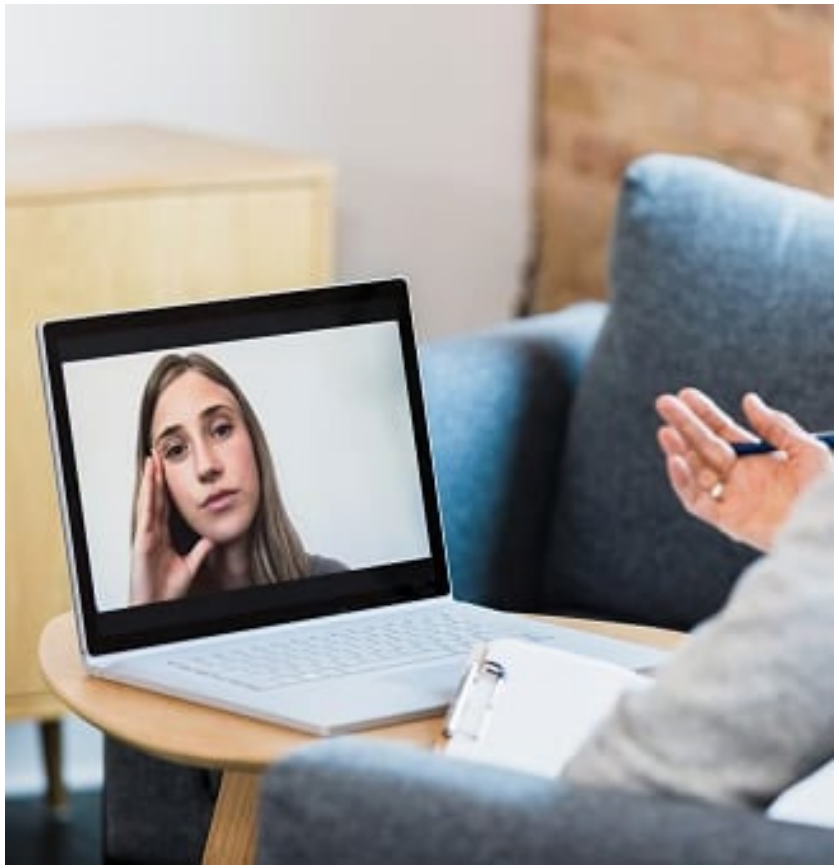
Mobile Crisis

How do you comply with Part 2 and HIPAA on deployment with Mobile Crisis?

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Use of Telehealth Equipment

- **All Staff** need to be trained on the use of Telehealth Equipment.
- Telehealth Practices:
  - Policies
  - Confidentiality
  - Location of the client
  - Verifying client and clinician
  - Appropriateness of platform for the client
  - Informed consent
  - How to manage emergencies
  - Ethical practices
  - Service documentation



PICS
PATHWAYS IN CRISIS SERVICES PROJECT

EHR / Documentation / Reporting

All Staff need to be trained on the Electronic Health Record protocols or other systems used in the provision, documentation, and/or reporting of mobile crisis services.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

EHR / Documentation / Reporting

- Electronic Record Management
  - HIPAA compliant platform
  - 2 step password protection
  - Security of devices when not in use
  - When and where to utilize devices
  - What happens if device(s) is lost or stolen?

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

EHR / Documentation / Reporting

- DMCTs shall maintain a daily log of all DMCT responses, as dispatched by a crisis call center and self-dispatched, within and outside of catchment area. Log will be made available to DHHS upon request. The log will include up to and including.
    1. HIPAA compliant identifier for the individual crisis response episode, and
    2. Date of crisis response episode, and
    3. Start and end time of crisis response episode (for the recipient on that day), and
    4. Mechanism of response (dispatch), and
    5. Name and credentials of all team members involved in response and supervising QMHP-level Independently Licensed provider.

PICS
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EHR / Documentation / Reporting

- DMCTs Medical records shall be kept in accordance with documentation standards set forth in MSM Chapter 100 Section and MSM Chapter 400.
- DMCTs Medical records shall be shared with whomever is providing the services (the follow up provider where the individual is being discharged) to support coordination of care (i.e., triggering words, specific circumstances of individual, etc.). Confidential regulations apply in this practice.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place that require follow up with an individual by phone or in person within 72 hours of engagement with the mobile crisis team. The policy states that follow-up is exempt for individuals admitted to a crisis stabilization center (CSC), inpatient hospital, or residential setting.

Mobile crisis teams have policies and procedures in place to coordinate timely follow-up services and/or referrals with providers, social supports, and other services, as needed, including but not limited to:

- Assigned case managers
- Managed care organizations (MCOs)
- Primary care providers
- Current (or referred) behavioral health providers/care teams, including mental health and SUD providers
- Recovery and peer-led organizations for mental health and SUD support, where available
- Harm reduction resources, where available.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place for follow up due to suicidality, indicating that a member of a mobile crisis team must make at least three attempts to contact the individual to assess continued stabilization.

Mobile crisis teams have policies and procedures in place indicating that this follow-up must be documented in the individual's clinical record.

Mobile teams have policies and procedures in place requiring documentation of an individual's discharge from the crisis episode when the following criteria are met:

- Acute presentation of the crisis is resolved
- Appropriate referral(s) and service engagement to stabilize the crisis are completed, including transfers to a CSC or other level of care
- Recommendations for ongoing services, supports, or linkages have been documented

Post-crisis follow-up has been completed within 72 hours of the crisis contact.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Coordination of Care

Mobile crisis teams have policies and procedures in place regarding the provision of bridge services and supports to individuals for up to 45 days to support continued stabilization until the first appointment with the receiving provider. The policies and procedures outline when this is necessary and clinically appropriate.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Privacy & Confidentiality

Mobile crisis teams have privacy and confidentiality policies and procedures to protect beneficiary information in accordance with federal and State requirements, addressing what can and cannot be shared, especially in emergency situations.

Mobile crisis teams have formal, written, collaborative protocols, memorandums of understanding (MOUs) and other agreements with the following partners:

- Local law enforcement agencies
- Local emergency medical service providers
- 988 call centers/dispatch centers and other crisis providers

Medicaid MCOs, as applicable in their catchment area

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Services – Privacy & Confidentiality

Mobile crisis teams have protocols in place that allow family members or other collateral contacts to represent an individual in crisis.

Mobile crisis teams have established data-sharing agreements with the partners listed above.

Mobile crisis providers have policies and procedures in place to ensure these partners are securing any data covered by federal or State privacy regulations.

Mobile crisis teams have established data-sharing protocols and member information release authorization with other behavioral health and medical providers, allowing access to and review of screenings, assessments, crisis plans, and/or PADs and other medical records/treatment information that will support crisis intervention activities.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place indicating that mobile crisis services are available 24/7/365 and ensure 24/7 on-call coverage and back-up availability.

Mobile crisis teams have policies and procedures in place, indicating that mobile crisis services shall not be restricted to certain locations or days/times within the covered area.

Mobile crisis teams have policies and procedures in place, indicating that mobile crisis services are provided to all Nevadans in the provider's catchment area, including specialty populations. The individual served does not have to be a current or previously established client to receive mobile crisis services.

Mobile crisis teams have continuity of operations/disaster plans developed, regularly updated, and submitted annually, or as requested by the state.

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place outlining response requirements:

- Teams respond to wherever the recipient is in the community, including private homes, schools, group homes, social service settings, etc.
- Individuals in crisis are never required to come to the crisis team
- Teams respond to the preferred location based on client and/or caregiver preference
- Teams respond with the least restrictive means possible, only involving public safety personnel when necessary

Teams prioritize community-based response; however, may respond to facilities

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PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis service providers have policies and procedures to ensure services are delivered in a manner that is culturally and linguistically appropriate.

Mobile crisis teams have policies and procedures in place to ensure individuals with limited English proficiency or language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and Americans with Disabilities Act-compliant services (e.g., sign language interpreters, TTY lines).

Mobile crisis teams have policies and procedures in place to ensure that all written materials meet cultural and linguistic appropriateness standards.

Mobile crisis teams have policies and procedures in place to ensure that services provided to children and youth up to 18 years old must adhere to the Department of Health and Human Services, Division of Child and Family Services system of care core values and guiding principles.

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis services are provided timely to individuals in a behavioral health crisis, as defined by State policy, regulations, and/or guidance.

Mobile crisis teams have policies and procedures in place indicating that designated mobile crisis teams (DMCTs) will be dispatched through designated call center(s).

Mobile crisis teams have GPS devices linked to the designated call center(s) and a means of direct communication, such as a cellular phone or radio for dispatch, available at all times.

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place, indicating that teams may not refuse a request for dispatch unless safety considerations warrant involvement of public safety:

- When public safety is involved, the policies and procedures include standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, and medical emergency, imminent risk of harm)
- Policies appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history)
- Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis while recognizing the need to maintain safety

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*Proposed criteria – not finalized at time of webinar

*DMCT Criteria: Access

Mobile crisis teams have policies and procedures in place, indicating how they will use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., access to health information technology, prior treatment information, including crisis and safety plans, hospital/provider bed availability, appointment availability/scheduling)

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PATHWAYS IN CRISIS SERVICES PROJECT

*Proposed criteria – not finalized at time of webinar

Continuous Quality Improvement

- Framework for Developing Performance Measures:
  - Timely
  - Safe
  - Accessible
  - Least Restrictive
  - Effective
  - Consumer and Family Centered
  - Partnership

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Continuous Quality Improvement Continued

- Model for CQI Plan
  - Policy
  - Training
  - Monitoring
  - Follow up TA and Training
  - Continuous

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The End, Thank You!

Questions & Answers

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Mercer, (2023) Executive Report, Mobile Crisis Intervention Service in Nevada

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(Nelis; 2021) Nevada Senate Bill 390, Crisis Response Account – 988 Crisis Services Sections 2-6 (NRS 433)

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Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

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Digital Resources

National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit

https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Peer Support Services in Crisis Care – SAMHSA Advisory June 2022

https://store.samhsa.gov/product/advisory-peer-support-services-crisis-care

Medicaid Service Manual Chapter 400

https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C400/Chapter400/

Collaborative Assessment and Management of Suicidality (CAMS)

https://cams-care.com/about-cams/

PICS
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Digital Resources Continued

Columbia-Suicide Severity Rating Scale (C-SSRS) or “Columbia”

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

Ask Suicide-Screening Questions (ASQ)

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

C-SSRS & SAFE-T Protocol Combo

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.healthcare.english

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Digital Resources Continued

- PHQ-9 (PHQ-A) & ASQ Combo
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- 988 Resources
  - https://988lifeline.org/
- 2022 National Survey on LGBTQ Youth Mental Health
  - https://www.thetrevorproject.org/survey-2022/
- PHQ Screeners (Multiple Languages)
  - https://www.phqscreeners.com/
- Verbal De-Escalation 101: Self-Paced Webinar
  - https://www.casatlearning.org/component/eventbooking/self-paced/verbal-de-escalation-101-self-paced-online?Itemid=762

PICS
PATHWAYS IN CRISIS SERVICES PROJECT

Digital Resources Continued

- Harm Reduction Strategies – SAMHSA
  - https://www.samhsa.gov/find-help/harm-reduction
- SAMHSA's Opioid Overdose Toolkit
  - https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf
- SAMHSA Trauma-Informed Care in Behavioral Health Services (TIP 57)
  - https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
- Trauma-Informed Crisis Response for Paraprofessionals (8 week learning series)
  - https://www.casatlearning.org/component/eventbooking/webinars/tic-parapro-event?Itemid=762
- Zero Suicide safety planning template
  - https://zerosuicide.edc.org/resources/resource-database/patient-safety-plan-template

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CASAT

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