Strengthening our region's crisis response system

Community mental health center leaders and partners have compiled findings outlining a shared approach to launching 988 across Missouri counties in the Kansas City region. These findings are the result of a six-month, community-led process to identify mental health crisis hotline best practices, opportunities for improvement and ideas to collaborate for a better future in mental health response.

July 15, 2022

There is hope.

988
SUICIDE
& CRISIS
LIFELINE

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A Shared Approach to Launching 988 Across Kansas City, Missouri, Community Mental Health Centers

Executive Summary

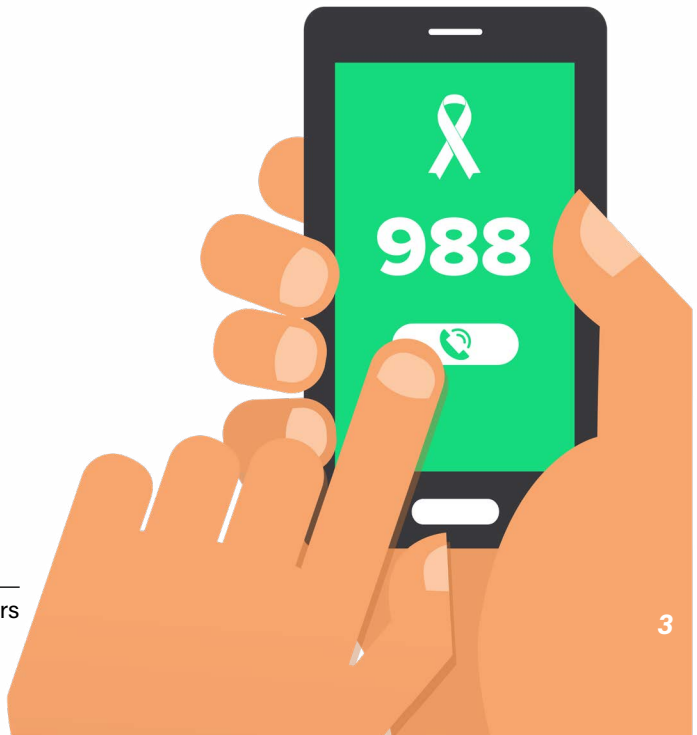
People accessing emergency mental health services in the Kansas City, Missouri, region would benefit from a more collaborative ecosystem. Community mental health centers can shift their approach from isolated, individual operations to a joint system of care where centers collaborate, pool resources, share information and create efficiencies.

In July 2020, a plan formed that shifted how people would access emergency mental health services in the future. The Federal Communications Commission adopted rules designating 988 as the new phone number for people experiencing a mental health crisis in the United States to access services. The new resource is meant to connect people with suicide prevention and mental health crisis counselors. Beginning on July 16, 2022, phone service providers will direct all 988 calls to the existing National Suicide Prevention Lifeline (NSPL).

Kansas City regional community mental health centers sought a collaborative process to determine how the area could effectively adapt to the new 988 system. Six community mental health centers and CommCARE, one of Missouri's NSPL operators, began conversations with public safety leaders, police departments, emergency services and the Mid-America Regional Council (MARC). The goal was to reduce economic inefficiencies, help with the overburdened police and emergency service systems, connect people with mental health needs to mental health professionals, and develop a plan for how the region could work together to create the best comprehensive 988 system.

Community mental health centers in Missouri counties in the Kansas City region[1] worked together for six months in a process facilitated by MARC and with feedback from community leaders representing law enforcement, emergency services, medical professionals, educators and people with lived experiences. Additionally, the steering committee coordinated with the Missouri Department of Mental Health to gather information and share feedback from the group back to the state level. The chair of the statewide 988 implementation effort served on the Kansas City region steering committee to help with state guidance and planning. The process was designed to ensure community members had input into how 988 could operate most effectively in the Kansas City area.

From the community mental health centers' deep knowledge of the field and with their collaborative spirit, they produced important recommendations and generated ideas that are highlighted in this report. A few of the highest leverage recommendations require ongoing, sustained coordinated work as a cohort. The report's recommendations focus on 988 calls and mobile response coordination. However, that is not representative of the holistic continuum of care that community mental health centers provide for clients and there is more work to do ensuring that clients receive excellent care from their first call through follow-up and ongoing services.



[1] In this report, reference to Kansas City community mental health centers will be referring to the community mental health centers in Missouri counties in the Kansas City region unless otherwise noted.

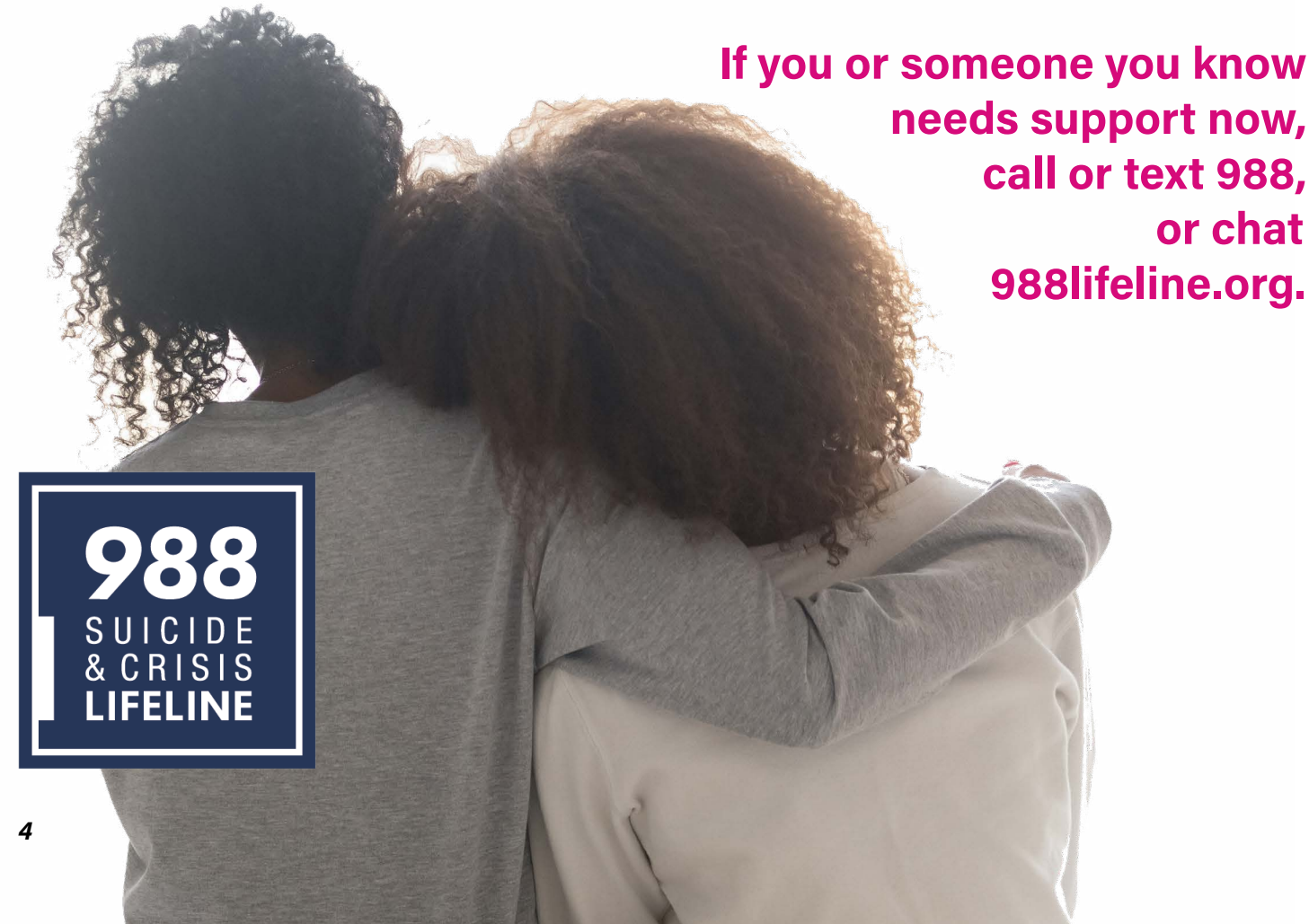
If the group maintains a partnership, some of the ideas for joint 988 implementation are:

- Develop standard definitions, protocols, and operating procedures for mobile response units using guidelines in this report as a starting place
- Develop a shared staff model for mobile response that coordinates not just among the six community mental health centers in the region, but also with law enforcement and emergency medical services serving that area
- Co-locate 988 calltakers within 911 public safety answering points (PSAPs) or introducing a warm, consent-based transfer policy between 911 and 988
- Implement a collective mental health information exchange system so shared patient data could be accessed by all appropriate care providers
- Create metrics and goals surrounding joint operations

The largest barriers for working together are:

- Funding
- Workforce shortages
- Complexity of pooling resources and collaborating in an ongoing manner across independent organizations with differing service boundaries
- Variance from long standing practices

This report represents the findings from a collaborative, people-centered process that took place from January 2022 to June 2022. The report summarizes best practices, ideas and research that the MARC team collected through focus groups, data analysis, one-on-one meetings, and steering group meetings. There is a broader continuum of care, beyond 988 and joint mobile response, that deserves attention. There is more improvement necessary to make a holistic, strong system of care for people struggling with mental health problems. This report does narrow the focus to implementation of 988 and the priority of mobile response units.



If you or someone you know needs support now, call or text 988, or chat 988lifeline.org.

The recommendations outlined in this report are a shift from the status quo. The shift moves from individual organizations operating with their own systems to as many as six individual entities adopting common practices and coordinating with external entities, such as law enforcement and emergency medical services. The reality that the shift is even named in the report demonstrates the collegial and collaborative nature of these leaders and their dedication to the mission of supporting people experiencing mental health crises.

Process

In December 2021, local community mental health centers approached MARC with a need to convene and collaborate in preparation of the launch of 988 set to take place in July 2022.

MARC outlined a strategic planning process with the six local community mental health centers that serve the Missouri side of the greater Kansas City region including the counties of Cass, Clay, Jackson, Platte and Ray. The steering committee also included CommCARE, the National Suicide Prevention Lifeline operator, for five of the six community mental health centers.[2]

Throughout the process, technical advisors from organizations that interface with the mental health community (law enforcement, funders, non-profits, etc.) gave their opinions, feedback and ideas to help generate the recommendations outlined in this report. People with lived mental health crisis experience and their family members were invaluable in identifying gaps in the current system and how to move toward a 988 model that would best meet their needs in the future.

The main elements of the strategic planning process included:

- ☐ Monthly steering committee meetings
- ☐ Election of a steering chair
- ☐ One-on-one interviews with the six participating community mental health center CEOs and their designees
- ☐ Nine focus groups with external community members
- ☐ Research and data collection
  - Best practices in mental health crisis response
  - Regional models and resources
  - Regional mental health call data
  - 911 trends
- ☐ Facilitated meetings to discuss best practices and next steps

The one-on-one interviews with community mental health center CEOs and their designees focused on four main topics: how their organization best supports people experiencing a mental health crisis; the biggest areas for improvement that they see; the current process for handling mobile crisis response; and their goals for the launch of 988. The recordings, notes and analyses from those meetings were highlighted in steering committee meetings and incorporated into the information leading to report recommendations.

The focus groups' intention was to get different perspectives from external, but tangential organizations on how the current mental health crisis systems work or do not work for people experiencing a mental health crisis. Eight different categories/industries participated in answering semi-structured interview questions. A ninth focus group of people who had lived experiences accessing a suicide prevention hotline shared their personal experiences in a less structured format. The findings are included in Appendix E and incorporated into the report recommendations.

Steering committee members represented leaders from the following organizations:

- Compass Health Network
- Comprehensive Mental Health Services (CMHS)
- ReDiscover
- Swope Health Services
- Tri-County Mental Health Services
- University Health Center Behavioral Health
- CommCARE

[2]See Appendix A - Memorandum of Understanding among MARC and Missouri Community Mental Health Centers

Other leaders supported the steering committee as technical advisors to represent various law enforcement agencies, emergency medical services, non-profits and entities that support people in a mental health crisis.

This work was completed with generous support and guidance from:

Health Forward FOUNDATION

REACH healthcare foundation

This report highlights the current state of mental health crisis care and the recommendations found through the collaborative, community-driven process described above. The report is structured to address the main goals the steering committee established at the beginning of the project.

Statement of Purpose: The CMHC's desire to work together to address the following:

1. What can we do to be as prepared as possible for the 988 implementation in July 2022?
2. What is the ideal crisis response system for the greater Kansas City region in Missouri?
3. Are there ideas we could pilot on a smaller scale before implementing region wide?
4. What works well in the current crisis response system that we can build upon to reach the ideal system?
5. What barriers and gaps must we overcome to achieve the ideal system?
6. How can we fill gaps and move toward the ideal system?

Current State

To assess the current operations, protocols and landscape for mental health crisis response, MARC conducted individual interviews with six community mental health center leadership teams.[3] The findings related to the current operations reflect the varied and inconsistent approach between centers, as well as lack of consistent execution in physical mobile response units.

Receiving and Responding to Mental Health Calls for Service

There is a variety of approaches to mobile response in the Kansas City region. While some teams have 24/7 direct staffing, some agencies reported very low mobile response utilization.

A majority of the centers (five of the six agencies) utilize CommCARE for suicide hotline calls. Some agencies accept their own calls during regular working hours and only rely on CommCARE for after-hours triage and referrals. Compass Health manages its own call center.

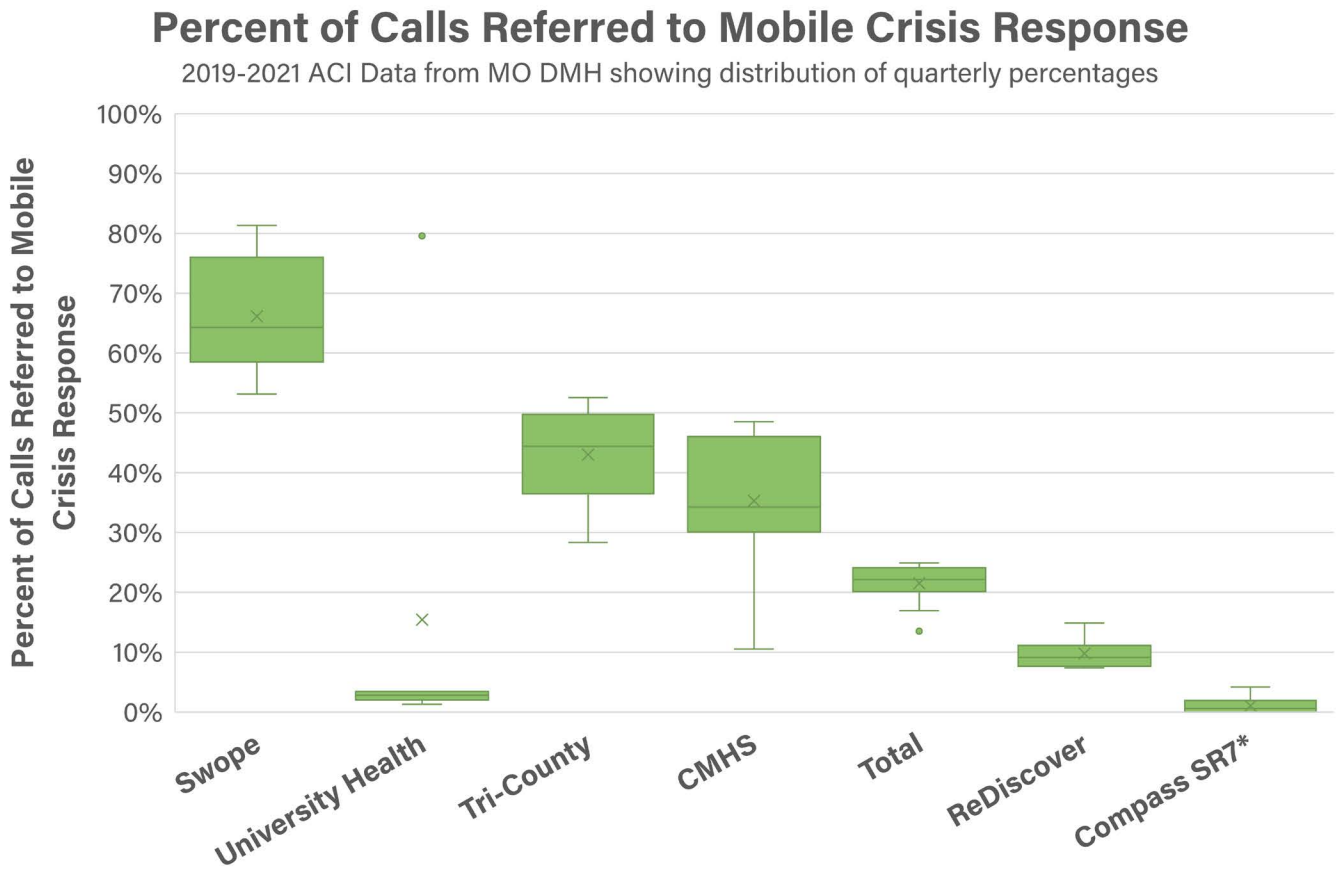
There is also variety in mobile response protocols to which each agency adheres.

Mobile Response Protocols

Each community mental health center has its own protocols and procedures for how to dispatch and handle mobile crisis response. While most of the centers have clear protocols for mobile response dispatch, the mobile crisis response does not take place with fidelity at each center. The average percentage of calls referred to mobile crisis for all community mental health centers combined over the three-year period was 27.45% for the Kansas City region. 18% of crisis calls (centers combined) in 2021 were referred to mobile crisis response teams. In the state of Missouri in 2021, 10% of crisis calls were referred to mobile crisis teams.

[3] See Appendix C - Phase 1 Interviews with Community Mental Health Centers Summary Report

The chart below shows the distribution of percentages by center over the past three years, with each quarter representing a discrete percentage. Swope had the highest average percent at 66.12%, but this number may be misleading due to how data is collected and reported.[4] Compass Service Region 7 had the lowest at 1.02%.



*Compass Service Region 7 is representative of Lafayette, Johnson, and Cass counties.

There are a variety of reasons why mobile response into the community does not happen (workforce, funding, safety concerns, etc.), even if protocol dictates that it should. There is not a commonly adopted definition for different states of crisis between centers, resulting in the calls getting coded and handled differently by each center.

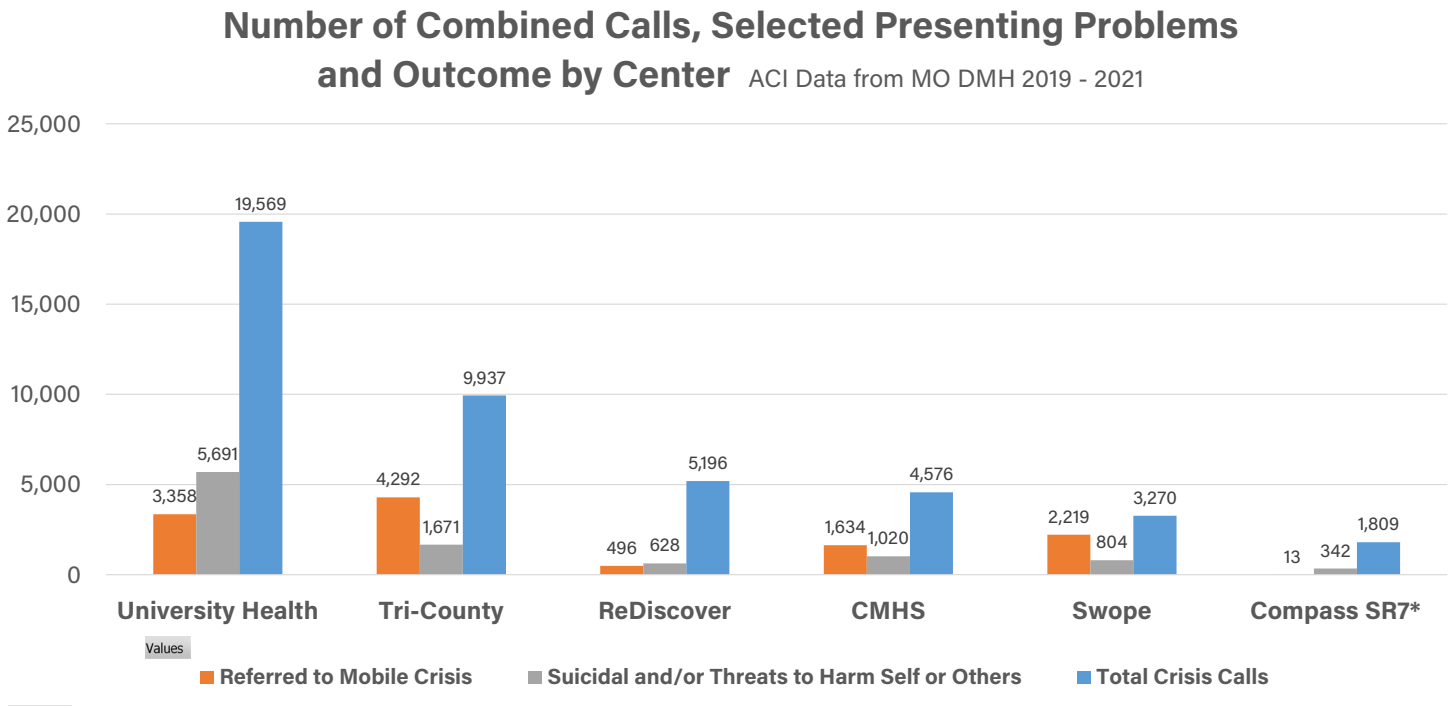
For example, mobile response calls might get coded as such, even if it gets routed to an emergency room referral instead of dispatching a mobile response team. For some of these centers, if a call comes in after hours and someone needs to be screened or needs mobile crisis response, the staff would direct the person to go to the emergency room.

So instead of paging mobile crisis for a community response, the crisis line staff would either refer the person to the emergency room and/or explore other call resolutions. This would impact the number of calls reported under the category of "mobile response" and validates the need for commonly adopted definitions for coding.

One potential indication there is a difference in reporting and operating habits is that there is not a direct correlation between the number of calls that would indicate the need for mobile response (client indicates they are currently suicidal, expressing harm or threats of harm to self or others) and the number of calls referred to mobile response.

[4] All crisis calls to Swope are routed to the crisis team, regardless of level of need. Staff estimates that less than 1% of the calls reported in the chart resulted in mobile crisis response that was deployed out in the community outside of a Swope clinic.

The graph below indicates the six centers and variety in the three categories: referred to mobile crisis, suicidal and/or threats to harm self/others, and total crisis calls. Between 2019 and 2021, there were 44,357 total crisis calls to the six centers.



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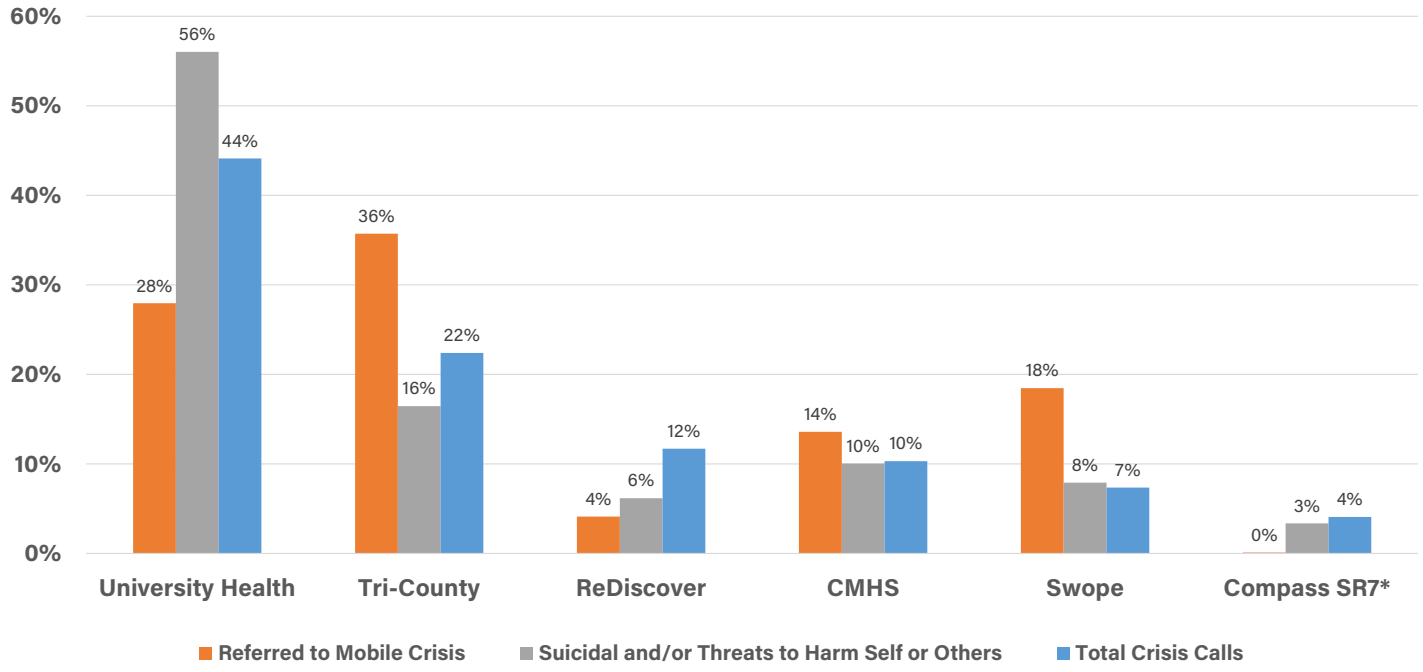
One could hypothesize that the percentage of the region's calls of specific presenting problems received by a single center (# X presenting problem received by center Y / # X presenting problem received by all centers) would mirror the percentage of all crisis calls received by a center (# Y center's calls / sum of all centers calls). However, this is not true for the ACI data received by Missouri Department of Mental Health (DMH) for 2019-2021.

The chart on the top of the next page shows that Tri-County handled more of the region's mobile response referrals than any other center at 35.73%, despite receiving only 22.40% of the total crisis calls in the region. Further investigation is required to understand why the numbers are not proportionate. Potential reasons include: different population needs in different regions/ catchment zones served by community mental health centers, differences in coding, definitions, and reporting, or differences in call response practices. However, there is clearly a difference in number of calls received and number of mobile crisis units dispatched across the region.

While the current landscape has room for improvement and room for better coordination between centers, it is important to highlight existing best practices as outlined by community mental health centers and community members, and look for opportunities to expand those practices.

Distribution of Combined Calls, Selected Presenting Problems and Outcome ACI Data from MO DMH 2019 - 2021



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Priorities to Improve and Best Practices to Continue

Through the interviews, focus groups and steering meetings, participants acknowledged the current system has elements that need to improve and elements that should continue.

Practices to Continue:

- Current staff is dedicated and skilled
- Use of peer specialists, trained people with lived mental health experiences who successfully accessed resources and can mentor others with similar struggles
- CommCARE provides strong support
- Police departments coordinate with mental health clinicians
- Offering Crisis Intervention Team (CIT) training from the Mid-America Crisis Intervention Team (MACIT), the CIT council serving our region through coordination among first responders and behavioral health resources
- Use of telehealth services in rural areas
- Sustaining strong respect and relationships among community mental health centers

Elements to Improve:

- Adjusting hiring models to recruit and hire more staff due to lack of qualified candidates
- Clear safety systems for how to keep staff and clients safe on mobile response teams
- Lack of crisis care bed availability
- Specialized mental health resources (ex. for youth)
- Lack of common definition and adoption of mobile response practices and protocols in use by community mental health agencies throughout the region

The topics listed as practices to continue and elements to improve are further incorporated in the remaining sections of the report.

988 SUICIDE & CRISIS LIFELINE

Findings and Recommendations for Kansas City, Missouri, 988 Implementation

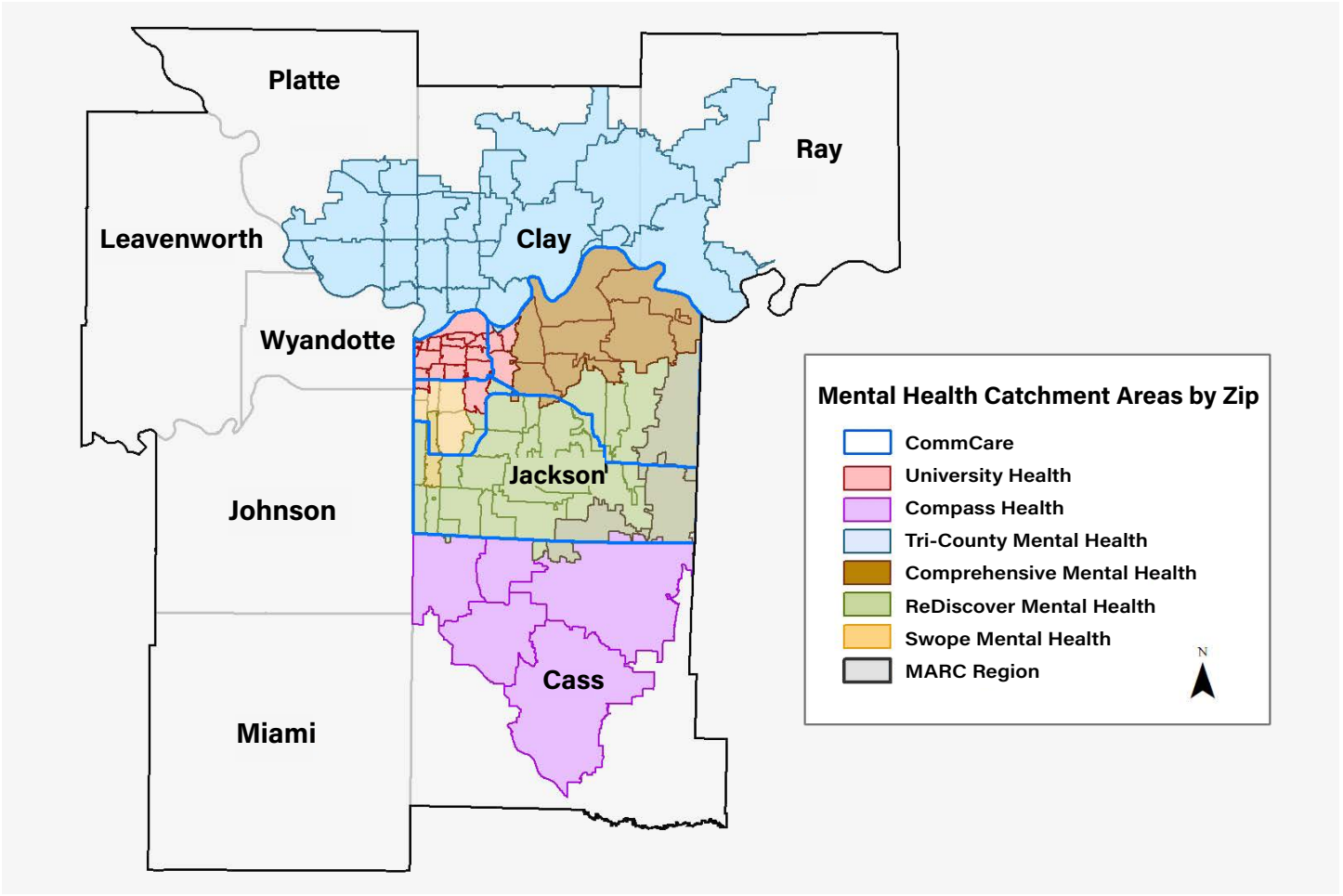
Steering committee members identified core elements they wanted to incorporate into a desired state of 988 implementation. A priority among the committee members was that 988 should have a collective, collaborative response to both crisis calls and mobile response. This is a fundamental shift from current operations.

Currently centers operate with their own staff, protocols, and systems and without fidelity to mobile response dispatch protocols. They are currently required to provide mobile response, but as the interviews and data demonstrated, service delivery is inconsistent across the region.

The Department of Mental Health is working to provide guidance to CMHCs on the new 988 mobile response process, so this is a good opportunity to rethink the process. The success of 988 in Kansas City will be influenced by how well the centers can collectively organize a mobile response system.

The collective response would move toward a shared resource of mobile response units that are on-call covering the entire catchment areas of the six partnering community mental health centers. The community response system would still follow the catchment zone boundaries for follow-up services based on where the person in crisis lived or worked. But the collective response would allow for easier shared information and consistent practices for all people who work with the providers and receive help from the providers.

The recommendations section of this report answers the six questions on which the steering committee aligned at the beginning of the engagement.



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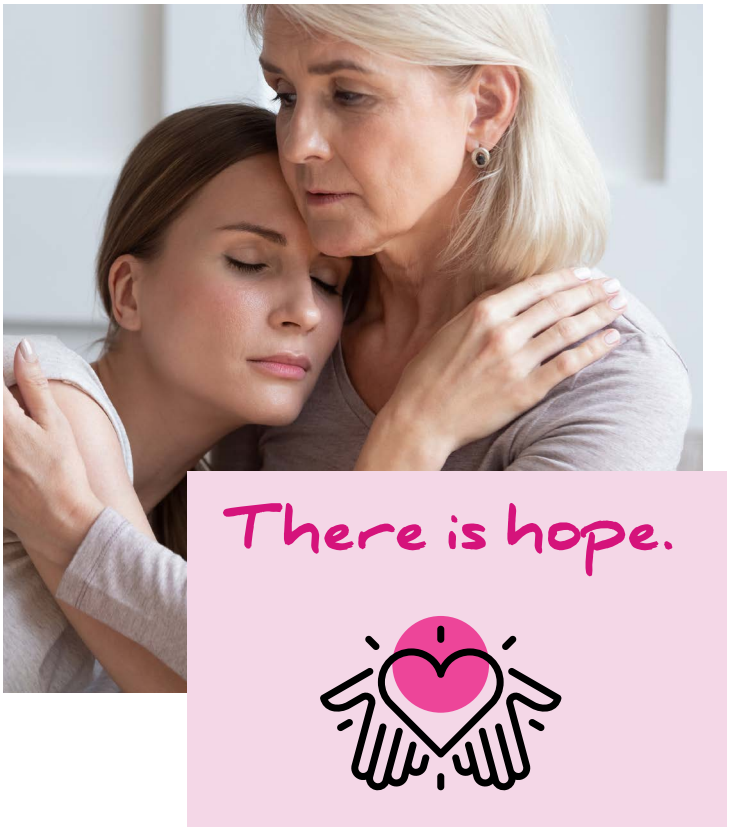


At a high level, the steering committee agreed that the Substance Abuse and Mental Health Services Administration (SAMHSA) offered best practices that they would adopt.[5] The first step in accomplishing these collective goals would be to continue engaging as a collective, rather than individual organizations working on separate plans to accomplish crisis response systems.

This report regularly mentions joint mobile response and resource allocation opportunities and those ideas are further detailed under Question 2.

1) What can we do to be as prepared as possible for the 988 implementation in July 2022?

The steering committee, with input from community members, developed a few key priorities for 988 implementation in the Kansas City, Missouri, region. The first recommendation for a sustained coordinating body would ensure that the timeline and action items listed below could occur. Without a sustained coordinating body, collaboration at a high and institutional level is unlikely to continue.

Formalize a Sustained Coordinating Body

In order to allow for collaboration across organizations and ensure that people who access 988 are best served, the steering committee recommends that the community mental health centers form a 988 sustained coordinating body of leaders.

This 988 sustained coordinating body of leaders should meet on an agreed upon schedule (monthly to start, quarterly once policies and procedures in place) with the following objectives:

- Define operating policies and procedures and align practices
- Schedule collective mobile response units
- Find solutions to challenges that arise from mobile response
- Review data collected from CommCARE and mobile response units to determine resource allocation
- Conduct simulations to replicate mental health crisis situations and align practices
- Share best practices

[5] National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration

Plan for Next Phase of Steering Committee Work

The steering committee and technical advisors outlined sequenced priorities for a collaborative, comprehensive 988 launch and mobile response coordination. Here are the recommended actions for the next phase of steering committee work:

1. Report findings to stakeholders
2. Establish new agreement among the six participating community mental health centers and CommCARE to continue planning and implementation work. Discuss adding additional steering committee members.
3. Begin new phase of monthly steering committee meetings to establish goals and metrics, such as:

   What to Track and Measure

   - Number of calls
   - Number of calls that qualify as a mental health crisis
   - Number of calls resolved before dispatching services
   - Number of calls transferred to 911
   - Number of calls where mobile dispatch is dispatched
   - Dispatch time
   - Number of mobile response units deployed/self-deployed to ER
   - Answer rate
   - Call abandonment rate
   - Average speed to answer

4. Design collective mobile response process (staffing, transportation, communication) and create a detailed budget for future collective costs
5. Design structure for how collective funds will work (who will host them, how much does each community mental health center pay into it, what do they receive because of it)
6. Create plans for collective data sharing and data collection between organizations
7. Create project plans for the collective ideas and priorities listed below

As the steering committee continues this collective planning and implementation work, there are four identified areas on which to focus: communication/coordination, workforce shortages, resource allocation and safety. This report outlines the ideas generated by the steering committee by category and recommends the steering committee create project plans for each idea presented.

Possible Steering Committee 988 Collective Planning and Implementation Action Items

Communication and Coordination:

The committee should determine how the community mental health centers and the auxiliary partners (police departments, emergency services, etc.) can share information internally and externally about 988 and to make 988 function efficiently across institutions.

- Communicate with stakeholders to build understanding about the shared standard procedure for mobile response throughout the region's community mental health centers to ensure shared expectations on client experience/intake.
- Create a call assessment matrix for routing 911 mental health calls to 988 for services (route them according to routine, urgent and emergency needs).
- Work with 911 public safety answering points (PSAPs) to create referral connection and transfer protocols between 988 and 911 (software, staff training, joint regional coordination between police departments). Explore the viability of co-location of 988 calltakers within 911 PSAPs to facilitate coordination.
- Coordinate with the national media campaign in late 2022 to align 988 messaging on both sides of the state line given a regional media market.
- Educate and inform law enforcement, local

non-profits, hospitals and school districts on 988 mission and procedures.

- Develop coordination plan for 988 texting capability between the state of Missouri and Kansas City regional community mental health centers (addressing cybersecurity and HIPAA).
- Develop a communication and coordination plan with the state to ensure the region is adopting state guidelines as the minimum standard of care and building additional support upon it (standards for safety, assessment, reimbursement, response time, staff training).
- Create a sustained coordinating body to continue the steering committee's work.
- Create a communication tool for sharing resources, funding opportunities, best practices, training and non-confidential information.
- Develop collective measurements of success for the region.

Workforce Shortages: This category is focused on the challenge of workforce shortages in the mental health profession. The hiring challenges were consistently named as the top priority and problem in interviews, focus groups and steering committee meetings.

- Develop a semester-long internship program from a degree-seeking and job shadowing program that rotates throughout the community mental health centers.
- Support the certification process for peer specialists.
- Develop a training program that provides candidates with exposure to the field and coordinates with emergency medical services/ paramedics to help triage patients.
- Create job shadowing or similar opportunities for career exposure.
- Customize training for nurses involved in mobile response units.

Resources for an Ideal Crisis System:

This category focuses on the second largest challenge that community mental health centers identified – resources. A critical element is how the community mental health centers could secure more funding by focusing on strategies that view people and systems as resources that enhance the mental health crisis care system.

- Utilize a coordinated funding approach and collective grant applications.
- Increase workforce to handle higher call volume, which needs resources (see above).
- Develop enhanced and coordinated data collection system.
- Update training for staff that are providing services both on the phone and through in-person mobile crisis.

Safety: This category focuses on safety as an essential priority for all people involved in the mental health crisis solution (police, emergency services, counselors, mobile response units, peer specialists, people experiencing crisis, etc.). In order to launch mobile crisis response well, safety must be a key priority and can be done in a coordinated fashion.

- Create standard training for mobile response units that involve de-escalation training, diversity/equity/inclusion training and emergency dispatch system training (ex. For ProQA).
- Work with area Crisis Intervention Team (CIT) telecommunications training to incorporate 988 for communications specialists and law enforcement.
- Recommend annual certification trainings for staff on safety, mental health and substance use, and diversity/equity/inclusion training.
- Develop a standardized uniform/vehicle protocol for 988 mobile responders and law enforcement on scene, such as no vests, use plain t-shirts and non-marked vehicles, to reduce stigma and fear.
- Develop and utilize a standardized assessment for dispatchers for scene safety.

These four priorities and action items were the top selected themes from the steering committee. They recognize that it is not an all-encompassing list and there is more work to do. Part of a successful launch will also include how 988 is publicly communicated and shared across the region and state.

Public Communication of 988 Launch

This process was focused on strategic planning for the ideal crisis response system and did not specifically address a marketing plan for public messaging about the launch of 988. There needs to be regional alignment with state and national communication strategy.[6] Since 988 has local, state and national implications, there are many entities that need to work together to share information with community members. The Missouri Department of Mental Health is leading that effort at the state level, and regional plans will support and amplify the state's strategy.

During focus groups, community partners mentioned concerns that this report highlights local, state and national communication efforts to consider. Many focus groups expressed concern that 988 is being marketed as a suicide prevention hotline, since best practice would indicate that the earlier you can intervene in a mental health crisis, the more likely you are going to be able to change the life trajectory. The messaging of whether 988 is a "suicide prevention hotline" or a "mental health crisis hotline" will affect how many people access the resource and at what level of severity.

If it is marketed as a "mental health crisis hotline" there will be an increase in the volume of calls and the cases will include a spectrum of crisis severity. The influx of callers would be high for an already overburdened workforce.

If it is messaged as a "suicide prevention hotline", fewer people may utilize the service. It may reduce the number of people who feel comfortable accessing the resource since people are less likely to identify as a person needing help with suicide and more likely to identify with needing mental health support. And for those that are suicidal, if they already have a plan, they may not call the line if they are far down the planning path. The question is what should 988 focus on in order to reach people in the mental health crisis spectrum, so that the mental health professionals can solve problems before they get to the most extreme stage of crisis.

The public communication in the local region regarding the launch of 988 can align itself with the state and national communication strategy to avoid confusion. As of now, the crisis line has the title "988 Suicide & Crisis Lifeline", which encompasses both suicide and mental health crisis. Since the topic arose in many focus groups, it is worth noting the community's opinion in this report.

This steering committee's recommended sustained coordinating body could meet with the Department of Mental Health on a quarterly basis to discuss topics, such as how 988 is being messaged and how their local community is reacting. Additionally, coordinating with the state would help share the region's progress towards goals and challenges they are facing so that the state and regional service and communication efforts are aligned in an ongoing manner. Given the bistate nature of the Kansas City region and its media market, coordination with outreach on the Kansas side will be important.

2) What is the ideal crisis response system for the greater Kansas City region in Missouri?

The steering committee recommends that the ideal crisis response system for the Kansas City, Missouri, region include, but not be limited to the following five items: shared mobile response dispatch adhering to SAMHSA standards of mobile crisis response; information flow between 911 and 988; standard operating procedures for community mental health centers; standard definitions across the centers; and a central health exchange system.

[6] See Appendix D - Missouri 988 e-newsletter

These recommendations would shift practices from the current model, described as siloed efforts, to meet a region's mental health needs. The current intentions between centers to collaborate are high and the inter-staff relationships are strong, but the new recommendations would require a more intense level of coordination.

Additionally, these recommendations focus on some elements of the continuum of care (988 crisis call, mobile response), but does not include recommendations for the entire continuum (ex. follow-up services and linking people to support after the mobile response). Those practices should be built out in order to include a strong holistic system of care.

Shared Mobile Response Dispatch

The ideal crisis response system for the greater Kansas City region in Missouri is collective and collaborative. Rather than individual community mental health centers conducting their own mobile response, people could better be served and efficiencies created, if the centers coordinated a joint response with shared staffing models and coordination across law enforcement and emergency mental health centers.

The steering committee defined an ideal mobile response team as one that includes:

- Up to five community mental health centers that share enough resources to staff a central unit of on-call mental health professionals
- On-call peer support (ex. five on call at a time, and on-call mobile response team request support based on location of the peer support specialists on call)
- On-call medical support if necessary
- Combined funding between the CMHCs to pay for shared vehicles and communication devices

Additionally, the steering committee agreed to follow the guidelines and protocols outlined by SAMHSA in the "National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit." The steering committee will also monitor state procedures and adhere to those guidelines as a minimum standard of care.

Here are the recommendations that the Kansas City mobile response teams need to adopt to meet the minimum standards outlined in the SAMHSA toolkit:

Mobile crisis teams must include:

☐ Triage/screening

- Determine if police/emergency services are needed and define under what circumstances police/emergency services would be needed

- ☐ Assessment
  - Causes leading to crisis event (substance abuse, psychiatric needs, social needs, etc.)
  - Safety and risk for individuals and others, assessment of suicide risk
  - Resources the person experiencing crisis has (family, connections, therapists, etc.)
  - Recent inpatient hospitalizations or relationships with mental health provider
  - Medications and their compliance with medication regimen
  - Medical history in relation to crisis

- ☐ De-Escalation
  - Goal is to determine what level of care the individual needs and resolve it at appropriate level
- ☐ Peer support
- ☐ Coordination with medical and behavioral health services
  - "These services may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis respite services and therapeutic mentoring)"[7]
- ☐ Crisis planning and follow-up
  - Develop or update a safety plan
  - Follow up with individuals to determine if services were provided in a timely manner and meeting their needs

- ☐ A licensed and/or credentialed clinician
- ☐ 24/7/365 response to any location in the region (may not restrict locations based on location or time of day as long as it falls within the catchment zone)
- ☐ Warm hand-offs, coordinating transportation to facility-based care if situations warrant a transfer

Mobile crisis teams are recommended to:

- ☐ Incorporate peer specialists on mobile crisis team
- ☐ Respond without law enforcement unless there are special circumstances
- ☐ Use real-time GPS technology with region's crisis call center hub which will help track engagement and appropriately located outpatient follow-up scheduling
- ☐ Have access to language line or other translation services

Adhering to the SAMHSA guidelines and using a shared mobile response unit is one of the major changes to mental health crisis response that the steering committee recommends. Another recommendation in coordination between local entities would be how 911 and 988 work together to share information.

Information Flow between 911 and 988

Best practices for 911 and 988 involve either collaboration between PSAPs and 988 call centers and/or a warm information flow between the two entities. A shared database for information to flow between 911, 988, and community mental health centers will allow entities to share important logistic, safety and health related information with the necessary professionals. When transferring calls between 911 and 988, they can operate with a consent to transfer model that allows 911 to transfer non-violent and non-medical emergencies to 988. They can utilize a warm transfer method that avoids getting off the call with the client, which risks the ability to get them back on the line once contact with 988 takes place.

[7] "National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit". Substance Abuse and Mental Health Services Administration, page 21.

Warm transfers and shared databases also benefit the client since it reduces the redundant questions that occur when calls transfer without a shared database and the new entity asks the same questions regarding name, location, health and related topics that the first entity asked. While the benefit of warm transfer between 911 and 988 seems simple, the burden it will reduce from the client is large. One of the biggest recommendations from the focus group of people with lived experiences was about increasing warm call transfers and leading with empathy before logistics. With this recommendation from community members, the steering committee also recognizes the importance of remembering that 911 and 988 have different priorities and operational goals. While 911 is moving urgently to direct resources, 988 is providing direct service delivery. Those goals require different approaches, and it is still possible to provide appropriate service, while also sharing information between organizations.

A larger task for 911 and 988 coordinating would be co-locating the services. It is considered a best practice to co-locate 988 and 911 services since it allows for information sharing, shared protocols, training and feedback models. There are exemplar models that follow this practice. Johnson County, Kansas, is planning on following this model. On the Missouri side, co-locating is possible by having 988 calltakers present at one or more 911 PSAPs. Whether the larger task is co-locating 911 and 988 or conducting warm transfers between the lines, clients benefit from stronger level of coordination.

Another opportunity to increase coordination in the Kansas City mental health field is by introducing standard operating procedures.

Standard Operating Procedures across Community Mental Health Centers

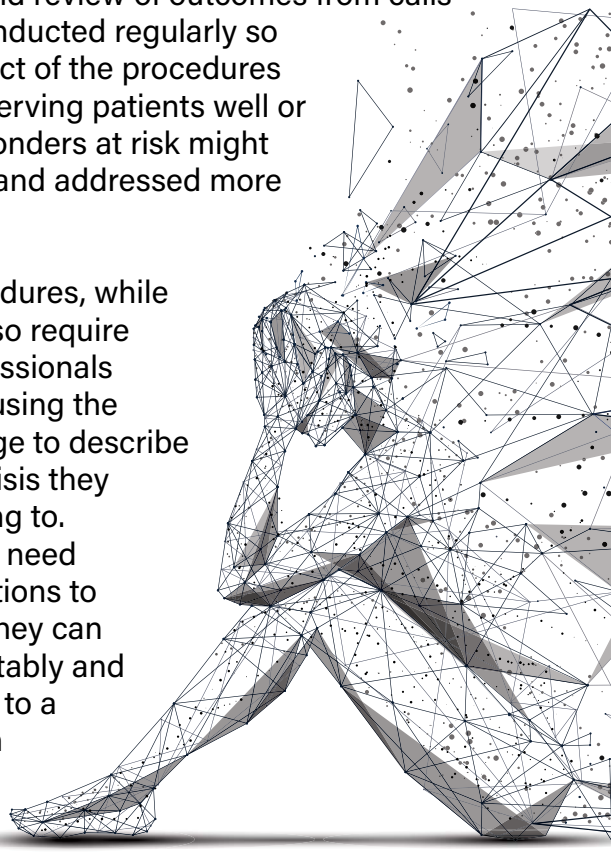
The ideal crisis response model includes standard operating procedures for community mental health centers who respond to 988 calls. If a shared mobile dispatch system is used, the protocol and training for how the staff responds needs to be outlined and agreed upon by the participating community mental health centers.

The recommendation on how to communicate adopted protocols is listed as an action item under "Future Steering Committee 988 Collective Planning and Implementation Ideas" in Question 1 of this report.

As the procedures are being designed, keeping people with lived experiences and clients at the center of the process will be key. They can provide feedback to the systems and procedures so that the mental health professionals and organizations that serve them can ensure that the future clients experiencing mental health crises will be best served.

To ensure that the procedures are meeting the needs of people experiencing a mental health, substance abuse, and/or suicide crisis, as well as the professional community that serve them (community mental health centers, police departments, emergency services, etc.), the procedures should be in action for six months and then go under review. The recommended sustained coordinating body can make necessary changes, provide rationale for shifts and make the procedures public. Although a formal review might take place after six months, ongoing monitoring and review of outcomes from calls should be conducted regularly so that any aspect of the procedures that are not serving patients well or that put responders at risk might be identified and addressed more quickly.

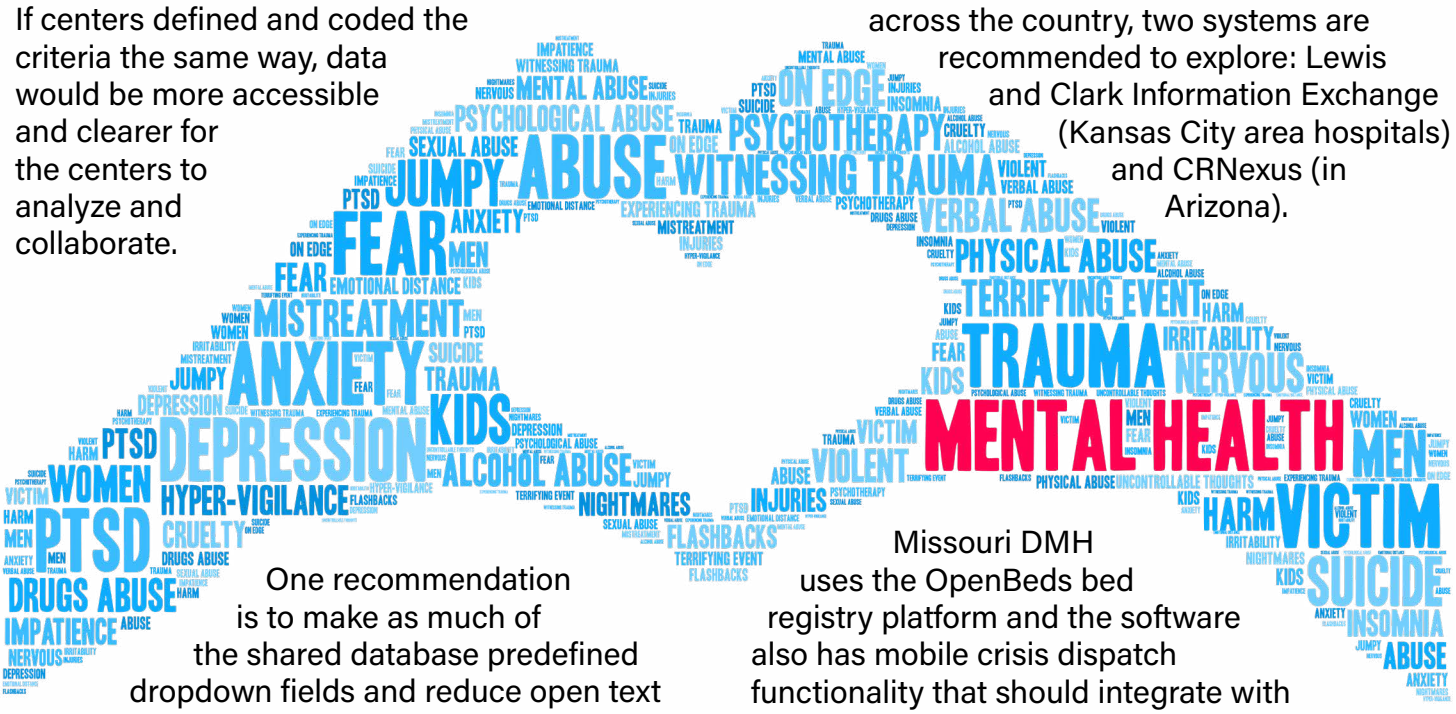
Shared procedures, while important, also require that the professionals involved are using the same language to describe the type of crisis they are responding to. Professionals need shared definitions to help ensure they can respond equitably and appropriately to a mental health crisis.



Shared Definitions for Actions and Coding

Currently, there are not commonly understood and adopted shared definitions for responding to mental health crisis among the six participating community mental health centers. There is a need for shared definitions, since it impacts how the centers code their cases. For example, if a client is a substance user and bipolar, one center may only code one of those situations, while another center may code a certain element primary and the other as secondary.

If centers defined and coded the criteria the same way, data would be more accessible and clearer for the centers to analyze and collaborate.



One recommendation is to make as much of the shared database predefined dropdown fields and reduce open text fields which would lead to data consistency.

Additionally, call log demographic collection information needs to be reviewed to ensure the categories are updated. The demographic information should include race and LGBTQ information since the information currently collected does not accurately reflect the population and how they identify. The consistent procedures, definitions and collected information helps create a unified approach to serving people who need mental health support.

Collective Health Information Exchange System

A collective health information exchange system will ensure that patients receive the best coordinated care. The system can share health-related patient information across organizations. It benefits the community because all participating organizations would have accurate information about patients, which is especially helpful for chronic users and users that access services at different access points. One goal would be to obtain user information that allows providers to see past information on clients, where crisis calls took place in the past, and any services received by other participating centers.

Through research of best practices locally and across the country, two systems are recommended to explore: Lewis and Clark Information Exchange (Kansas City area hospitals) and CRNexus (in Arizona).

Missouri DMH uses the OpenBeds bed registry platform and the software also has mobile crisis dispatch functionality that should integrate with each mental health center's electronic health records (EHR). Further exploration is warranted to determine if this resource can facilitate better information sharing.

The recommendation for a collective health information exchange system also aligns with the SAMHSA guidelines for best practices. In designing and selecting the collective health information exchange system, priorities such as patient privacy, can be held as essential while also prioritizing coordinate care.

3) Are there ideas we could pilot on a smaller scale before implementing region wide?

The steering committee recommends pilots on two important topics: 911/988 coordination and

joint staffing for mobile response units. The pilot details could be built out by the recommended sustained coordinating body, operated for six months and reviewed to make adjustments.

911/988 Coordination Consent-Based Call Transfers between 911 and 988

As outlined earlier in this report, an essential component of suicide hotline support is how 911 and 988 coordinate together. There are two options for how the Kansas City, Missouri, region can pilot coordination. One option is to do consent-based call transfers between 911 and 988. The other is to co-locate 988 call takers with one or more 911 public safety answering points.

St. Louis and other cities are piloting a consent-based call transfer between 911 and 988. The benefit of that option is that it gets callers to the right place quicker. When someone calls 911 with a mental health need and is not in danger of harming themselves or others, the call could operate on a policy of consent-based transfer to get that client into the hands of a mental health professional.

To do so, the local law enforcement agencies who answer the 911 and 988 calls need to establish clear parameters for when consent-based transfers can safely take place. Additional resources for Public Safety Answering Points (PSAPs) can be found in the Resource Repository in Appendix G.

Option two is for CommCARE to pilot co-location of 988 call takers within one or more 911 public safety answering points (PSAPs). Memorandums of Understanding (MOUs) could be developed between the host agency and CommCARE staff to jointly address mental health calls and then quickly send people to the correct platform.

Joint Staffing Models for Mobile Response Units

Since one of the largest recommendations from the steering committee is a joint mobile response approach, the group could pilot a smaller version of joint staffing models before coordinating among all centers. Since this steering committee started meeting, certain centers developed partnerships with local law enforcement and emergency medical services to create joint staffing models for mobile response units. It is recommended that these pilots continue to operate while the larger steering committee continues to envision and plan for a larger Kansas City, Missouri, collective effort. All of the recommendations in the report do not negate the bright spots that the current community mental health centers, emergency medical services, law enforcement and other participating organizations provide for people experiencing suicide crisis. Outlined in the next question, those practices should continue to best serve people in crisis.

4) What works well in the current crisis response system that we can build upon to reach the ideal system?

The individual community mental health center CEO interviews, focus groups and steering committee meetings examined the elements of the current crisis response system that work well so that those practices can continue in the future of Kansas City, Missouri, regional efforts. The willingness for local community mental health centers to join together in a steering committee demonstrates the strength in relationship between the centers and desire to put the mission of serving people in need first. As the steering committee designs the next phase of 988 work, other components of the current response system that should be noted include:

Quality of the Mental Health Professional Staff

One of the most important elements of the current crisis response system is the staff that are client-facing. Consistently during the external focus group phases, people highlighted the skill and dedication of staff that work in the mental health crisis profession. The focus groups also

mentioned the importance of peer specialists, CommCARE and police department coordination with mental health clinicians.

Providing a Wide Variety of Resources to People in Need

People who call resource lines, such as 988, are often facing mental health crises along with other basic needs. Regional staff do an excellent job at providing resources and connections to additional resources that are outside of the mental health community so that people can address the basic needs in addition to the present mental health needs.

Community Connections

There are a variety of schools, non-profit and faith-based organizations that are currently operating mental health resources, call lines and counseling services for people experiencing mental health dilemmas. The plethora of resources available will help ensure that 988 is not the sole resource for people.

Reduced Stigma

There is more awareness for mental health and suicide problems, as well as an increased willingness for people to receive help for trouble they are experiencing. This reduction in stigma associated with experiencing suicide ideation allows for more people to seek and receive help. The steering committee can build on this awareness level as they communicate about 988 launching so that people will feel equipped to utilize the service if they need to use it.

5. What barriers and gaps must we overcome to achieve the ideal system?

The resounding majority of focus groups, interviews and members in steering group meetings mentioned there are two large barriers to achieving a stronger mental health crisis response system as 988 launches: workforce shortages and funding.

Workforce Shortages

One of the largest barriers to achieving a strong 988 system is workforce shortages. In almost every interview and focus group, workforce shortages were mentioned as a gap and priority. For some mental health centers, there was even available funding without the qualified staff.

There are creative solutions that the steering committee is willing to pilot (see project plans in the section "Work Plans for Next Phase of Steering Committee Work"). Other solutions include changing the criteria necessary for professionals to handle mental health crisis responses and/or utilizing more peer specialists in the hotline, mobile response and follow-up services.

Funding

The other large barrier to implementing 988 at full capacity is funding. There is available funding, but right now it is dispersed to individual centers. Approximately $12.7 million was approved in the FY23 state budget for 988 call, text and chat centers including CommCARE and Compass. Missouri DMH is working on guidance for mental health centers about additional funding to support mobile crisis response. If there was a collective partnership, grant or organizing body that could oversee collaboration, it would both increase coordination and pool funding so that the same people are not competing over the same resources.

6. How can we fill gaps and move toward the ideal system?

In order to achieve the ideal system, the steering committee members recommend the following budget items as a starting list of items necessary for coordinated, collaborative 988 response in the Kansas City, Missouri, region:

- Coordinated mobile response - shared vehicles
- Coordinated mobile response - shared communication devices (ex. cell phone, tablets)

- Coordinated mobile response - joint staffing model for on-site and on-call responders
- Data collection - shared data collection system across participating community mental health centers
- Sustained coordinating body - meeting space, facilitator/support
- 911/988 coordination - materials
- 911/988 coordination - joint staffing/ co-location/training for warm transfer

It is worth noting that in the national key messaging framework, SAMHSA ends the short "about section" with a declaration of need for funding saying that the "network has been massively underfunded and under-resourced. This patchwork of local, state and private funding for the network has fallen way short of meeting the need. It's crucial that we shore up the infrastructure of the lifeline and support the local crisis centers."[8]

The sustained coordinating body of mental health professionals and crisis response leaders in the Kansas City, Missouri, region can achieve more together than alone when it comes to addressing the system's current workforce shortage and funding barriers.

CONCLUSION

The new national suicide and crisis lifeline, 988, is ushering in a new era for mental health crisis support. 988 can be viewed as a tool that is more successful and more useful if implemented well by those that are utilizing it.

While the steering committee's work in 2022 to determine how they can work together to successfully adapt to 988 in the region is tremendously important, it does not solve all the problems the metro faces when it comes to meeting the needs of those experiencing a mental health crisis.

The recommendations included in this report bring the area to a more collaborative, coordinated approach. The top four priorities to ensure that Kansas City can implement 988 in a comprehensive manner are:

- Establish agreement for ongoing convening amongst steering committee members to sustain collaborative efforts
- Develop shared mobile response dispatching goals, protocols, budget and operations for participating organizations
- Plan ideal coordination and information sharing efforts between entities operating 911 and 988
- Coordinate and build upon the Missouri 988 procedures to ensure alignment with standards of care

To accomplish those priorities, steering committee members and their technical advisors can build upon the work reflected in this report and maintain their collaborative spirit. The next phase of work will be vital to 988 launching as a region instead of a siloed approach. If the community mental health centers implement the recommendations from this report, they could be an exemplar for other regions across the country who are looking to work with more than just one community mental health center, law enforcement agency, emergency medical service group and community partner.

[8] 988 Key Messages. SAMHSA

APPENDIX A

**MEMORANDUM OF UNDERSTANDING AMONG
MID-AMERICA REGIONAL COUNCIL AND
MISSOURI COMMUNITY MENTAL HEALTH CENTERS SERVING THE GREATER KANSAS CITY REGION**

I. Purpose

The purpose of this Memorandum of Understanding (MOU) is to set forth an agreement between the Mid-America Regional Council ("MARC"), CommCARE, and the six Community Mental Health Centers ("CMHCs") that serve the Missouri side of the greater Kansas City region including the counties of Cass, Clay, Jackson, Platte and Ray (collectively "the Parties"). This MOU affirms the intent of the Parties to engage in a strategic planning process to prepare for use of 988 as the 3-digit code for the National Suicide Prevention Lifeline in July 2022. The purpose is for the Parties to work together to determine the ideal crisis response system for the greater Kansas City region in Missouri and to be as prepared as possible to achieve the ideal system concurrent with implementation of 988. The planning process is further described in Exhibit A: Proposal to Facilitate a Shared Approach to 988 Across Missouri Community Mental Health Centers (CMHCs) Serving the Five-County Kansas City Region, attached hereto and incorporated by reference.

II. Organizational Responsibilities

A. The Parties agree the following will be the responsibilities of MARC:

1. Act a neutral project manager to oversee the execution of the planning project outlined in Exhibit A.

2. Submit applications to philanthropic partners and administer grants and/or service agreements for funding awards to support the costs outlined in the proposal budget in Exhibit A.

3. Secure agreements with qualified subconsultants and dedicate the necessary staff to complete the work assigned to MARC in Exhibit A.

4. Schedule all project meetings and maintain agendas, meeting notes and other documentation related to the planning project.

5. Provide notifications of all project meetings to designated points of contacts for the Parties.

B. The Parties agree the following will be the responsibilities of the CMHCs and CommCARE:

1. CMHCs and CommCARE will work with MARC towards utilizing each agency's existing databases in order that information may be shared with MARC to complete the research described in Phase 3 of Exhibit A. CMHCs and CommCARE will not share confidential information, but will share relevant information in the aggregate to avoid disclosure of confidential information. The Parties agree that they will comply with all state and federal statutes and regulations and policies governing the confidentiality of the information shared among the Parties pursuant to this agreement.

2. CMHCs and CommCARE will designate at least one primary point of contact to serve as the agency's representative on the project steering committee.

3. CMHCs and CommCARE will actively engage in the strategic planning process outlined in Exhibit A including, but not limited to, engaging in one-on-one advance interviews (Phase 1), identifying contacts to participate in focus groups (Phase 2), and attending steering committee meetings (Phase 4) to the extent feasible.

III. Period

A. This MOU covers the period from January 24, 2022, to the end of the planning project outlined in Exhibit A (estimated July 31, 2022).

B. This agreement may not be revised or otherwise modified except on written agreement by the Parties.

C. In the event of a default with respect to any of the provisions of this MOU or the obligations under it, the non-defaulting party shall give the defaulting party written notice of such default. After receipt of such written notice, the defaulting party shall have fifteen (15) days in which to cure any default, provided the defaulting party shall have such extended period as may be required beyond the fifteen (15) days if the nature of the cure is such that it reasonably requires more than fifteen (15) days and the defaulting party commences the cure within the fifteen (15) day period and thereafter continuously and diligently pursues the cure to completion. The non-defaulting party may terminate this agreement with written notice to the Parties only after the defaulting party has failed to cure the same within the time period provided.

This Memorandum of Understanding is agreed to and accepted:

Kristin Feeback _____ 1/20/2022

Kristin Feeback
CommCARE

Date

This Memorandum of Understanding is agreed to and accepted:

Lauren Moyer	*03/07/2022*
Lauren Moyer, LSCSW, LCSW Executive VP of Clinical Innovation Compass Health	Date

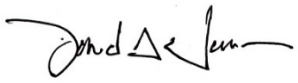
This Memorandum of Understanding is agreed to and accepted:

03/04/2022

Julie Pratt
President & CEO
Comprehensive Mental Health Service

Date

This Memorandum of Understanding is agreed to and accepted:



3/4/2022

David Warm
Executive Director
Mid-America Regional Council

Date

This Memorandum of Understanding is agreed to and accepted:

Jennifer Craig
President/CEO
ReDiscover

2/25/2022
Date

This Memorandum of Understanding is agreed to and accepted:

Authorized Representative — Date

Mark Miller
Vice President, Behavioral Health Services
Swope Health

This Memorandum of Understanding is agreed to and accepted:

Janice Storey — 3/8/22

Authorized Representative — Date

Title

Janice Storey
Chief Clinical Officer
Tri-County Mental Health

This Memorandum of Understanding is agreed to and accepted:

DocuSigned by:
Charlie Shields/MJGL
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3/10/2022

Authorized Representative Charlie Shields Date
Title President and CEO
University Health Center Behavioral Health

EXHIBIT A

Proposal to Facilitate a Shared Approach to 988 Across Missouri Community Mental Health Centers (CMHCs) Serving the Five-County Kansas City Region

I. Background

In August 2019, Federal Communications Project steering committee (FCC) staff—in consultation with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, the Department of Veteran Affairs, and the North American Numbering Council—released a report recommending the use of 988 as the 3-digit code for the National Suicide Prevention Lifeline. In July 2020, the FCC adopted rules designating this new phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. The transition will result in phone service providers directing all 988 calls to the existing National Suicide Prevention Lifeline by July 16, 2022. *Source: https://www.fcc.gov/suicide-prevention-hotline.*

There are three components to implementation of 988:

1. Front-end answering of calls for service: CommCARE is a not-for-profit behavioral health management organization that works in collaboration with Community Mental Health Centers (CMHCs) and other providers to improve access to affordable, high quality and effective behavioral health services. CommCARE provides the First Step for HELP for Missouri residents in crisis through a 24-hour toll-free telephone crisis line. It is expected that CommCARE will accept and route 988 calls for assessment and referral to Community Mental Health Centers (CMHCs). (Note: Compass Health Network does not use CommCARE).

2. Mobile crisis - There are six CMHCs serving the Missouri side of the greater Kansas City region including Cass, Clay, Jackson, Platte and Ray counties:

    1. Compass Health Network
    2. Comprehensive Mental Health Services (CMHS)
    3. ReDiscover
    4. Swope Health Services
    5. Tri-County Mental Health Services
    6. University Health Center Behavioral Health

    The CMHCs have different standards of care for crisis response and after hours response. Because CMHC catchment areas do not mirror jurisdictional boundaries for public safety (police, fire and EMS), the inconsistencies undermine community trust because people in crisis cannot rely on a standardized level of care. Philosophically the CMHCs agree that a

consistent model for crisis response across all six agencies is ideal prior to implementation of 988, yet there are barriers including geography and limited resources.

3. Behavioral Health Crisis Centers (BHCC) – The Kansas City Assessment and Triage Center (KC-ATC) and Behavioral Health Urgent Care Clinic (BHUCC) are public and private partnerships among Kansas City stakeholders – ReDiscover, EMS, courts, law enforcement, hospitals, city officials and the Department of Mental Health – to divert persons with mental health and substance use disorders away from jails and emergency rooms to a safe place where they can be assessed, stabilized and referred for behavioral health treatment. The Missouri Department of Mental Health desires to expand centers like KCATC statewide and to develop a health information exchange system to share bed availability among centers. CMHS has plans to open a BHCC in mid-2022.

Statement of Purpose: The CMHCs desire to work together to address the following:

1. What can we do to be as prepared as possible prior to the 988 implementation in July 2022?
2. What is the ideal crisis response system for the greater Kansas City region in Missouri?
3. Are there ideas we could pilot on a smaller scale before implementing region-wide?
4. What works well in the current crisis response system that we can build upon to reach the ideal system?
5. What barriers and gaps must we overcome to achieve the ideal system?
6. How can we fill gaps and move toward the ideal system?

Several leaders among the CMHCs requested assistance from the Mid-America Regional Council to conduct a planning process to respond to these questions.

Guiding Principles:

- Standards of care need to be culturally responsive and equitable.
- Crisis response should involve coordinated care and collaboration among CMHCs and other agencies and partners.
- Solutions should involve emerging or best practices that are evidence based.
- The ideal crisis system of care will not add burden to CMHCs for data already tracked for Access Crisis Intervention (ACI).
- Others to be determined by the project steering committee.

II. Experience

Mid-America Regional Council (MARC) was formed in 1972 by eight counties and the region's four largest cities to build a stronger regional community and support cities and counties in serving their constituents. Five counties in Missouri are active members of MARC and involved in numerous regional committees. MARC is the Metropolitan Planning Organization and association of city and county governments, serving the region's nine counties and 119 cities. MARC provides a forum for local governments to convene and define shared solutions to common challenges.

For the services described in this proposal, MARC proposes to utilize resources of its Government Training Institute (GTI). Because of expressed interest of local government leaders who were striving to maintain and improve the ability of their organizations to make effective decisions and deliver quality services, MARC established the Government Training Institute (GTI) in 1996. Over the years GTI has evolved into a training provider of choice for local governments in the metropolitan area by offering cost-effective training of the highest quality in the form of certificate programs, leadership training and customized training programs. It is designed to provide a consistent and responsive mechanism for meeting the training and organizational development needs of local government employees. Since 1996, over 160,000 constituents have participated in GTI special events, regional, state, and multi-state conferences, certificate programs, seminars and technical workshops.

MARC is responsible for preparing and adopting plans on behalf of area local governments, and public engagement and committee deliberations of technical and policy information is a fundamental part of the work of the agency. GTI routinely supports these planning and public engagement processes through professional facilitation.

To meet the needs of MARC members, GTI offers a wide range of customized training, including consulting and facilitation services. GTI consultants are some of the area's top professionals. They provide affordable know-how about strategic planning, communications, organizational effectiveness and collaborative decision-making.

III. Scope of Work

MARC will staff a project steering committee comprised of representatives of each of the CMHCs and CommCARE to be appointed by each agency's chief executive officer. The steering committee will provide oversight for the work and be accountable for final project recommendations.

A team of technical advisors will be invited to participate in steering committee meetings to help guide and support the work. Technical advisors include key stakeholders such as philanthropic partners (Health Forward Foundation, REACH Healthcare Foundation), law enforcement (KCPD and KCFD), First Call and Kansas mental health agencies in Wyandotte and Johnson Counties.

Lauren Palmer, Director of Local Government Services, will be the lead assigned staff with support as needed from Marlene Nagel, Director of Community Development; and support staff within the Local Government Services department. MARC will act as a neutral facilitator to guide and administer the process with support from qualified subcontractors. Decisions about the approach to the work and recommendations for proposed changes to ensure continuity in the crisis response system will rest exclusively with the project steering committee.

Phase 1: Advance Planning to Define the Issues

MARC proposes to conduct one-on-one (or small group) interviews with the chief executive officers of the CHMCs and/or their designees. The goal is to conduct these interviews before the

next convening of the project steering committee. Interview questions will be designed to gather input about the ideal mobile response system or areas of interest for review. This work is important to establish MARC as a neutral facilitator and to hear first-hand any expectations or concerns about the process. Doing this legwork upfront will help garner buy-in for the process and generate an initial list of opportunities and challenges for creating an ideal crisis response system. MARC will summarize the feedback in the aggregate without attributing specific comments to individual interviews, unless desired. This information will be shared with the project steering committee to form the basis for the review process.

Phase 2: Stakeholder Engagement

MARC's subconsultant, Social Impact Advising Group (SIAG), will conduct up to eight focus groups to gather input from key stakeholders. SIAG will thoughtfully design these meetings, with input from the project steering committee, to ensure maximum and productive audience participation. In general, focus groups will be held virtually with 8 – 12 participants representing key stakeholder groups. The project steering committee will identify groups and individuals to participate and will review and finalize the focus group invitations. Emphasis will be placed on diverse representation from those most involved with or impacted by the mental health system.

Possible focus groups:

- Police departments (CIT)
- Non-profit and social service partners (First Call, Hope House, Community Services League, etc.)
- Fire (paramedics) and Emergency Medical Services (EMS)
- Individuals or family members with lived experience accessing services of CMHCs
- Hospitals
- K-12 schools
- Faith-based community or other neighborhood/community leaders
- City and county leaders including courts

Project steering committee members will be encouraged to attend and participate in focus groups as their interests and schedules allow. MARC does not anticipate full participation by all project steering committee members at all focus groups. SIAG will be responsible for compiling feedback into a summary report for review with the project steering committee once all meetings are concluded.

Phase 2 (optional): General Public Engagement

MARC does not anticipate conducting open public meetings for general public input. If desired, MARC will facilitate an open public comment period to solicit public input once the project steering committee has formulated its preliminary recommendations. Comments will be obtained primarily through electronic mediums (website and social media). If the steering committee desires additional general public engagement, that can incorporated as an addendum to this proposal.

Phase 3: Research

Concurrent with phase 2, MARC's Research Services will conduct research to determine best practices in regional behavioral health crisis response models. MARC will need support from the CMHCs and CommCARE to collect data to perform analysis. Analysis may include and not be limited to the following:

- Current responses models and resources (budget and personnel) for CMHCs including business hours and after hours response.
- Best practices from peer communities with strong reputations or performance indicators for regional crisis response models.
    - Expertise will be sought from state and national associations such as the Missouri Department of Mental Health, the National Alliance on Mental Illness (NAMI) or others.
    - MARC will research Kansas Behavioral Health Services and/or mental health agencies serving the Kansas side of the region to understand their approach(es) to 988 and seek opportunities for bi-state coordination.
- Analyzing regional mental health calls over the past 1-3 years based on available data to understand trends
    - Call volumes – rate of increase/decrease over time
    - Projected increase/decrease following conversion to 988
    - Peak days and time periods for mental health calls
    - Frequency of calls and outcomes
        - Resolved on call
        - Referred for CMHC for service
            - Number/percentage of referrals who access and complete treatment
        - Referred to CMHC for mobile response
        - Referred to 911 for police/EMS/fire response
        - Other
- Analyzing regional 911 behavioral health calls for service to understand trends
    - Call volumes – rate of increase/decrease over time
    - Projected increase/decrease following implementation of 988
    - Peak days and time periods for mental health calls
    - Frequency of calls and outcomes
        - Arrests
        - Transport to hospital/EMS
        - Referred for CMHC for service
        - Other

The research phase will be coordinated with the Missouri Department of Mental Health and its consultant partner, Solari Crisis & Human Services. MARC will request data sharing from the state to the extent feasible to ensure alignment with the state's planning efforts and avoid duplication of research and analysis.

Phase 4: Project Steering Committee meetings

MARC proposes monthly project steering committee meetings to be intermingled with stakeholder input and best practices research. Meetings will be scheduled to allow time for the

MARC team to respond to direction from the project steering committee. The schedule is tentative and subject to change based on available funding and notice to proceed.

1. Meeting 1 – January 2022
    a. Welcome and introductions
    b. Establish group ground rules and select a chair
    c. Discuss and build consensus around guiding principles
    d. Process overview
    e. Discuss stakeholder engagement approach and select stakeholders for focus groups
    f. Determine data sets available and finalize research objectives
    g. Set future meeting dates

2. Meeting 2 – February 2022
    a. Review summary report of advance interviews
    b. Finalize project objectives and guiding principles
    c. Define the key challenges and opportunities

3. Meeting 3 – March 2022
    a. Further review of challenges and opportunities – how can we build on strengths and overcome barriers?

4. Meeting 4 - April 2022 – half-day workshop
    a. Review best practices research
    b. Review summary report of stakeholder engagement
    c. Begin to frame preliminary project steering committee recommendations

5. Meeting 5 - May 2022
    a. Finalize project steering committee recommendations

6. Meeting 6 – June 2022
    a. Review draft report that finalizes recommendations including budget(s) and timelines for implementation

7. Meeting 7 – July 2022 – Stakeholder summit
    a. Present final report to CEOs, funding partners, other key stakeholders

8. Meeting 8 – July/August 2022
    a. Wrap up meeting to determine next steps for implementation

IV. Timeline

- Phase 1 – January 2022

- Phase 2 – February – March 2022
- Phase 3 – February – March 2022
- Phase 4 – January – June 2022
- Final Report – July 2022
- Implementation Begins – July 2022

V. The Team

MARC identified qualified subconsultants to assist with the work who are available to meet the project demands within the established schedule. MARC is prepared to engage other partners if desired by the project steering committee. Detailed resumes/biographies from the proposed team are available upon request.

Project Lead - MARC: MARC will provide staff support to the project steering committee throughout the process including coordinating and overseeing all subconsultant work, scheduling meetings, preparing agendas, taking minutes, administering grants, etc. MARC will be available for update meetings with executive leaders or boards of directors upon request. Lauren Palmer, Director of Local Government Services, will be the lead assigned staff. She will attend all project steering committee meetings and advance interviews.

Lauren joined the Mid-America Regional Council (MARC) in 2018. She oversees local government services including emergency services, 9-1-1 public safety, Government Training Institute, Communities for All Ages, First Suburbs Coalition, Managers Roundtable, Kansas City Regional Purchasing Cooperative and other shared services. Prior to joining MARC, Lauren worked for 14 years in local government administration, including serving as city administrator in Parkville, MO and assistant city manager in Independence, MO and Manhattan, KS. Lauren serves on the advisory board for the Greater Kansas City Local Initiatives Support Corporation (LISC). Lauren is currently administering a grant from the U.S. Department of Justice for mental health co-responders on behalf of ReDiscover, CMHS and the police departments in Blue Springs, Independence and Lee's Summit. She is an ICMA Credentialed Manager and was named a 2019 Woman of Distinction for Eastern Jackson County, Missouri. Lauren has a bachelor's degree in political science from the University of Missouri-Columbia and a Master of Public Administration degree from Indiana University.

MARC's Research Services Department will lead the research and data analysis phase of the scope of work. MARC facilitates regional partnerships to enhance the performance of the metropolitan economy and expand inclusive economic opportunity, focusing on workforce development systems, postsecondary educational attainment, and research and analysis. Research Services routinely collects, analyzes and reports regional data related to economic forecasting, quality of life indicators and demographic trends.

Stakeholder Engagement and Recommendations - Social Impact Advising Group (SIAG): SIAG will lead the stakeholder engagement work including conducting the focus groups. SIAG specializes in new program design and will take the lead to assimilate steering committee input, stakeholder feedback and research analysis into the final project report with recommendations.

Jacqueline Erickson Russell is Founder and CEO of Social Impact Advising Group, which provides custom-designed solutions and consulting services that help businesses, philanthropic organizations, and non-profits align their purpose, community investments, stakeholders, and strategy. Previously, Jacqueline led a strategy at the Ewing Marion Kauffman Foundation, which has over $2.6 billion in assets and $36 million of annual giving from the education department. Her expertise is in strategy design, program launches, and complex organizational change initiatives. While at the Ewing Marion Kauffman Foundation, Jacqueline designed, launched, and funded over 10 unique non-profits and programs that impacted over 540 education leaders annually.

She started the Kansas City Teacher Residency organization, including securing over $2 million additional funding, school partnerships, leadership hires, and 501c3 status. Additional experience included mobilizing stakeholders and facilitating committees to achieve project goals; she organized 17 universities and 21 school districts to participate in an initiative called TEACH Kansas City. Also at Kauffman, Jacqueline designed grant management strategies, grant application programs, and metrics for organization strategy and diversity, equity, and inclusion goals. Before joining the Kauffman Foundation, Jacqueline founded the talent department for a charter network. She also completed Teach For America, teaching and coaching at a KIPP school. Currently, she leads a national participatory grantmaking coalition. She volunteers her time as the board chair for Single Mom KC, a Big Mentor for Big Brothers Big Sisters, and at her church. Jacqueline holds an undergraduate degree from Yale University and a graduate degree from University of Missouri- St. Louis.

VI. Fee Proposal

MARC proposes to complete the work outlined herein for a lump sum price of $91,500 (see attached pricing sheet).

MARC Government Training Institute

Pricing Proposal - 988 Crisis Response Model Planning - Updated Dec. 12, 2021

Facilitator Expense								
		Hourly Rate		**Hours**				
Subcontract	**Team Lead**	**Services**	**Travel**	**Meetings**	**Travel**	**Prep & Follow-Up**	**Reports**	**Total**
Coordination, Oversight, Engagement	MARC GTI	$150.00	$75.00	28	0	114.5	67.5	$31,500.00
Stakeholder Engagement and Recommendation Development	SIAG	$175.00	$175.00	43.5	0	99	52.5	$34,125.00
Research and Best Practices	MARC Research Services	$150.00	$150.00	15	0	60	25	$15,000.00
								$80,625.00

Reimburseables	**Details/Notes**	**Rate**		**Number**		**Lump Sum**		**Total**
Mileage	anticipate most meetings will be virtual	Per Mile	$0.58	Miles	300			$174.00
Rental Car		Per Day		Days				
Lodging		Per Night		Nights				
Meals		Per Diem	$79.00	Days				
Fuel		Per Gallon	$3.00	Gallons				$0.00
Total								**$174.00**

Support Staff Expense								
	MARC Staff Contact	**Hourly Rate**	**Hours**					**Total**
Contracting	Chris Allen	$50.00	10					$500.00
Scheduling	Chris Allen	$50.00	20					$1,000.00
Virtual/Live Room Setup	Chris Allen	$50.00	20					$1,000.00
Grant reporting	Chris Allen	$50.00	20					$1,000.00
Deliverables (minutes, agendas, edit reports)	Chris Allen	$50.00	30					$1,500.00
Quality Control/Support	Marlene Nagel	$175.00	25					$4,375.00
Total								**$9,375.00**

Direct Expenses	**Details/Notes**	**Rate**		**Number**		**Lump Sum**	**Subtotal**	**Total**
Materials	handouts, meeting supplies, etc.	Per Packet		Attendees		$500.00		$500.00
Staff Travel		Per Mile	$0.58	Miles				$0.00
Staff Rental Car		Per Day		Days				$0.00
Staff Lodging		Per Night		Nights				$0.00
Staff Meals		Per Diem	$79.00	Days				$0.00
Staff Fuel		Per Gallon	$3.00	Gallons				$0.00
Event Food								$0.00
Per Meal		Per Meal	$15.00	Attendees	15		$225.00	
Estimated Meals	half-day workshops			Meals	2			$450.00
Total								**$950.00**
GRAND TOTAL								**$91,124.00**

APPENDIX B

988 Strategic Planning Project
Steering Committee Meeting #1
Monday, January 24, 2022
9:00 – 10:30 a.m. (central)
Virtual via Zoom

Login instructions
Address: https://marc-kc.zoom.us/j/9352038883?pwd=RTFyY0t6THlWYzcrUHJwNWkvd0FUQT09
Meeting ID: 935-203-8883
Passcode: 217256

Timeframes are estimates only

1. Welcome and introductions (5 min)
2. Review changes to the MOU and process for signatures (5 min)
3. Process overview and timeline (10 min)
4. Establish group ground rules and participant roles; and select a chair (15 min)
5. Discuss and build consensus around guiding principles (20 min)
6. Discuss stakeholder engagement approach and selecting stakeholders for focus groups (15 min)
7. Discuss data sets available and research objectives (15 min)
8. Wrap up (5 min)

Future meetings (via Zoom) – 9:00 – 10:30 a.m. unless otherwise noted
Meeting 2 - February 28
Meeting 3 - March 21
Meeting 4 - April 18 – 9am – noon
Meeting 5 - May 16
Meeting 6 - June 20
Meeting 7 - July 18
Meeting 8 - August 15

Agenda
988 Strategic Planning Process
Steering Committee Meeting #2
Monday, February 28, 2022
Virtual (see login instructions below)
Times listed are tentative and subject to change.

1. 9:00 a.m. - Welcome and Introductions – Shannon Moss, Chair

2. 9:10 - Review and finalize project objectives and guiding principles (see Attachment #1 – pg. 2)

3. 9:20 - Review summary report of advance interviews (see Attachment #2 – starts on pg. 3)

   The summary report is included as draft for review and input by the committee. Please let Lauren (lpalmer@marc.org) know if any content is missing or unclear.

4. 9:45 - Define the gap between the current and ideal state for mobile response (see Attachment #3 – start on pg. 7)

   SAMHSA published the National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. We will reference this during the meeting. Please be generally familiar with the toolkit, particularly the section on Mobile Crisis Team Services beginning on pg. 18 of the document.

5. 10:15 - Review plans for focus groups

6. 10:30 – Adjourn
   Next meeting – March 21, 2022 – 9:00 a.m.

Login Instructions
Address: https://marc-kc.zoom.us/j/9352038883?pwd=RTFyY0t6THlWYzcrUHJwNWkvd0FUQT09

· You may need to run the Zoom opener to join the meeting.
· This link also works with the Zoom smartphone app.

Meeting ID: 935-203-8883
Passcode: 217256

Audio:
· **We encourage the use of computer audio** especially if you are viewing a webcam or sharing your webcam.
· **Dial Toll-Free**
  - o 877 853 5247 US Toll-free
  - o 888 788 0099 US Toll-free
· **One tap mobile**
  - o +18778535247,,9352038883#
  - o +18887880099,,9352038883#

Agenda
988 Strategic Planning Process
Steering Committee Meeting #3
Monday, March 21, 2022
9:00 – 10:30 a.m.
Virtual (see login instructions below)
Times listed are tentative and subject to change.

1. 9:00 a.m. - Welcome and Introductions – Shannon Moss, Chair

2. 9:05 a.m. – Coordination Opportunity – DMH Grant for Substance Use and Mental Health Services Mobile Unit Provider Readiness Application (Attachment 1) – Shannon Moss, Chair

3. 9:15 – Update on Focus Groups and Research – Jacqueline Erickson-Russell, SIAG and Erin Cardwell, MARC

4. 9:20 – Review Barriers and Opportunities from February Meeting – Lauren Palmer, MARC (Attachments 2 - 4)

5. 9:30 – Large Group Discussion – Opportunities to Address Barriers

6. 9:45 – Small Group Breakouts – Top 3 Solutions for Each Barrier

7. 10:15 – Homework Assignment

8. 10:30 – Adjourn
   Next meeting – April 18, 2022 – 9:00 a.m. – noon (extended work session)
   This meeting will be held in-person at the MARC offices.

Login Instructions
Address: https://marc-kc.zoom.us/j/9352038883?pwd=RTFyY0t6THlWYzcrUHJwNWkvd0FUQT09
· You may need to run the Zoom opener to join the meeting.
· This link also works with the Zoom smartphone app.

Meeting ID: 935-203-8883
Passcode: 217256

Audio:
· **We encourage the use of computer audio** especially if you are using a webcam.
· **Dial Toll-Free**
  - o 877 853 5247 US Toll-free
  - o 888 788 0099 US Toll-free
· **One tap mobile**
  - o +18778535247,,9352038883#
  - o +18887880099,,9352038883#

Agenda
988 Strategic Planning Process
Steering Committee Meeting #4
Monday, April 18, 2022
9:00 a.m. - noon
Mid-America Regional Council – Board Room
600 Broadway, Suite 200, Kansas City, MO 64105-1659
Times listed are tentative and subject to change.

1. 9:00 a.m. - Welcome and Introductions – Shannon Moss, Chair

2. 9:05 a.m. – Process Overview and Status Update – Lauren Palmer and Erin Cardwell, MARC

3. 9:15 a.m. – Stakeholder Engagement Gallery Walk - Jacqueline Erickson-Russell, SIAG
   Resource 1: Focus Groups Summary

4. 9:50 a.m. – Small Group Work Time

5. 10:00 - Reports from Small Groups – Barriers and Opportunities
   Resource 2: Barriers and Opportunities Summary
   a. Workforce
   b. Resources

6. 10:40 a.m. – Break

7. 10:50 a.m. – Reports from Small Groups – Barriers and Opportunities, cont.
   a. Safety Protocols
   b. Coordination and Communication

8. 11:30 a.m. – Reflections and Preliminary Recommendations – Lauren Palmer, MARC
   Resource 3: National Guidelines for Behavioral Health Care – Toolkit Executive Summary
   Resource 4: Phase 1 CMHCs Interviews Summary

9. Noon – Adjourn

Save the Dates

- Monday, May 16 – 9:00 – 10:30 a.m. (Virtual) – Steering Committee: Review and finalize project recommendations and timelines
- Friday, June 17 – 9:00 – 10:30 a.m. (Virtual) – Steering Committee: Review draft report
- Friday, July 15 – 1:00 – 2:30 p.m. (tentative – in-person – location TBD) – Public presentation: report to stakeholders
- Monday, August 15 – 9:00 – 10:30 a.m. (virtual) – Steering Committee – Project debrief and next steps

Agenda
988 Strategic Planning Process
Steering Committee Meeting #5
Monday, May 16, 2022
9:00 a.m. – 10:30 a.m.
Virtual via Zoom

Address: https://marc-kc.zoom.us/j/9352038883?pwd=RTFyY0t6THlWYzcrUHJwNWkvd0FUQT09
Meeting ID: 935-203-8883
Passcode: 217256

Times listed are tentative and subject to change.

1. 9:00 a.m. - Welcome and Introductions – Shannon Moss, Chair

2. 9:05 a.m. – Process Update – Plans for Remaining Meetings – Lauren Palmer, MARC

3. 9:20 a.m. – Update on 988-911 Coordination – Lauren Palmer, MARC

4. 9:30 a.m. – Review and Validate Ideas within Focus Areas (Small Groups) – Jacqueline Erickson-Russell, SIAG

https://jamboard.google.com/d/1FTAFnBeKaNJ05rf7-hXICVaXRGi3b9ph5lMPUl-gXPw/viewer?f=0

5. 10:00 a.m. – Prioritization Exercise – Jacqueline and Lauren

6. 10:30 a.m. – Adjourn

Save the Dates

- Friday, June 17 – 9:00 – 10:30 a.m. (Virtual) – Steering Committee: Review draft report
- Friday, July 15 – 1:00 – 2:30 p.m. (tentative – in-person – location TBD) – Public presentation: report to stakeholders
- Monday, August 15 – 9:00 – 10:30 a.m. (virtual) – Steering Committee – Project debrief and next steps

Agenda
988 Strategic Planning Process
Steering Committee Meeting #6 – Hybrid Meeting
Friday, June 17, 2022
9:00 a.m. – 10:30 a.m.

Participants are strongly encouraged to attend in-person at the Mid-America Regional Council.
MARC Offices – Heartland Room
600 Broadway, Suite 200, Kansas City, MO 64105-1659

A virtual option via Zoom is available for those who need remote access.
Address: https://marc-kc.zoom.us/j/9352038883?pwd=RTFyY0t6THlWYzcrUHJwNWkvd0FUQT09
Meeting ID: 935-203-8883
Passcode: 217256

Times listed are tentative and subject to change.

1. 9:00 a.m. - Welcome and Introductions – Shannon Moss, Chair

2. 9:05 a.m. – Overview of the Draft Project Report – Jacqueline Erickson-Russell, SIAG

3. 9:15 a.m. – Group Discussion on Draft Report – Lauren Palmer, MARC

   Key Questions for Discussion
   a. Is there anything essential missing from the report?
   b. Is the report an accurate reflection of the work and consensus of the committee?
   c. Is there concurrence and support to continue this work with a coordinating body?
   d. If so, can we further define the "sustained coordinating body?"

4. 9:55 a.m. – Preview for Report for Community Stakeholders on July 15 – Lauren Palmer

   Key Questions for Discussion
   a. Who should be invited?
   b. How can we best represent engagement from all steering committee members in the program?
   c. What, if anything, should be the call to action for those in attendance?

5. 10:15 a.m. - SAMHSA Grant Opportunity to Create or Enhance Existing Mobile Crisis Response Teams – Shannon Moss

6. 10:30 a.m. – Adjourn

Save the Dates
- Friday, July 15 – 1:00 – 2:30 p.m. (in-person – location TBD) – Public presentation: report to stakeholders
- Monday, August 15 – 9:00 – 10:30 a.m. (virtual) – Steering Committee – Project debrief and next steps

APPENDIX C

988 Strategic Planning Project

Phase 1 Interviews with Community Mental Health Centers (CMHCs)
Summary Report

MARC conducted one-on-one or small group interviews with the chief executive officers of the CHMCs and/or their designees. Interview questions were designed to gather input about the ideal mobile response system or areas of interest for review. Feedback gathered is summarized in the aggregate without attributing specific comments to individual interviews, to the extent feasible. This report is not an exhaustive recital of information shared but rather represents common themes across all conversations. The ultimate goal of this work is to assist with well-informed, cohesive preparation and planning for the implementation of 988 at the regional level, guided by a steering committee made up of CMHC and CommCARE leadership. The information gathered helped form the basis of future planning work with the steering committee.

Interviews were conducted with the following agencies:

January 28, 2022 – Tri-County Mental Health (Candis Boily, Janice Storey)

February 3, 2022 – ReDiscover (Stewart Chase, Jennifer Craig, Ed Cullumber, Shelby Finley, Astra Garner, Betsy Henderson, Angela Manns, Shannon Moss)

February 9, 2022 – Compass Health (Jamie Bartin, Michelle Horvath, Lauren Moyer)

February 10, 2022 – University Health (Cass Davis-Guinn, Robbie Phillips)

February 16, 2022 – CMHS/Burrell (Stacie Newberry, Julie Pratt)

February 22, 2022 – Swope Health (Laurie Cox)

Current Process for Receiving and Responding to Mental Health Calls for Service

Five of the six agencies utilize CommCARE for suicide hotline calls. Some agencies accept their own calls during regular working hours and only rely on CommCARE for after-hours triage and referrals. Compass Health manages its own call center.

There is a wide variety of approaches to mobile response in the region. A few agencies have mobile response teams that are available 24/7 through direct staffing and on-call support, yet all agencies provides some level of community response. Some agencies reported very low utilization of mobile response as most clients are walk-in or referred through related programs. Some agencies utilize mental health co-responders who are embedded with local police departments. One agency expressed interest in expanding mobile response coupled with concerns about feasibility and safety.

What works well now?

- Dedicated, skilled clinicians who are well trained to help people where they are without judgment.
- Coordinating crisis response with other treatment team members for clients who are already enrolled in services.
- Praise for CommCARE – good level of support and access to information.
- Co-responders embedded with police departments to respond to calls for service. Clinicians require a special skill set to work within law enforcement. It takes time to build the relationship for a successful partnership between behavioral health and law enforcement.
- Telehealth services are particularly useful in areas with less access to crisis utilization centers and public transportation, though internet access is not always reliable in service areas.
- There are strong relationships and respect among CMHCs. People navigate across the catchment area lines as needed to best serve people. KC Assessment and Triage Center and urgent care are utilized regionwide.
    - Catchment areas have pros and cons. Agencies can get a little territorial about "who is responsible" for this person, but there is also more demand than supply. If people have the courage to seek treatment, the catchment area should not be a barrier (i.e. you're in the wrong place). Also, it makes sense to get people connected closer to home.

What could be improved?

- **Staffing** is a significant challenge that was expressed in all interviews. Multiple agencies are trying to increase staff for mobile response and struggling to find qualified applicants.
    - Staffing is a challenge throughout the behavioral health system (not just crisis response). Many agencies have lengthy waiting lists for therapy services. Retention of existing staff is a challenge due to fatigue and burnout.
    - There is a need for bilingual clinical staff. Agencies can use a language line service, but it is not ideal for therapy.
- **Safety** was a key recurring concern for expanding mobile crisis response. We need a consistent approach to monitor situational safety for employees. We need to be thoughtful about training, communication and equipment. Ex. Should staff wear bulletproof vests or is this off-putting? Is staffing adequate to implement a buddy system? How and when do engage law enforcement?
- **Basic needs** is a major barrier for treatment. Patients who do not have stable housing and transportation are unlikely to complete treatment. We have to solve for general needs concurrent with addressing mental health. We need better resources to solve immediate problems (eviction prevention, housing, transportation, etc.). Even the bus

system, if available, can be a struggle to navigate for people experiencing anxiety or psychosis.

- Lack of psychiatric **bed availability** – crisis care helps, but it is temporary to assess people and get them into treatment. How do you help someone who should be hospitalized?
- There is still a strong **stigma** on mental health that creates avoidance for clients to be willing to accept support. Many people repeatedly "churn" through the system because they avoid engaging in therapy.
- We don't **involve clients** enough in decision making to understand what they need and what will work for them.
- Resources are lacking for **youth mental health** and substance abuse issues, especially if parents are not cooperative. Schools are underserved. Missouri lacks clear protocols for crisis screening. The Missouri Department of Social Services – Children's Division is not tapping into the full range of CMHCs services and community resources.
- There is a frustration in the community about **police response** to people in mental health crisis. "Defunding the police" really means redirecting certain calls for service to a more appropriate resource. We need to coordinate and gain buy-in for expanded mobile response from law enforcement and Fire/EMS.
- Change the mindset for staff, especially psychiatrists, who send patients to the hospital rather than exploring other treatment options. Hospitals are the wrong intervention for a safety net.
- CommCARE does a good job of triaging calls and only refers to CMHCs on an as-needed basis. Some CMHCs would like more direct transfers so callers can immediately begin a relationship and access to services.
- Not all CMHCs share the same philosophy of mobile response. The Kansas City region has the lowest crisis response rate compared to the rest of the state. We need to better understand this. Perhaps CommCARE is doing a better job with initial response, or perhaps they don't make as many referrals if they know an agency won't respond.

Ideas for future

- Create joint mobile response teams with shared staffing across CMHCs. This may not be feasible regionwide, but perhaps within Jackson County.
- Expand the law enforcement co-responder model to paramedics/EMS.
- One agency started a same-day therapy program as a strategy to fill acute need. It doesn't require full intake, just "have a seat, someone will talk with you."
- Better training for mental health providers of basic need resources available.
- The current crisis line is not well known. There are opportunities for better marketing of 988 to help more people access services.
- We need technology to share information about patients across organizations.

- Calls to 988 can be “warm” transferred to 911, but 911 calls cannot be reverse transferred to 988. We need to work with PSAPs to create the referral connection between 911 and 988.
- Introduce triage into waiting lists so that those with the highest need are attended.
- Find ways to get more into the community and provide more convenience (schools, pre-K, community-based organizations) so people can access services prior to crisis.
    - Seek opportunities to partner with the faith community. In some communities, people may be more likely to seek help through church.
    - More staff support designated to schools to do education with staff and students on suicide prevention and access to services.
    - Utilize peer workers, church support groups, etc. to provide immediate services for people who are less acute to add system capacity in spite of clinical workforce shortages.

What does success look like for this project?

- Increased collaboration among the CMHCs.
- Think beyond the crisis system of care and look at the whole system. Get people into treatment faster and address their basic needs for long-term success.
- Make it as easy as possible for people to access care. Don’t let bureaucracy get in the way of meeting people where they are.
- A system that works for community members and staff supporting it.
- Consistency across the system. Common standard of care.
- Reduce stigma of accessing care. More people will use 988 like they use 911.

APPENDIX D

Dear Community Partners,

The 988 Suicide & Crisis Lifeline is coming to Missouri. According to the Centers for Disease Control and Prevention and the Missouri Department of Mental Health, there is tremendous need for 988 services in our state:

- Suicide is among the top 3 leading causes of death in Missouri for ages 10-34
- Approximately one in five Missourians above the age of 18 has a mental health condition
- Approximately 377,000 of Missourians age 12+ (or 7.4%) live with a substance use disorder
- Prior to the pandemic in 2019, 8.5% of adults in Missouri reported an unmet need for mental health treatment in the past year

Behind each of these data points, there are people, families and communities who have been impacted. Yet, in the face of these urgent realities, **there is hope.**

On July 16, 2022, Missouri will join the rest of the United States in beginning to use the 988 dialing code. 988 will be the new three-digit number for call (multiple languages), text or chat (English only) that connects people to the existing National Suicide Prevention Lifeline, where compassionate, accessible care and support are available for anyone experiencing mental health–related distress. The chat feature will be available through the Lifeline's website. People can use 988 if they are having thoughts of suicide, mental health or substance use crises, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support.

The Lifeline works! Since the Lifeline began in 2005, it has served as an invaluable resource, helping thousands of people overcome suicidal crisis or mental health-related distress every day. With the transition to 988, these life-saving services will be even easier to reach.

MISSOURI BEHAVIORAL HEALTH COUNCIL

Missouri Department of MENTAL HEALTH

988 Task Force

In preparation for the transition of the Lifeline to 988, the federal government and partners from across many industries in the public and private sectors are working together to provide guidance and resources to make our work a little easier.

Notably:

- The National Action Alliance for Suicide Prevention and its messaging task force developed the 988 Messaging Framework to provide guidance on developing 988-related messaging. We encourage you to closely review these guidelines. The framework provides strategies related to the timing of messaging before and after the transition to 988 in July. It also discusses the importance of understanding how 988 works locally, following communication best practices, and tailoring 988-related messages for specific audiences.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) created a one-stop shop, the 988 Partner Toolkit, at samhsa.gov/988. The toolkit is intended for SAMHSA's 988 implementation partners—including crisis call centers, state mental health programs, substance use treatment providers, behavioral health systems, and others—and provides key messages, FAQs, logo and brand guidelines, and more information about 988. SAMHSA will add social media posts, wallet cards, magnets, and other materials about 988 to the toolkit over time.
- SAMHSA has worked with partners across several critical industries to create a holistic view of readiness for the implementation of 988 for states, territories, tribes, crisis contact centers, public safety answering points (PSAPs) and behavioral health providers. Through these collaborative efforts, SAMHSA created guidance documents (e.g., "playbooks") for these critical groups to support implementation of 988.

While this is an exciting time to reimagine how we provide crisis services in our state and in the United States, the full vision of a transformed crisis care system with 988 at its core will not be built overnight. Transformation of this scale will take time, and we must all work together to make it happen. **It is important that we speak with one voice about 988 to ensure clear understanding about what it is and how it will work.** As SAMHSA continues updating its partner toolkit and providing guidance on 988 implementations, we look forward to working with all of you to bring these critical services to our Missouri communities.

For more information on 988 in Missouri, please visit https://dmh.mo.gov/behavioral-health/988-suicide-and-crisis-lifeline. If you have questions regarding 988 implementation in Missouri, please contact Casey Muckler at Casey.Muckler@dmh.mo.gov.

MISSOURI BEHAVIORAL HEALTH COUNCIL

Missouri Department of MENTAL HEALTH

988 Task Force

APPENDIX E

Mid-America Regional Council: 988 Focus Group Report

Background and Purpose of Focus Groups

In July 2020, the Federal Communications Commission adopted rules designating 988 as the new phone number for people living in crisis in the United States to connect with suicide prevention and mental health crisis counselors. Beginning on July 16, 2022, phone service providers will direct all 988 calls to the existing National Suicide Prevention Lifeline.

Mid-America Regional Council (MARC) is collaborating with Kansas City regional community mental health centers, public safety leaders, and emergency services in Missouri to develop a plan for how the region can work together to create the best system to serve people who need to use 988.

MARC is facilitating a steering committee of community mental health center leaders to examine best practices, hear ideas from local stakeholders, and collaborate on the future 988 implementation.

The 988 steering committee identified 122 people to participate in focus groups, all of whom were invited to participate in the conversation. The focus groups were divided into representatives of the following groups:

1. Police departments
2. Non-profit and social service partners
3. Fire, paramedics, and emergency medical services
4. Individuals or family members with lived experience accessing suicide prevention resources
5. Hospitals
6. K-12 schools
7. Faith-based community leaders
8. City, county, and court leaders
9. Funders and community leaders

Structure and Goals

Each focus group consisted of people from a specific industry or vantage point in order to gather diverse perspectives of how 988 can operate effectively.

Focus group meeting agenda:

- Welcome and introductions
- Background of 988
- Purpose of MARC 988 steering committee
- Goals of the focus group
    - Explore how each entity engages in the current process for suicide prevention resources
    - Discuss what is working well and what needs to be improved with the current system

    - Brainstorm future implementation of 988
- Closeout and next steps

Every focus group answered the following questions:

- What does your involvement look like with suicide prevention hotlines and response?
- What works well with the current process?
- What areas could be improved? If you could have the "perfect" system, what would it look like?
- What do you want to see for the future of 988?
- What should we be considering as we work with the region on best practices for suicide prevention hotline and response?

It is important to note that the structure of focus group 4 looked different than the others, as to be mindful of the personal and emotional nature of the topic. People in focus group 4 have lived experiences with accessing suicide prevention resources or are family members of those who accessed services. This focus group was organized to prioritize the story they had to share and insights for us to keep in mind throughout the design process.

Focus groups 3 and 5 were combined due to limited response from invited participants.

Trends Across Multiple Focus Groups

While each focus group had their unique perspectives on current suicide prevention resources and the future of 988, there were a few common pieces of feedback. The trends are organized by current and future state of suicide prevention.

Current State of Suicide Prevention Trends:

When asked about the past and current state of suicide prevention, these were common topics and feedback:

Mobile response is currently unreliable and not consistently implemented.

- While it depends on the community mental health center and area of the region, mobile response is supposed to happen, but does not always take place.

Future State of Suicide Prevention Trends:

When asked about the future state of suicide prevention, these were common topics and ideas:

Need for increased funding

- Almost every focus group mentioned the need for consistent funding streams to go to local community mental health centers in order to accomplish the goals.
- If funding does become available for these services and quality is achieved, the funding needs to continue rather than get redistributed to other needs or else the quality and access to services will decrease.

Empathy is essential in 988 responders

- When hiring or training, the importance of empathy emerged. Focus group attendees emphasized the need for 988 responders to treat the person on the other line as a human being first before addressing the logistic information needed (address, location,

etc.). They understood the importance of responders knowing the physical location of the caller; however the topic is so emotional and heavy, that addressing the needs of the caller is more important at the time.
- How the first call is handled will impact that person's overall experience and likelihood to seek out services in the future.

Community organizations and elected officials need to learn more about 988.
- Focus group attendees were unclear about how 988 was being shared across the region, but felt that civic leaders needed to learn more since it impacts so many industries.

The marketing of 988 should focus on preventative mental health support rather than suicide prevention.
- By the time someone has a plan to enact suicide, they are less likely to call for support. If 988 is marketed as mental health support, responders can get people connected to resources at an earlier stage and potentially reduce the amount of people reaching a heightened suicidal state.

Workforce shortages are concerning both community mental health centers and outside industries supporting mental health needs.
- The competitive job market and lack of financial resources are making hiring mental health professionals difficult.

Focus Groups: Key Takeaways and Additional Details

Focus Group 1: Police departments

Organizations Represented:
- Kansas City Missouri Police Department
- Lee's Summit Police Department
- Independence Police Department
- Emergency Management at Johnson County

Number of People Present: 5
Date and Time: 3/22 1-2

Big Takeaways:
- Having a mental health professional on dispatch is very helpful.
- A centralized dispatch center is desirable.
- Elected officials, hospitals, and police boards need to know more about and buy in to 988.
- Mobile response is not happening in the Kansas City urban/downtown area for a variety of reasons (including perceived safety issues, workforce shortage, and other reasons that are unknown to the focus group attendees).
- Phoenix has a good model of suicide prevention response that Kansas City could examine with a tax that helps fund it.

Additional Details:
Current process:
- Conceptually, the current process works well, but in practice, it is not following protocols.
- Police departments are creating separate and differing plans regarding 988 implementations across the region. A unified approach is preferred but that requires coordination.
- For many of the cases of people that reach out to crisis lines, they are calling in a state of suicide ideations, rather than suicide attempts, and therefore do not need police presence. But if the police are called, there is a duty to respond until they can get the correct resource in place. Liability is a primary concern for police departments when transferring calls.

Future process:
- The ideal mobile response team would be made of representatives from the fire, paramedic, social worker, peer support specialist groups.
- There is interest in having a centralized dispatching system like Johnson County.
- People desire safe places to take people who are experiencing a crisis other than a hospital.
- The ability and process to transfer calls and information between 911 and 988 is unknown, but important.
- Information sharing across organizations will be crucial in informed and timely response.

- Branding will be important for these responders. A badge/uniform can be a barrier for people wanting to access support, but identification will be necessary. Shirts and vehicles are recommended in a 988 brand rather than police brand.

Focus Group 2: Non-profit and social service organizations

Organizations Represented:
- Jackson County Community Mental Health Fund
- Tri-County Community Mental Health Services
- The Children's Services Center
- Benilde Hall
- Heartland Center for Behavioral Change
- Jackson County Children's Services Fund
- Artists Helping the Homeless
- Blue Springs Police Department
- Youth Thrive
- Community Services League
- Kansas City Care Center
- Lee's Summit Housing Authority
- Samuel U Rodgers Community Health Center

Number of People Present: 14
Date and Time: 3/14 1-2

Big Takeaways:
- There is a workforce shortage that Kansas City needs to address in order to successfully launch 988.
- In order to see change and improvement for mental health crisis response, there needs to be funding, transparency and accountability.
- The voice of people who experience suicide ideation or struggle with mental health issues need to be at the table for the design and implementation of 988.
- The current system does a good job identifying people who are struggling.
- One major improvement for suicide prevention resources is to have immediate follow-up for people that access services. They need to be scheduled for an appointment right away. Instead, there are often wait times to receive follow-up support. But a crisis doesn't wait months and people need support immediately.
- Public and shareable data across mental health organizations and supporting organizations would be helpful (ex. Are people connecting with services post crisis line?, How long does it take to connect them to services?, etc.)
- People suggested an online system that could connect people in crisis to the no-show appointments at local community mental health centers. There are many no-shows at the centers, so could there be a universal online system where people sign up and attend a video conference?

Additional Details:
Current process:

- The concept of mobile response is on target, but it is not implemented at full capacity.
- Wait times for follow-up services are too long for people who need support.

Future process:

- It is important to keep the people in crisis at the center of the process.
- The people who are responding to the crisis line should be culturally competent and diverse in background, including language, in order to best serve the community.
- The call line should be robust, responsive, and compassionate.
- There is concern that new people will access 988 and there will not be enough staff to handle the calls.
- There needs to be a focus on follow up and connecting to resources; The onus should not be on the client to take the action or reach back out.
- Priority should be placed on connectedness amongst actors in the ecosystem. For example, connectedness could look like help with warm handoffs, better follow up, and shared information systems.

Focus Group 3 and 5: Fire, paramedics, emergency medical services, and hospitals
Organizations Represented:

- Children's Mercy Hospital
- University Health
- Lee's Summit Fire Department
- Raytown Fire Department
- Independence Fire Department.

Number of People Present: 6
Date: 4/1/22 9-10am

Big Takeaways:

- Hospitals, emergency medical systems, and community mental health centers need to know each other's playbooks, including a well-defined triage protocol, and how they respond to crisis.
- Consistency in response is vital. Standard community mental health center protocols are preferable.
- Coordinated funding is necessary to make collaboration happen. Current grant programs are not coordinated across the ecosystem. Funding must be long-term to sustain efforts.
- It took 30 years to get the public aware of 911 and operating properly. It will take time for people to use and understand 988 as well.
- There needs to be a feedback loop on the 988 process to fire/emergency medical systems/hospitals so they know what to expect and can support it well.
- Many agencies are currently developing new systems for 988 but they are not integrated. Better integrated systems will be essential for a more coordinated response across agencies.

Additional Details:
Current process:

- The general public does not understand where to get services, so they reach out to resources like 911 or the hospital.
    - Resources should be provided to non-emergency callers
    - Connecting people to non-optimal resources can cause people to avoid reaching out for help again
- There is a heightened unawareness of resources for the pediatric mental health crisis situations.
- There is less stigma on receiving help for mental health crises than there used to be, but stigma still persists, particularly among parents of youth needing mental health services.
- Families with people who have autism or disabilities that are in crisis do not know where to go for help. They call for a variety of reasons or resources, but where can we direct them?

Future process:

- There needs to be clear expectations of what happens to a call for 911 and how to transfer to 988, and vice versa.

Focus Group 4: Individuals or family members with lived experience accessing suicide prevention resources

Organizations Represented:

- *Not included for respect of people's privacy due to the sensitive nature of the topic at hand.*

Number of People Present: 4
Date and Time: 3/15 9-10

Big Takeaways:

- Peer support specialists are helpful and underutilized.
- Calls should address people "warmly" and as human beings first before doing logistical and informational questions (address, etc.).
- Empathy, safety, and trust are the most important factors to make a successful call.
- The crisis line should address the crisis with multiple expertise on the phone including both clinical and nonclinical professionals.
- Avoid law enforcement presence if possible. There is a history of hard experiences for certain communities and the uniform can send the wrong message.
- Market 988 as a mental health crisis line rather than suicide prevention, so people can access resources before the severe suicide crisis is needed and it may be too late.

Additional Details:

Current process:

- People experiencing mental health crisis often access the line before they are about to act on suicide. If they are in a really dark place, then they will not use the service so it is better to operate 988 with a more preventative approach and connect people to resources or someone to talk to.
- There is not enough access to immediate resources when people call to receive help.
- People may use non-ideal resources in the absence of awareness or access to another option (police used for transportation, hospitals used as a safe place to stay).

Future process:

- The title suicide prevention hotline" already sounds like a finality, rather than preventative support.
- Different ethnicities of people responding to the phone and in-person is very important. People relate to others that they view as similar to them.
- A warm, empathetic response that creates an environment of safety and trust is essential.
- People working within the emergency services (and other high-stress environments) space need their own form of support and care through their employers (living wages, crisis planning, time off, culture of awareness and reaching out).

Focus Group 6: K-12 Schools

Organizations Represented:

- Rockhurst High School
- Kansas City Kansas Public Schools

Number of People Present: 2
Date and Time: 3/23 9-10

Big Takeaways:

- Empathy and compassion are essential for staff working 988.
- Schools need to learn more and understand the 988 process and what happens when students call it.
- A feedback loop for schools would be helpful. Can/should they ask students if they want someone at their school to know that they called this line?
- The way that 988 is marketed will matter to students. If it is marketed as a suicide prevention hotline, some children will not relate to that language. Many kids do not associate themselves as someone in crisis, even if they are in crisis.
- Accessing clinics can have one to three week wait and that is not acceptable for people in need.
- A text component to 988 will be essential to reaching youth. Social media (TikTok) is where they spend their time and attention.

Additional Details:
Current process:

- Schools have varying levels of services offered and have their own systems established. Some are internal (mental health school staff) and some are connections to outside resources (psychiatric centers and private practices). Some districts offer a 24-hour care line for youth or staff in crisis.
- There has been an uptick in deaths related to youth violence and drug overdose in the area.
- It is difficult to fill positions related to mental health roles.
- Students in this generation do not have language to articulate their feelings and so they do not know how to express themselves.
- Schools have existing structures and networks of support that should work in tandem with 988, including relationships with clinicians, sports programs, faith programs, and other youth groups.
- Schools have adopted different awareness campaigns and approaches to identifying individuals and helping connect them to resources for staff and students.

Future process:

- The focus group expressed desire for 988 to be accessible, quick, connective, and compassionate.
- The post-call connection to resources is one way 988 should measure success.
- It will be important to coordinate across state and county lines.
- Students need to be connected to sustainable resources and support for longer term care.

Focus Group 7: Faith-based community leaders

Organizations Represented:
- Faith Consultant
- Woods Chapel
- Church of the Resurrection

Number of People Present: 3
Date and Time: 3/28 11-12

Big Takeaways:
- Faith communities could host mental health community groups.
- Use faith communities as trusted messengers to share information about 988 resources with their constituents.
- If the faith community is involved in crisis response at a regional level, there needs to be a standard of care so they support all types of people. Certain religious organizations have philosophies on who can be members of their organization or what suicide means, and that should not reflect who they serve in this capacity. Hospital chaplains are non-denominational and could be incorporated into a faith-connection strategy.
- One practical step for 988 would be encouraging everyone to put 988 in their phones as a way to help their friends and family members who may struggle with it.
- The focus group recommended training people on how to be in the moment with their connections who are in crisis.

Additional Details:
Current process:
- Some faith leaders do not feel equipped to handle severe mental health crises.
- Some faith communities have devoted entire departments to mental health needs, including developing their own emergency crisis lines, counseling services, and robust standards of care.
- People are more receptive to seeking help for mental health needs than in the past. That may not be the case in more rural environments, however.

Future process:
- Standard of care is clear and shared across the community.
- Could there be a community chaplain (such as those in hospitals) that is not tied to any specific faith, but can be a referral for 988 services?
- 988 should help with prevention and warning signs before a crisis occurs.

Focus Group 8: City, county, and court leaders

Organizations Represented:

- Johnson County Mental Health
- 16th Circuit Court
- City of Raytown
- Jackson County COMBAT *(conducted on a separate phone call and included in this focus group summary)*
- Raytown Chamber of Commerce
- County Official of Jackson County

Number of People Present: 6
Date and Time: 3/28 10-11

Big Takeaways:

- Marketing should address mental health and not suicide so you can catch people earlier. The earlier and easier you make intervention, the better. Early intervention and connecting people to resources can keep people out of the criminal justice system for non-violent and minor offenses.
- There is a need for intentional communications internally and externally. Some jurisdictions are using grant funding for communications staff.
    - Internally: Messaging to law enforcement will be important
    - Externally: Public needs to be informed on how to use 988.
- Law enforcement should be used to make sure a scene is safe, but disturbance calls can often be managed without law enforcement, which is preferable.
- Resolve non-violent offenses without jail and with mental health resources instead. An example of how to do this is the Deferred Prosecution Program in partnership with ReDiscover.
- Access to text and video modes of communication are essential, especially for the younger generations.
- More funding is needed for 988 to provide additional resources.

Additional Details:

Current process:

- The criminal justice system should be used as an access point for mental health services.
    - Upon entering the system: For people entering Johnson County jails, there is a brief mental health screen that allows them to provide services on the spot and prevent repeat offenders. Then they have services in place after they exit jail.
    - Upon exiting the system, individuals should be connected to resources and ongoing support.
- Crisis hotlines are listed on all the jail resources
- People who call a crisis line should not be put on hold, but there is a lack of resources to add staff.
- The corrections system is a cycle, especially for those with substance use disorder.

Future process:

- The public needs to be educated on how to use 988 to support friends and family.

Focus Group 9: Funders and community leaders

Organizations Represented:

- Missouri Department of Mental Health
- Clay County Children's Fund
- Jackson County Community Mental Health Fund –
- Johnson County Mental Health Center
- Kansas City Area Transportation Authority

Number of People Present: 5
Date and Time: 3/25 1-2

Big Takeaways:

- Hyper-focusing on suicide does not address larger mental health crisis that the community faces. Branding should include mental health.
- We need better coordination and more consistency across the ecosystem. If funding is piecemealed, then implementation is piecemealed.
- Mobile response needs a universally understood definition and application.
-
- Accountability will increase the answering of calls and reduce wait times for people.

Additional Details:
Current process:

- The current process has too long of wait times to answer calls.
- Transportation is a barrier to services for some individuals.
- There is a need for better coordination and more consistency across the ecosystem

Future process:

- Safety is a concern for mobile crisis response. How is the dispatch being determined? Is it by someone locally or at a centralized location? How are they going to assess safety?
- The role of law enforcement should include triage and safety.
- Location-based tools can help with security concerns. Ideal equipment would include GPS tracking for non-police responders that are connected to police for monitoring.
- Mental health service providers could gather to share processes and when to do warm handoffs to one another.
- Speed of response is a priority for callers and service providers.
- We need a safe place to bring folx that is not jail.
- There are a lot of funds available for mental health through a variety of sources.

APPENDIX F

988 Quantitative Findings Report

Report last updated 6/7/22

Contents

Executive Summary

As outlined in the Memorandum of Understanding Among Mid-America Regional Council and Missouri Community Mental Health Centers Serving the Greater Kansas City Region, the quantitative analysis aspect of the 988 strategic planning process was an exploratory one. It was unclear at the outset of the project what type of data would be available to consider and in what condition that data would be. The MOU outlined some core analysis elements to consider, most of which are addressed by the data, but with a higher level of uncertainty than preferable.

- **Call volumes:** Missouri Department of Mental Health (MO DMH) data from 2019 to 2021 showed a decrease in total crisis calls in 2020 (-8.9%) and very little change in volume in 2021 (-1.58%). Further investigation into these trends showed that the 2020 decrease was a data integrity issue, not a true decrease of 8.9%. NSPL call data provided by CommCare showed an increase in crisis calls by 143% from 2019 to 2020, and by 16% from 2020 to 2021.
- **Projected increase in call volumes following 988 implementation**: Using the Vibrant model, which includes a *low*, *moderate*, and *significant* scenario, call outreach is expected to have little change (low scenario) to 127% increase (significant scenario). In all scenarios, SMS and chat outreach is anticipated to increase.
- **Frequency of calls and outcomes**: 24% of Missouri DMH Access Crisis Intervention (ACI) calls for the KC region (Missouri only) were resolved on call. 18% were referred to mobile crisis, and of those, 20% were seen face-to-face (80% phone contact only). Only 2% were referred to law enforcement.
    - One of the questions that could not be answered by the data provided is the percentage of referrals who access and complete treatment. This is not part of the data collected by MO DMH or CommCare through ACI reporting, and it is not currently possible to track a client from call to resolution in a systematic manner.

The most significant finding of this analysis was that the availability and quality of data available were considerable limiting factors to this work. The implications of this finding are that there is significant work to be done in order to set up a robust monitoring, evaluation and information sharing system at the regional level, and across agencies (Community Mental Health Centers and others).

Methodology

Methods used in this analysis were exploratory and are outlined below.

Data Requested and Received

Data was requested from a number of partners throughout the Kansas City region to support quantitative analytics related to the mental health crisis response system. These partners included, but were not limited to, hospitals, police departments, the Department of Mental Health (DMH), CommCare, and Community Mental Health Agencies. Partners responded with varied degrees of detail, which is explored further in the findings.

The goals of the analysis were roughly formed before a clear understanding was gained of what data would and would not be available to the research team, and these goals were met to the extent possible with the information provided from the above outlined partners.

Outline of Analysis Request

The expectation of quantitative exploration for data related to the mental health crisis response system in the Kansas City region was defined in the Memorandum of Understanding Among Mid-America Regional Council and Missouri Community Mental Health Centers Serving the Greater Kansas City Region as the following:

-- Excerpt from page 15 of the MOU --

Analysis may include and not be limited to the following:

- Current responses models and resources (budget and personnel) for CMHCs including business hours and after hours response.
- Best practices from peer communities with strong reputations or performance indicators for regional crisis response models.
    - Expertise will be sought from state and national associations such as the Missouri Department of Mental Health, the National Alliance on Mental Illness (NAMI) or others.
    - MARC will research Kansas Behavioral Health Services and/or mental health agencies serving the Kansas side of the region to understand their approach(es) to988 and seek opportunities for bi-state coordination.

- Analyzing regional mental health calls over the past 1-3 years based on available data to understand trends
    - Call volumes – rate of increase/decrease over time
    - Projected increase/decrease following conversion to 988oPeak days and time periods for mental health calls
    - Frequency of calls and outcomes
        - Resolved on call
        - Referred for CMHC for service
            - Number/percentage of referrals who access and complete treatment
        - Referred to CMHC for mobile response
        - Referred to 911 for police/EMS/fire response
        - Other
- Analyzing regional 911 behavioral health calls for service to understand trends
    - Call volumes – rate of increase/decrease over time
    - Projected increase/decrease following implementation of 988
    - Peak days and time periods for mental health calls
    - Frequency of calls and outcomes
        - Arrests
        - Transport to hospital/EMS
        - Referred for CMHC for service
        - Other

-- End excerpt –

Data Requested and Received from Partners

Data requests were facilitated by MARC subject matter experts, partners, steering committee members and technical advisors. They were approached with a specific request as a recommendation, but with a description of the research goal and invitation to suggest other or additional pieces of information that might be helpful to inform the work of the 988 Steering Committee.

Hospitals

Hospital contact was facilitated by Dr. Betsy Henderson, M.A., LMFT, the clinical director at KCATC and HDI. Data request was sent with the goal to "understand the need and predicting the volume of calls, type of calls, and what the resources they might need to access are. Because there is no central database for this information shared across different providers, I'm trying to piece together different sources to best predict what resource needs might be.", and detailed the following fields as useful information, but also opened up the opportunity for discussion:

- Unique ID
- Date Time
- Zip code of residency
- Housing status
- Presenting to emergency room with mental health and/or substance use diagnosis
- Walk-ins, police department, EMS
- Discharge location

Request was sent to Saint Luke's, North Kansas City Hospital, University Health (formerly Truman Medical Center), and Missouri Hospital Association.

Data Received

Saint Luke's Health System

Saint Luke's Health System shared aggregated data and findings rather than a raw dataset. The following is a copy of the information shared from Derek Collins of SLHS.

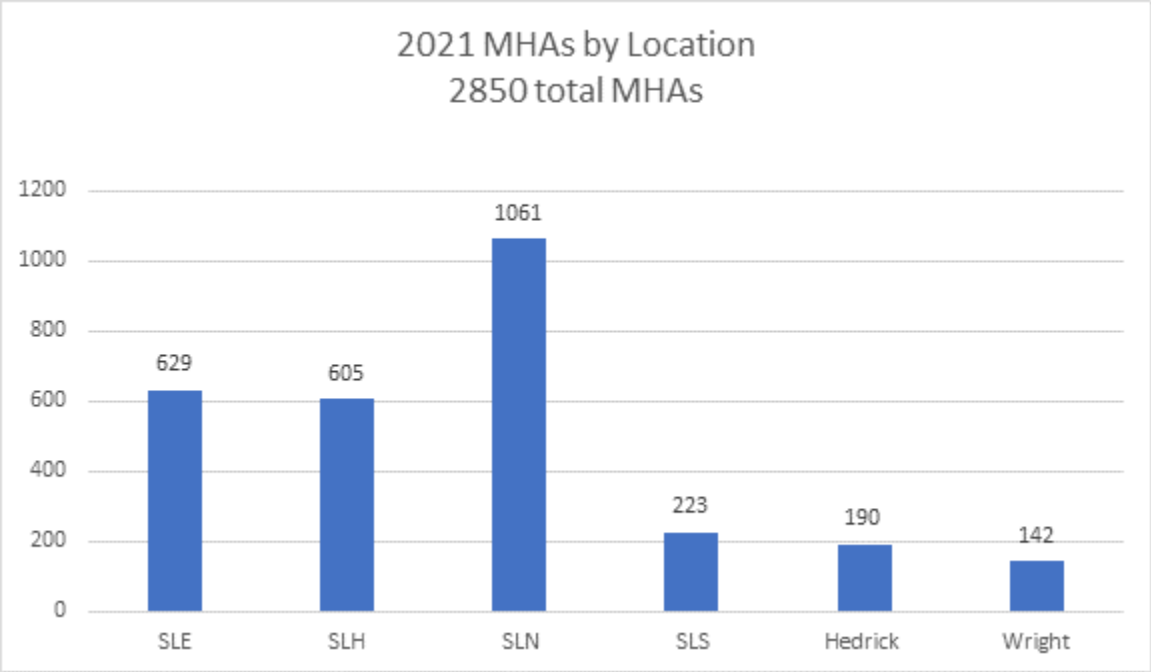
Below is information I was able to gather for SLHS Emergency Departments. Please let me know if this is what you are looking for.

1st quarter 2022, SLHS EDs saw 381 BH patients.

279 were admitted internally or transferred to an external facility.

102 were discharged from ED.

Below is a chart that shows the number of mental health assessments conducted by locations (ED) in 2021. I will continue to see what I can pull.



North Kansas City Hospital

North Kansas City hospital shared the following summary data:

University Health

University Health shared line-by-line data in an attachment for the following line items for 2021- Q1 2022:

- Unique ID
- Location
- Year
- Day of Week
- Hour of Day
- Age
- Arrival Mode Group
- Language
- Disposition Group
- County
- 3 Digit Zip

Additional comments from UH: Unfortunately, any part of a date more specific than the year is considered PHI. I can tell you our overall ED volume in Q1 increased about 2% from 2021 to 2022, but the volume of identified visits for psych/ substance abuse decreased 18%. It definitely doesn't feel like that in the ED – the impression is we're seeing far more patients with psychiatric and substance issue issues than ever before – so my guess is that's an anomaly in the data rather than a true decrease. For example, instead of documenting things like "alcohol intoxication" and "PCP use" they may have started using more generic descriptions like "altered mental status."

Missouri Hospital Association

The Missouri Hospital Association (Bryant McNally) expressed a willingness to assist through HIDI data but shared that requests can take months and therefore it would not be ready in time for this strategic planning process.

Police Departments

Police department contact was facilitated by MARC Public Safety Program Director, Eric Winebrenner. Data request was sent with the goal to "Help with understanding community needs/future projections", and detailed the following fields as useful information, but also opened up the opportunity for a discussion:

- *Unique ID*
- *Date Time*
- *Call Type Code (substance use, mental health)*

- *Zip Code*
- *Discharge location / Result of response*

Request was sent to Kansas City Police Department, Lee's Summit Police Department, and the City of Independence Police Department for 2019 – present, or whatever data was available.

Data Received

Kansas City Police Department

The Kansas City Police Department contact facilitated by MARC staff did not respond to the request, however, ReDiscover's Shannon Moss was able to share KCPD 911 Call Stats for July 2021 as summary statistics shared in a Word document:

KCPD 911 Call Stat Compilation – CIT Unit

CIT/EDP Stats – Calls for Service July 2021

- **EMOTIONALLY DISTURBED PARTY (EDP) = 957 (Total 911 Calls)**

  SUB-CATEGORIES:

  - ***Responding with Ambulance = 66***

    PATROL DIVISIONS:

    CPD: 16

    MPD: 14

    EPD: 13

    NPD: 4

    SPD: 9

    SCP: 8

    Other: 2

    Alt. handled/Cancelled: 0

    WATCH:

    W-1 (0100-0600) - 7

    W-2 (0700-1500) - 40

    W-3 (1600-2400) – 19

  - ***Check the Welfare = 186***

    PATROL DIVISION:

    CPD: 55

    MPD: 45

    EPD: 25

    NPD: 13

    SPD: 13

SCP: 16

Other: 3

Alt. handled/Cancelled: 14

WATCH:

W-1 (0100-0600) - 33

W-2 (0700-1500) - 84

W-3 (1600-2400) – 69

- ***Disturbance = 215***

PATROL DIVISION:

CPD: 49

MPD: 65

EPD: 34

NPD: 22

SPD: 21

SCP: 23

Other: 3

Alt. handled/Cancelled: 1

WATCH:

W-1 (0100-0600) - 15

W-2 (0700-1500) - 110

W-3 (1600-2400) – 90

- ***Youth = 4***

PATROL DIVISION:

CPD: 1

MPD: 0

EPD: 0

NPD: 0

SPD: 0

SCP: 2

Other: 0

Alt. handled/Cancelled: 0

WATCH:

W-1 (0100-0600) - 1

W-2 (0700-1500) - 1

W-3 (1600-2400) – 2

- ***Missing = 28***

PATROL DIVISION:

CPD: 2

MPD: 7

EPD: 2

NPD: 2

SPD: 6

SCP: 2

Other: 0

Alt. handled/Cancelled: 2

WATCH:

W-1 (0100-0600) - 4

W-2 (0700-1500) - 13

W-3 (1600-2400) – 10

- ***Check Welfare Suicidal EDP = 402***

PATROL DIVISION:

CPD: 99

MPD: 67

EPD: 93

NPD: 42

SPD: 44

SCP: 45

Other: 2

Alt. handled/Cancelled: 10

WATCH:

W-1 (0100-0600) - 47

W-2 (0700-1500) - 150

W-3 (1600-2400) – 207

- ***Suspicious Party EDP = 38***

  PATROL DIVISION:

  CPD: 12

  MPD: 6

  EPD: 9

  NPD: 2

  SPD: 4

  SCP: 3

  Other: 1

  Alt. handled/Cancelled: 1

  WATCH:

  W-1 (0100-0600) - 5

  W-2 (0700-1500) - 27

  W-3 (1600-2400) – 6

- ***Weapon Party Armed = 15***

  PATROL DIVISION:

  CPD: 5

  MPD: 2

  EPD: 1

  NPD: 2

  SPD: 3

  SCP: 1

  Other: 0

  Alt. handled/Cancelled: 0

  WATCH:

  W-1 (0100-0600) - 0

  W-2 (0700-1500) - 11

  W-3 (1600-2400) – 4

- **CHECK THE WELFARE = 788 (Total 911 Calls)**

  PATROL DIVISION:

  CPD: 141

  MPD: 150

EPD: 177

NPD: 80

SPD: 78

SCP: 101

Other: NA

Alt. handled/Cancelled: 27

Lee's Summit Police Department

The City of Lee's Summit shared the following:

"We track this information quite closely due to our involvement in the Crisis Intervention and Mental Health Co-Responder program. I think the challenge will be figuring out what calls would be appropriate for 988 as opposed to emergency response. That seems like it would require a more significant drill down into each call.

We do have a code, but without digging in deeper and actually evaluating each call it is tough to determine if it is an emergency requiring a police response or something that 9-8-8 is more appropriate for.

We have estimated that out of 1,276 mental health calls from 2021, we would estimate 45-50% of those calls could have been diverted to 988 (somewhere in the neighborhood of 600 calls). This was based upon a review of a selected period of the calls that will likely carry forward."

City of Independence Police Department

The City of Independence provided the following CIT numbers from IPD/Comprehensive Mental Health over 2021:

"After discussion with Captain Garcia and CIT Officer Abraham, it appears we don't have an accurate way to track the needed information from past calls. We receive so many calls with potential ties to mental health, but those calls get classified any many different ways. To further complicate things, since we brought on our Co-Responders, some calls get routed straight to them and might not get a call classification. We can try to track this information in the future, but it will require some hard work from dispatch to set things up.

I do want to ask the reason behind the need for 988. A known crisis line exists, and many departments have active Co-Responders partnerships. I have been an active member of the Kansas City area CIT council for 15 years, and the issues in this area don't revolve around the initial call for help. The area needs more hospital beds and transportation for consumers when they need help. Many consumers need extended stays in an in-patient facility, but those only exist for extreme cases. Many people don't have vehicles or reliable support, so they miss appointments and fall into crisis. Those crisis calls cause unnecessary taxing on our officers, AMR, and ERs. Beds and supports to appointments are what KC needs, not an additional contact number."

Month	Independence
Jan	45
Feb	29
Mar	46
April	53
May	59
June	43
July	47
Aug	50
Sept	63
Oct	51
Nov	84
Dec	66
Year Total 2021	***636***

Department of Mental Health (DMH)

The Missouri Department of Mental Health contact was facilitated by their Suicide Prevention Specialist, Casey Muckler. Data request was sent with the goal to "look at existing datasets that might inform our steering committee to help support their decision-making processes.", and detailed the following fields as useful information but also opened up the opportunity for a discussion:

ACI Quarterly report data for the region's CMHC's (SWOPE Health, ReDiscover, Tri-County Mental Health Services, Truman Behavioral Health/ University Health, Comprehensive Mental Health Services (CMHS) / Burrell Behavioral Health, Compass).

Request was sent to the Missouri Department of Mental Health, who sought approval from each of the CMHCs to share their data before providing data to MARC.

Data Received

The Missouri Department of Mental Health shared three documents in response to this request: FY21 Annual ACI Report (pdf report), ACI Aggregate Data FY 2011-2021 (pdf report), and ACI Data FY 2019-2022 (summary dataset).

CommCare

CommCare is represented on the 988 Steering Committee by Michelle Watson, who facilitated contact with Dale Gray who assisted with the data request. Data request was sent with the "ultimate objective… to provide valuable insights to our regional partners that might help inform their work in planning for 988 implementation.", and detailed the following fields as useful information:

- Date
- Time
- Duration
- Caller geography
- Line/DFN
- Termination Number
- Status
- Total Calls

The request also outlines the following research objectives, and opened the door do additional recommendations:

- Pre and post-pandemic comparisons (therefore hoping for a 3 year lookback if possible)
- Projections for 988 impact on call volumes
- High and low times of day, days of the week, months of the year, etc.
- Demographic trends
- Call types and call resolutions

Data Received

CommCare shared data for 1/1/2019 to 1/31/2022 in the form of an excel document containing the following fields:

- CallTypeName
- DateOfCall
- TimeOfCall
- CallerID
- ClientID
- ReferToAgency
- AssessmentID
- CallDuration
- CallCount
- City

- State
- Zip

CommCare noted that some fields like Call Count and Call Duration were not being captured in the beginning of the report. Also, many clients do not give their address so there will be missing data for those calls.

Community Mental Health Agencies

Community Mental Health Agencies (CMHAs) have been integral throughout the strategic planning process. They were asked to help define the research questions to explore in the data exploration process. They did not express any additional questions beyond what was outlined in the MOU. They were also asked to provide any data their agency thought might be helpful to the strategic planning process.

Data Received

No quantitative data was shared by the CMHAs during the strategic planning process. Rich qualitative data was shared in the form of focus groups, interviews, protocol and operating procedure documents, and input throughout the strategic planning process.

A more structured request to the CMHCs for specific data would likely yield better results in data collection from the CMHCs for future work.

Findings

Performance Indicators

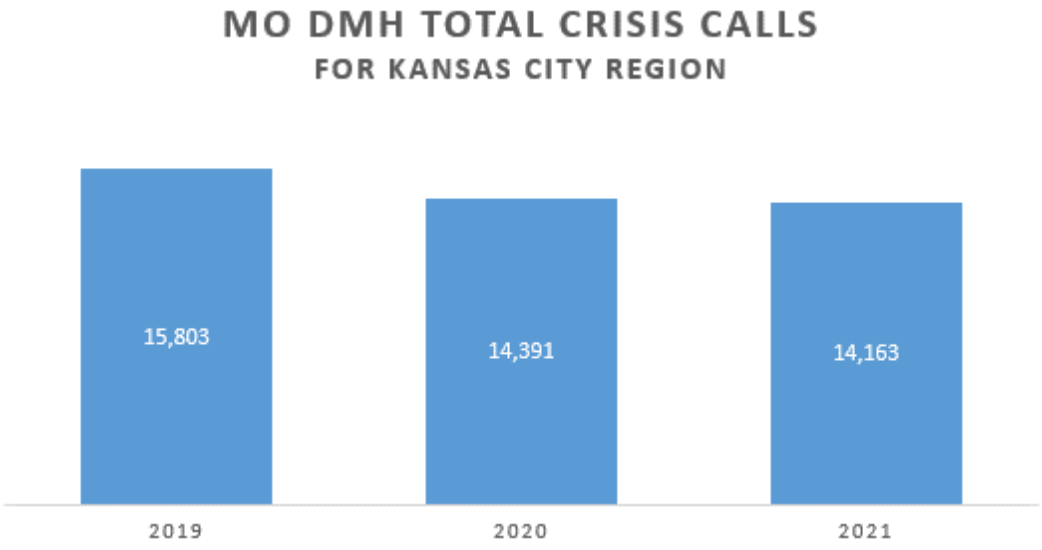
As part of the broader 988 strategic planning process for the Kansas City region facilitated by MARC, the CMHCs agreed upon the SAMHSA

Trends in Regional Mental Health Calls

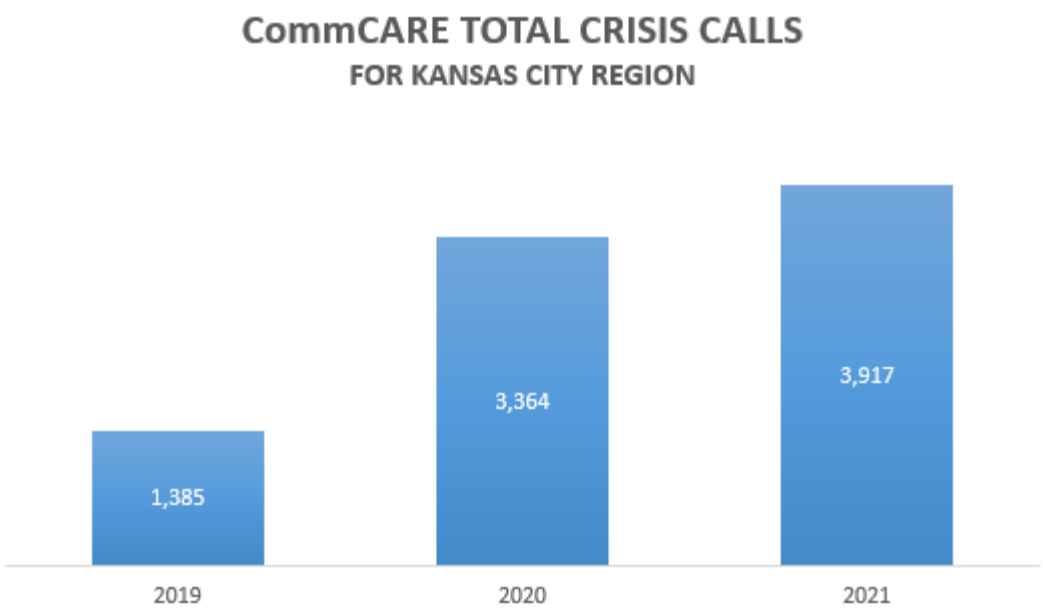
Call volume trends at the regional level are difficult to discern due to data integrity issues. While CMHAs reported increasing demand in their service areas, data available for year-over year comparison showed no increase in crisis call volume (and actually showed a decrease).

Call Volumes

Missouri Department of Mental Health (MO DMH) data from 2019 to 2021 showed a decrease in total crisis calls in 2020 (-8.9%) and very little change in volume in 2021 (-1.58%). Further investigation into these trends showed that the 2020 decrease was a data integrity issue, not a true decrease of 8.9%. According to the MO DMH research team, "*crisis calls were separated from information-only calls in 2019, resulting in fewer "crisis calls". Previously, crisis calls and information-only calls were categorized together, but this wasn't actually capturing true crisis calls.*"



NSPL call data provided by CommCare showed an increase in crisis calls by 143% from 2019 to 2020, and by 16% from 2020 to 2021.



Projected Increase/Decrease Following Conversion to 988

Vibrant Emotional Health has compiled models to project the populations likely to utilize 988, and the potential volume of contacts via phone, SMS, and online chat for the first five years of 988's service[1]. Following this model, we estimate the baseline of callers to be 14,143, or the number of NSPL calls reported to MO DMH in 2021. The estimated divertible 911 mental health-related calls is the most difficult to estimate, as the sample for 911 data available was very limited and not very compatible. This rough estimate resulted in 10,974 divertible 911 calls. The serviceable population in the five-county region (Cass, Clay, Jackson, Platte and Ray) is estimated to be 260,560, or 26% of the population ages 12 years and older[2]. Using the Vibrant methodology, the estimated volume of calls, chat, and SMS for each scenario model (low, moderate, and significant) are as follows:

Scenario	NSPL Growth (New)	Serviceable Population as New	Crisis Center Diversion	911 Diversion	Total
Low	143	13,028	6,393	1,097	20,670
Moderate	991	26,056	7,306	2,195	36,548
Significant	1,983	39,084	8,220	2,292	51,579
	> 50% of projected increase resulting from new clients				

Vibrant predicts 65% of this volume to be calls, 30% online chat, and 2-6% SMS, resulting in the following volume of each for the Kansas City Region:

Scenario	Call	Chat	SMS	Total
Low	13,435	6,201	1,033	20,567
Moderate	23,756	10,965	1,827	36,548
Significant	33,526	15,474	2,579	51,579

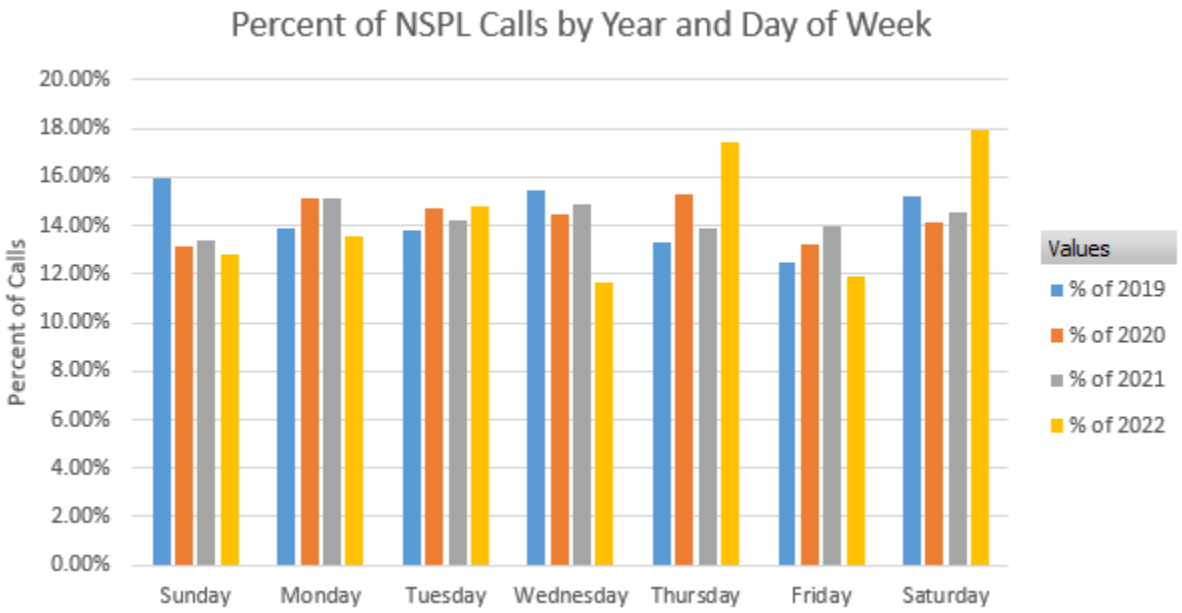
The Low scenario shows a *decrease* in call outreach compared to the baseline of 14,163 crisis calls reported to MO DMH in 2021, but an increase of overall outreach (when including chat and SMS). The Moderate scenario estimates a 90% increase in call outreach, and the Significant scenario estimates a 127% increase in call outreach.

1 Vibrant Emotional Health 988 Serviceable Populations and Contact Volume Projections Dec 2020 Report

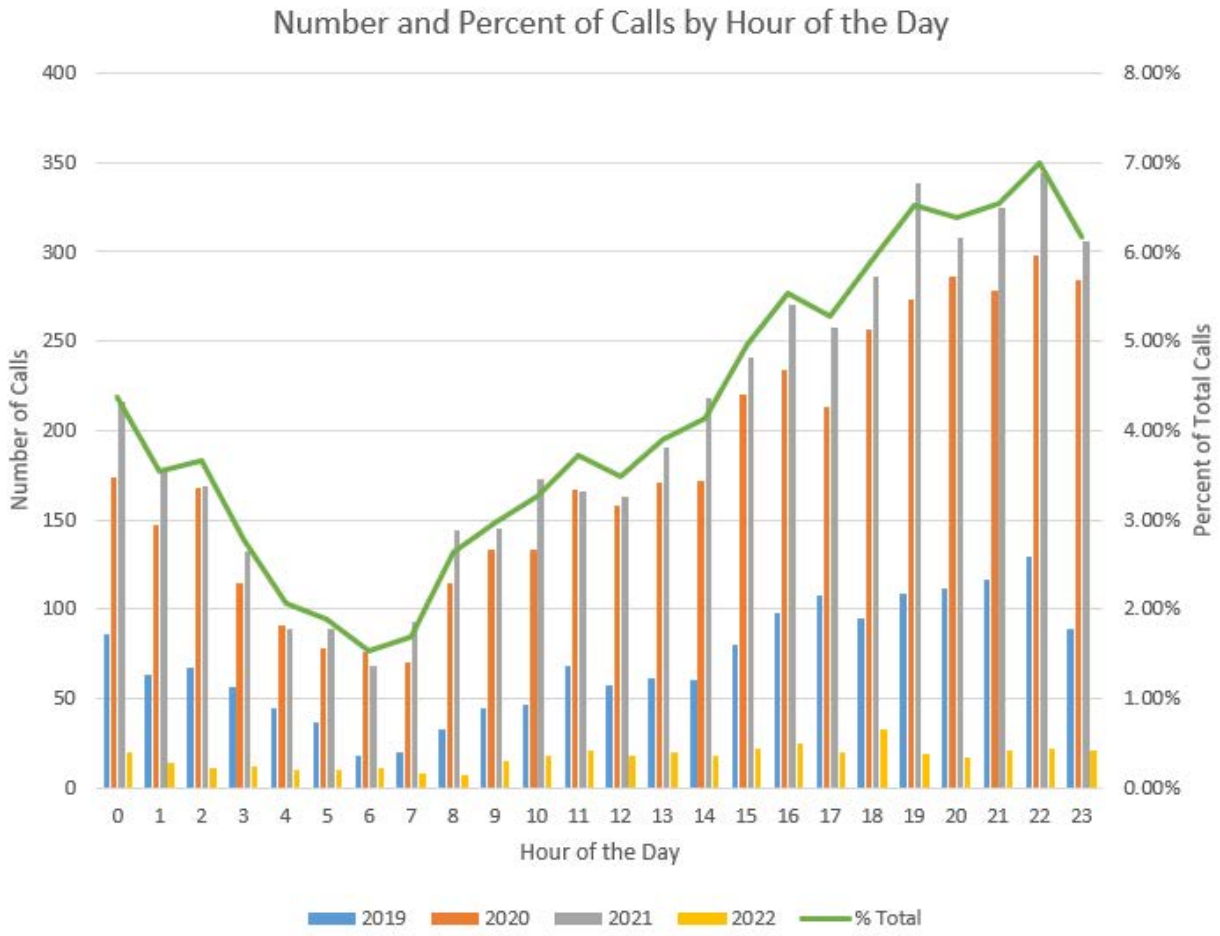
2 Using 2019 American Community Survey Population Estimates

Peak Days and Time Periods for Mental Health Calls

Day and time of call were not provided by MO DMH. The data provided by CommCARE showed very little variation in call volume by day of the week.



Because CommCARE acts as the after-hours service for many of the region's CMHA's it is to be suspected that the busiest time periods for the data provided to us by CommCARE shows the busiest hours of the day to be after most CMHA offices have closed for the day, with 38.5% of calls taking place between the hours of 6:00 pm and midnight, and 10:00 – 11:00 pm being the "peak" time period. The lowest percentage of calls occur in the early morning hours, with only 1.5% of calls occurring between 6:00 and 7:00 am.



Data regarding time of day was not provided by MO DMH.

Frequency of Call Outcomes

The Missouri Department of Mental Health shared with us their FY21 Annual ACI Report for July 1, 2020 – June 30, 2021, as well as the data for the CMHCs in the Kansas City region. The outcome of crisis calls for the state of Missouri compared to the Kansas City Region were outlined as follows:

Outcome of Crisis Calls	KC Region	Missouri
Problem resolved	24%	15%
Referred to Mobile Crisis	18%	10%
Referred for urgent or emergent appointment for CPS Services	3%	3%
Referred for urgent or emergent appointment for ADA Services	1%	<1%
Referred to other community agency	6%	29%
Referred/Admitted to Psychiatric Inpatient Hospital/unit	14%	4%
Referred to 911/law enforcement/juvenile officer	2%	2%
Referred to hospital alternative	2%	<1%
Referred to existing provider for follow-up	19%	22%
Referred for involuntary detention activities	3%	<1%
Referred to medical facility for med. Reasons	1%	1%
Referred to emergency subs. Abuse trmnt	0%	<1%
Non-emergency: Referral to DMH CPS services	5%	11%
Non-emergency: Referral to DMH ADA services	2%	<1%
Non-emergency: Referral to DMH MRDD services	0%	<1%

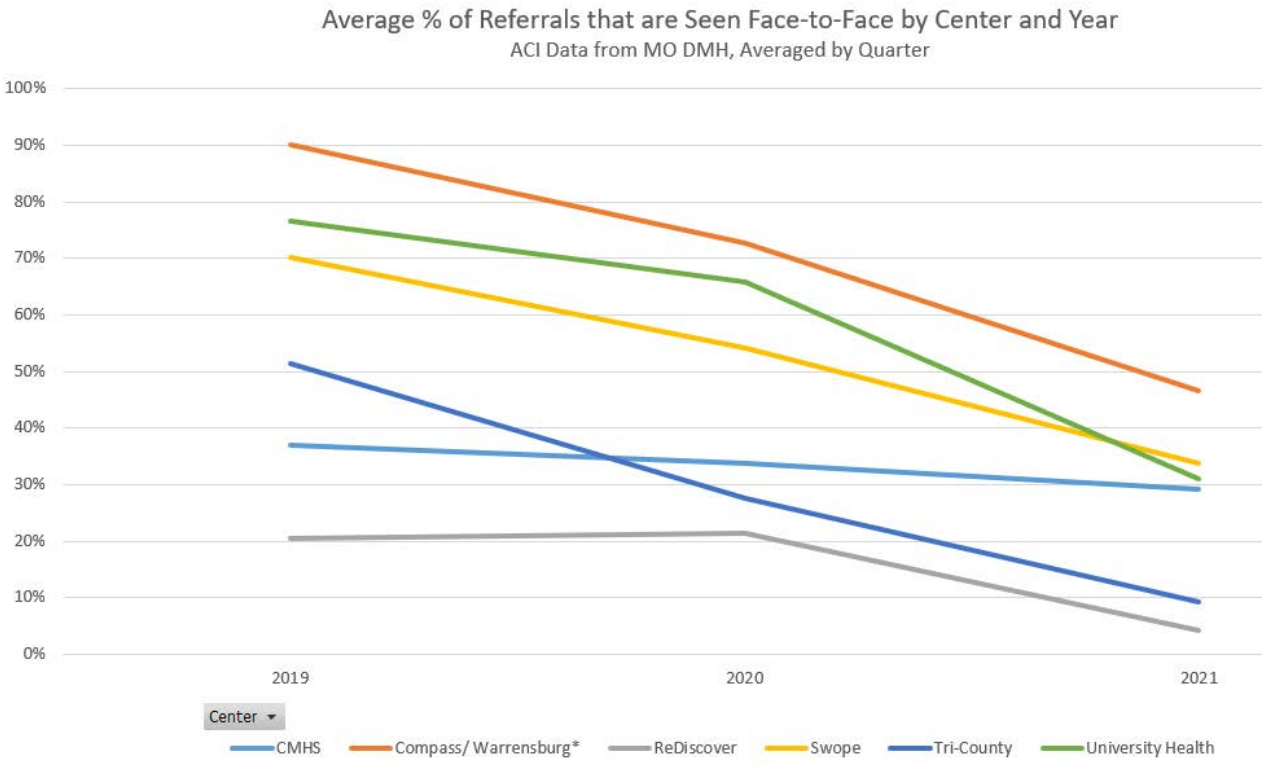
In instances of large percentage differences between the state of Missouri and the KC Region, further investigation is required to understand *why* the region differs from the rest of the state.

Of those that were referred to mobile crisis (18% of crisis calls for Missouri, 10% for the Kansas City Region), the disposition of the referrals break down as follows:

Disposition of Referrals	Missouri			KC Region		
	2019	**2020**	**2021**	**2019**	**2020**	**2021**
Phone Contact Only	30%	22%	45%	25%	60%	80%
Face-to-Face Contacts	70%	78%	55%	75%	40%	20%

Compared the state of Missouri, the Kansas City Region CMHCs have less face-to-face contacts. This has been true since 2020, when we saw a significant decrease in face-to-face contacts as a percentage of total referrals, and continue to see a decrease. This decreasing trend is true across CMHCs, but to different degrees and with very different baseline percentages (a high of 90% to start and a low of 20% to start). In 2021, 55% of Missouri referrals were face-to-face contacts, whereas only 20% were face-to-face in the Kansas City region.

Once crisis calls are referred to mobile crisis, CMHCs see a different percentage of these referrals face-to-face. From 2019 to 2021, all CMCHs saw a decrease in the percentage of referrals that were seen face-to-face. However, Compass saw nearly 70% of referred calls face-to-face on average, while ReDiscover saw just over 15%.



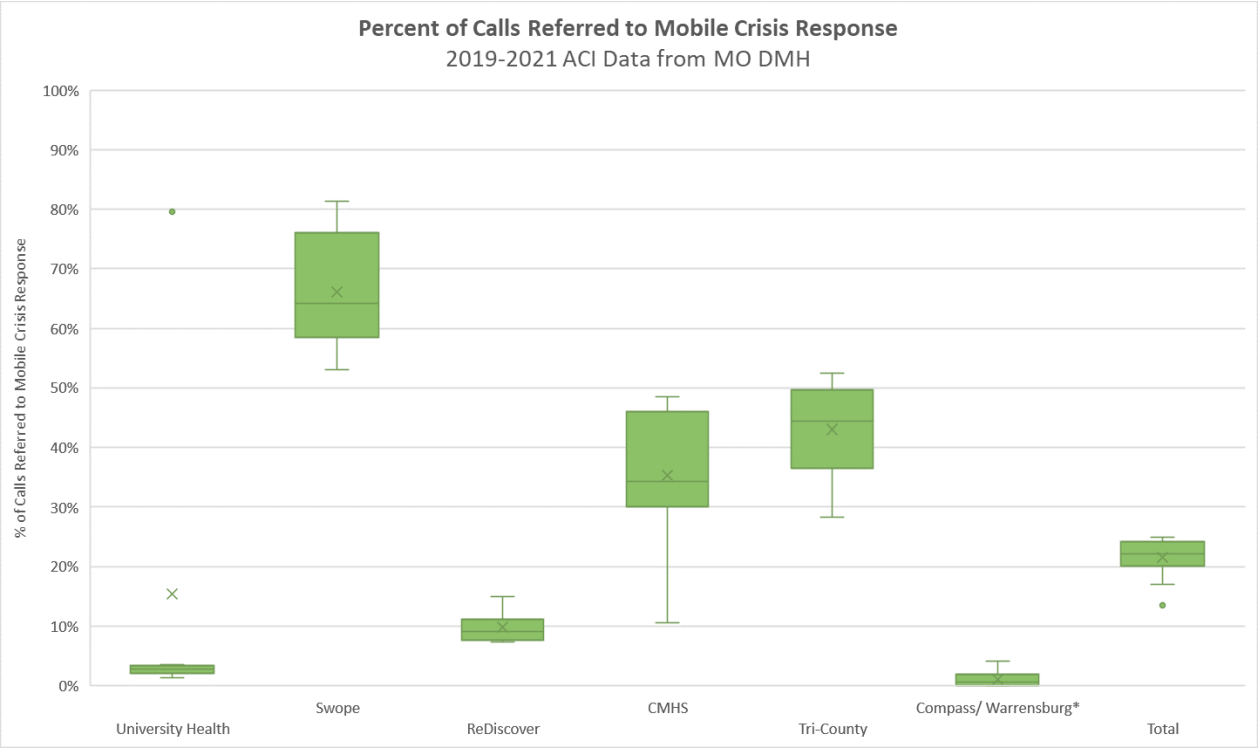
Regional Variation

Based on the data provided by MO DMH, it is clear that there are significant differences across the CMHCs in the Kansas City region. What is less clear is the reason for the differences in data reported:

The percentage of total Crisis Hotline calls referred to mobile crisis response varies widely by CMHC.

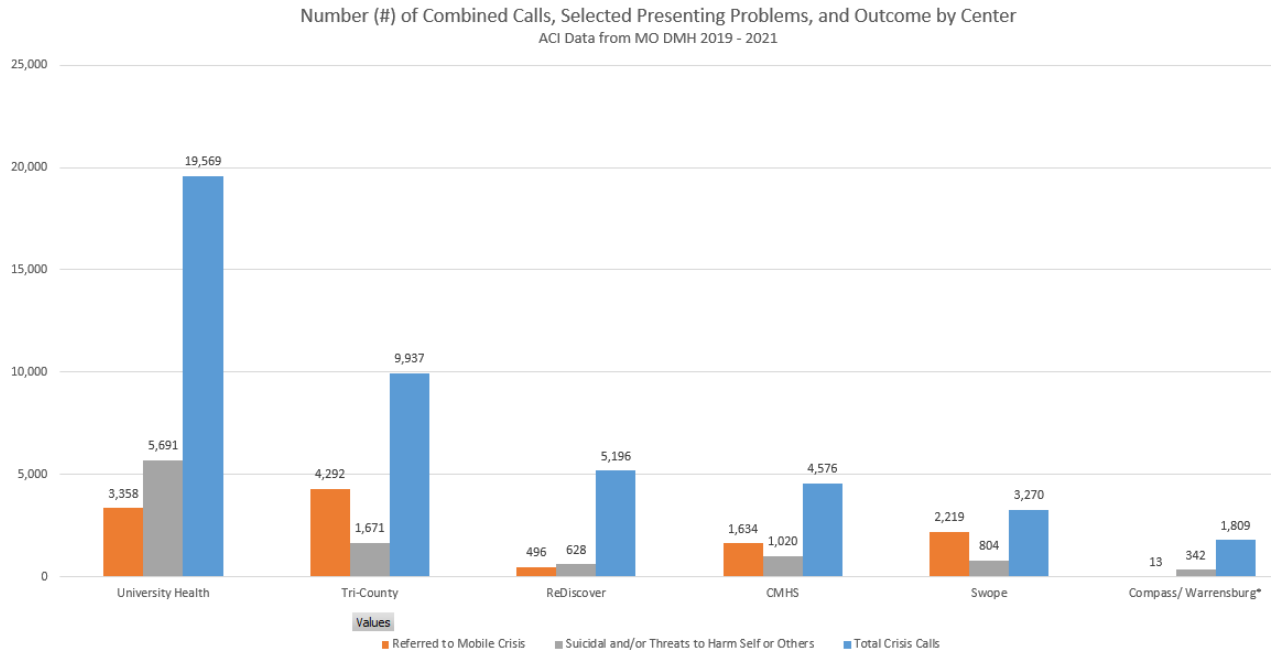
The average percentage of calls referred to mobile crisis for all centers combined over the three-year period was 27.45% for the Kansas City Region CMHCs. 18% of crisis calls (centers combined) in 2021 were referred to mobile crisis. In the state of Missouri in 2021, 10% of crisis calls were referred to mobile crisis.

Below you can see the distribution of percentages by center over the past three years, with each quarter representing a discrete percentage. Swope had the highest average percent at 66.12%, and Compass/ Warrensburg had the lowest at 1.02%.

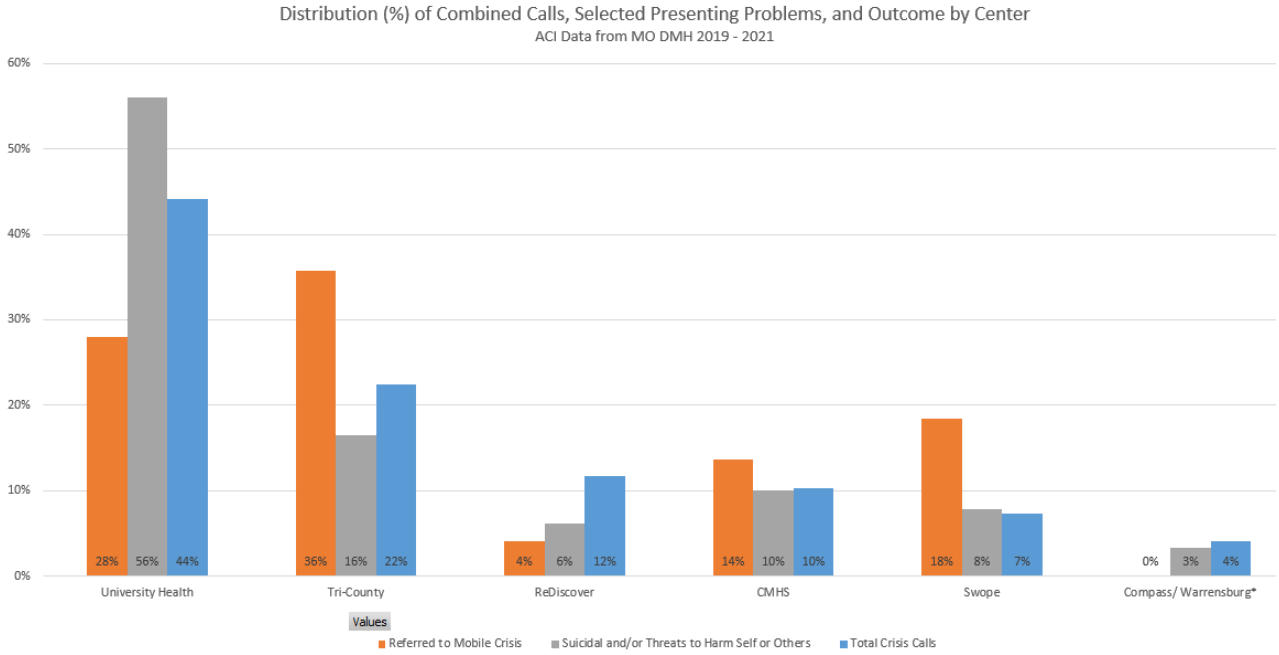


One possible reason for the low percentage at University Health is that historically, specifically after hours, University Health's mobile crisis staff work in the ER. If someone needed to be screened or needed mobile crisis, their staff would ask the person to be sent to the ER. So instead of paging mobile crisis for a community response, the crisis line staff would either refer the person to the ER and/or explore other call resolutions and not page mobile crisis. This may have influenced the mobile crisis numbers seen above.

There is not a direct correlation between the number of calls that would indicate the need for mobile response (Currently Suicidal, Harm or threats of harm to self (other than suicidal), and/or Harm or threats of harm to others), and the number of calls referred to mobile response. This may indicate a discrepancy in the way centers complete their ACI reports, or the point at which they refer a client to mobile response.



One could hypothesize that the percentage of the region's calls of specific presenting problem received by a single center (# X presenting problem received by center Y / # X presenting problem received by all centers) would mirror the percentage of all crisis calls received by a center (# Y center's calls / sum of all centers calls). However, this is not true for the ACI data received by MO DMH for 2019-2021. Below you can see that Tri-County handled more of the region's mobile response referrals than any other center at 35.73%, despite receiving only 22.40% of the total crisis calls in the region.



Variation in numbers may be the result of different ways of interpreting reporting fields or differences in actual response actions. Further investigation is required to understand the reason behind variation throughout the region, but it is clear that significant differences do exist across centers in the region.

Trends in Regional 911 Behavioral Health Calls

Quantitative data regarding behavioral health calls received by 911 resulted in the most limited dataset. Limitations of the data provided are discussed in the following *Limitations* section.

Data provided by police departments did not indicate a rate of increase or decrease in call volumes over time. The only longitudinal data provided was the CIT numbers by month for the year of 2021 from Independence Police Departments,

which wouldn't account for seasonal trends, nor pandemic impacts on the call volume. News reports from 2021 do report a surge in *overall* 911 calls in Kansas City, and national numbers

Peak days and time periods for mental health calls were also not extractable from the information shared by police departments, nor were outcomes of those calls.

Trends in Hospital Emergency Department Use

While trends in hospital emergency department use was not part of the initial data request, hospitals are certainly part of the mental health continuum of care.

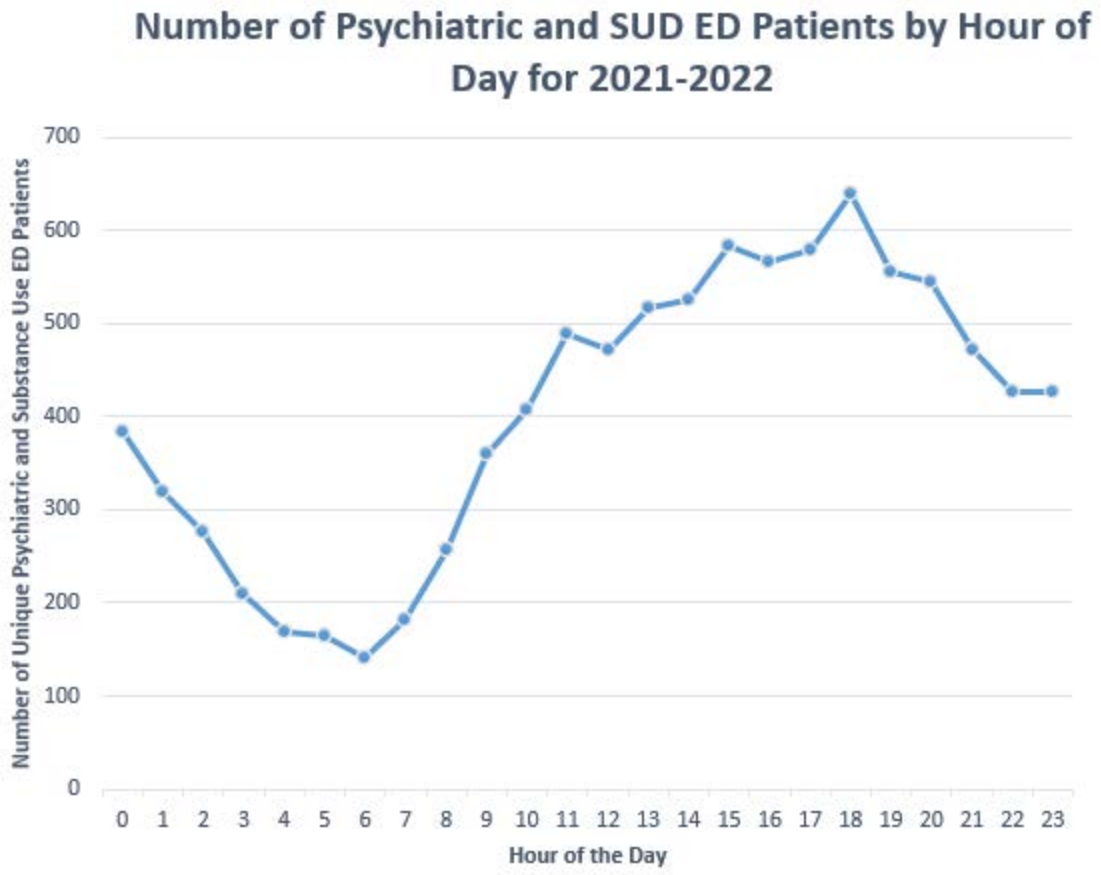
North Kansas City Hospital saw **2,650** psychiatric patients in 2021. Of those, just over half were a home or routine discharge, and nearly 45% were transferred to a psychiatric facility or unit.

Saint Luke's Health System saw **381** behavioral health patients in the first quarter of 2022, of which 279 (73%) were admitted internally or transferred to an external facility, and 102 (27%) were discharged from the ED.

University Health saw **7,968** behavioral health patients in 2021. Of those, 6.2 % arrived by law enforcement. Of those patients arriving via law enforcement, 57.7% were discharged to their homes, 22.5% were admitted, 9.9% were discharged to law enforcement, 7.9% were transferred, and 2.0% were discharged to detox.

	All Psych and Substance Abuse ED Patients	Arriving via Law Enforcement
Admitted	15.55%	22.47%
Discharged-Detox	4.91%	2.02%
Discharged-Home	72.13%	57.69%
Discharged-Law Enforcement	1.00%	9.92%
Transferred	15.55%	7.89%
Expired	0.1%	0%

Similar to the CommCARE data, data provided by University Health showed a fairly even volume distribution across days of the week. Dissimilarly, the hours of the day with the highest emergency department utilization by psychiatric and substance use patients were between 3:00 pm and 8:00 pm.



Limitations

There were significant limitations in this analysis. Findings are preliminary and would require additional validation with expanded and verified datasets. The contents of this report should be used with the understanding of these limitations and in conjunction with other information sources to validate qualitative experiences shared by the stakeholders engaged in the strategic planning process.

Scope of Work

This report is the result of exploratory data analysis. Research questions, other than those outlined in the MOU, were unclear. As a result, the data requests made to partners providing data were also not well defined. There is great opportunity for future work with a clearly defined set of research questions and data requirements that could build upon the connections established during this investigative process.

Completeness

With the exception of Missouri DHS ACI report data, no dataset acquired was comprehensive of the entire Kansas City Region. Particularly in the cases of hospital and police department data, the small sample collected could not be assumed to be representative of the entire region. It is, however, a starting place for agencies looking to expand their knowledge of the experiences of partner agencies.

Comparability

Among the samples that were collected, variables available were often unique, formatted differently, had different standards of reporting or interpretation, and were stored in different ways, making them difficult if not impossible to compare across organizations.

Data were also, in many cases, not provided for multiple time periods and therefore not amenable trend analysis.

Sample Size

For smaller CMHCs in particular, percentages of outcomes may be skewed in a way that does not indicate a trend but rather, analysis based off a small number of clients. Larger sample sizes of data would be useful in generating findings with a higher level of confidence.

Additional Limitations

Reporting burden on short-staffed agencies: This analysis was conducted in early 2022, as the COVID-19 pandemic continued to impact the US health systems; This may have impacted agencies (including hospitals) ability to respond promptly and completely to data requests.

Privacy concerns: Given the sensitive nature of the topic of mental health, many organizations are hesitant to share data.

Inability to track clients from beginning to end of crisis experience: Some individuals touch multiple points of the health care continuum during a single crisis experience. They may call NSPL, be connected to law enforcement, transported to the hospital and referred to a CMHA. There is no way to deduplicate records because there is no identifier that ties an individual's records together across these disparate systems.

Findings in this report are exploratory and are not meant to be interpreted as scientific fact. Rather, they are a starting point for future analysis and/or may be validated with contextual inquiry with on-the-ground service providers to validate the findings.

Conclusions

The most significant finding of this analysis was that the availability and quality of data available were considerable limiting factors to this work. The implications of this finding are that there is significant work to be done in order to set up a robust monitoring, evaluation and information sharing system at the regional level, and across agencies (Community Mental Health Centers and others).

APPENDIX G

Resource Repository

Resources shared with and/or discovered by the consulting team during the Strategic Planning Process

Mental Health and Wellbeing, Behavioral Health

National Council for Mental Wellbeing

National Alliance on Mental Illness

Brookings Building a Sustainable Behavioral Health Crisis Continuum

Crisis Care

NAMI 988 Crisis Response Research

SAMHSA National Guidelines for Behavioral Health Crisis Care

Northern Michigan Crisis System Assessment

Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System

Mobile Response

National Association of State Mental Health Program Directors Research Institute: Using Data to Manage State and Local-Level Mental Health Crisis Services

Assessing the Impact of Mobile Crisis Teams: A Review of Research

911 Call Diversion

Vera Behavioral Health Crisis Alternatives: Case Study: Robust Crisis Care and Diverting 911 Calls to Crisis Lines

Colorado Crisis System: Signal Behavioral Health Network

Best Practices

Oklahoma Uniform Transportation Standards for Qualified Transportation Service Providers Taking Consumers to Designated Mental Health Facilities

Princeton University: American Rescue Plan Provides New Opportunity for States to Invest in Equitable, Comprehensive, and Integrated Crisis Services

Planning Tools

NASMHPD 988 Convening Playbook: Public Safety Answering Points

National Council for Mental Wellbeing: Roadmap to the Ideal Crisis System

Georgia Emergency Admission Process Map

State of Georgia Provider Manual

Michigan Suicide Prevention Commission: Building a Crisis Services System for All Michiganders: 988's & MiCAL's Role

Communications Tools

Internal Communications

CRNexus (Solari EHR Product)

LACIE (health information exchange product)

Public Communications

Oklahoma Comprehensive Crisis Response

Colorado Crisis Services Crisis Line Data Dashboard

News

988 Hotline for Mental Health Emergencies Will Launch Nationwide on July 16. Will States be Ready?

MARC
MID-AMERICA REGIONAL COUNCIL

The Mid-America Regional Council would like to recognize the mental health leaders who worked together on the project steering committee to develop a shared approach to launching 988 across Missouri counties in the Kansas City region.

This work was completed with generous support and guidance from the Health Forward Foundation and the REACH Healthcare Foundation