C·B·H

a division of DBHIDS

CLINICAL PERFORMANCE STANDARDS

Mobile Crisis Response Services

Updated June 2024

Community Behavioral Health

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1. INTRODUCTION AND PURPOSE

The purpose of the Adult and Children Mobile Crisis Response Clinical Performance Standards (CPS) is to serve as the practices and procedures that represent the values that underlie the implementation of mobile crisis response services in Philadelphia County. These standards serve as procedures that align with federal and state requirements, the **Department of Behavioral Health and Intellectual disAbilities** (DBHIDS) standards, **Community Behavioral Health** (CBH) guidelines, and minimum requirements for the provision of mobile crisis response services.

These standards include short-term mobile crisis response services for adults and children, specifically Adult Community Mobile Crisis Response Teams (CMCRT) and Children's Mobile Crisis Teams (CMCT). They apply to all agencies funded by DBHIDS and CBH to provide CMCRT and CMCT.

These CPSs are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, increase the consistency of service delivery, and improve member outcomes. The CPS reflect the core values of the DBHIDS practice guidelines, articulate requirements for mobile crisis services, and provide a guide for providers to design and monitor their programs. This document does not supersede state or federal regulatory requirements or CBH quality, compliance, or credentialing requirements. CBH expects providers to apply these standards when developing internal quality monitoring activities. CBH will use this document as a guide when conducting quality reviews.

1.1. Crisis Care Continuum Description

Philadelphia crisis system services are available 24 hours a day, every day of the year. The crisis system is an integrated continuum, serving people with mental health and substance use concerns. The crisis system can address all levels of understanding; people in crisis at any level of risk for violence to self or others can be served by the continuum through a formal risk assessment. The crisis system can serve people with concomitant needs: intellectual and developmental disabilities (IDD), physical illness, LGBTQIA+, English as a second language, deaf/hard of hearing, immigrant/refugees, domestic violence (DV), homelessness, and criminal justice involvement as well as respond to all ages in a developmentally appropriate manner.

The crisis system is integrated with the broader behavioral health system so that individuals with lower acuity needs can be connected directly to ongoing care, reserving more intensive crisis services for those with higher acuity needs. The Philadelphia crisis care continuum includes short- and longer-term mobile crisis services, Crisis Response Center (CRC), and behavioral health urgent care. These performance standards are being developed for short-term adult and children mobile crisis services.

Fundamentals of mobile crisis response services as per the **Substance Abuse and Mental Health Services Administration** (SAMHSA), mobile crisis team services offer community-based intervention to individuals in need wherever they are, including at home, work, or anywhere else in the community where the person is experiencing a crisis. Mobile crisis services are delivered in the community, home, school, or other community-based environments. They are face-to-face with the individual and family, providing appropriate crisis intervention strategies. Crisis intervention services shall be available 24 hours a day, seven days a week, wherever needed. The person in crisis must be present for most of the service delivery duration. The focus is

on resolving or improving the crisis so the individual can remain in their natural setting. Timely access to support and treatment is emphasized to divert from CRC presentations and other emergency room presentations while offering alternatives to inpatient psychiatric care. The Philadelphia mobile crisis response teams are regionalized to meet access needs throughout the city.

1.2. Mobile Crisis Response Services Program Descriptions

CMCRT and CMCT must meet the service definition for Mobile Crisis Service as defined in the **Office of Mental Health and Substance Abuse Services** (OMHSAS) Mental Health Manual, Chapter 5240.101; "The mobile crisis service is service provided where the crisis is occurring or a place where a person in crisis is located. The service shall be available with prompt response. An individual or team may deliver the service of mental health professionals or workers. Service includes crisis intervention, assessment, counseling, resolution, referral, and follow-up. Extended service by mobile crisis aides is available. The service provides back-up and linkages with other services and referrals. Access to mobile crisis service shall be obtained through approved sources."

To address high acuity levels, CMCT and CMCRT programs should support families/communities/individuals seeking crisis services early. As such, the caller defines "crisis" as events that exceed the current capacity of youths, caregivers, schools, etc. to cope. In keeping with the CBH "no rejection" policy, the selected provider must accept all individuals to the service that CBH deems appropriate. CMCT and CMCRT providers are responsible for shifting resources to best match demand and developing a strategy for managing surges in demand

CMCRT and CMCT's explicit objectives are to provide a behavioral health response to individuals in crisis, obviating the need for law enforcement involvement to the extent possible. All mobile crisis dispatches are from the DBHIDS Philadelphia Crisis Line (PCL) dispatch center. These standards are to be applied to CMCRT and CMCT programs. The providers will be contractually obligated to apply these standards to their service delivery. DBHIDS and CBH will monitor and support programs to implement the standards and conduct audits regularly.

1.2.1. Mobile Crisis Competencies

- Universal Competencies
  - Welcoming
  - Hopeful
  - Safe
  - Trauma-Informed
  - Timely
  - Culturally Affirming

- Information Sharing (including coordination of care and information sharing in a life-threatening emergency)
- Wellness Recovery Action Plan (WRAP) Crisis Plan/Psychiatric Advanced Directive Awareness
- Interculturally Competent and Culturally Responsive Care
- Conflict Resolution
- Motivational Interviewing
- Integrated Assessment Tools for the entire continuum
- Maximization of Trust
- Minimization of Coercion
- Suicide Risk Screening, Assessment, and Intervention
- Postvention in the aftermath of a death by or attempted suicide
- Violence/Harm to Others Risk Screening, Assessment, and Intervention
- Substance Use Disorder (SUD) Triage and Screening
- Capacity to make referrals to community-based care with a warm hand-off
- CPR/First Aid
- Psychiatric Medications/Side Effects
- Incorporation of **Mental Health Advance Directives** into crisis care
- 72-Hour Follow-Up with Continuity of Care

1.2.2. Mobile Crisis Team Services Best Operation Practices

To fully align with best practice guidelines, mobile teams must meet the minimum expectations, in addition to:

- Responding without law enforcement accompaniment unless special circumstances warrant inclusion to support true justice system diversion
- Implementing real-time Global Positioning System (GPS) technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement

- Scheduling follow-up appointments in a manner synonymous with warm hand-offs to support connection to ongoing care

1.2.3. Mobile Crisis Team Duties and Responsibilities

- Rapid Response to a crisis dispatch
- Triage/Screening, including explicit screening for suicidality
- Assessment
- Intervention/De-escalation
- Resolution/Disposition
- Referral and Care Coordination
- Crisis Planning and Follow-Up

1.2.4. Adult Community Mobile Crisis Response Team (CMCRT)

CMCRT provides short-term rapid response, crisis stabilization, and case management services to individuals over the age of 18. CMCRT services should be resolution-focused, with referrals to new services occurring as clinically indicated and coordination with existing services. At the heart of the intervention is the belief that the individual in crisis, with support from mobile crisis and their community, can regulate and transition through the current crisis. These immediate response teams should provide communities with more direct and appropriate access to support services that do not require law enforcement involvement for behavioral health crises. Teams may be responding to direct calls or those appropriately directed to the Philadelphia Crisis Line (PCL) from the 911 system. Staff will utilize training, skills, and experience to ensure non-violent crisis resolution and least restrictive care.

1.2.5. Children's Mobile Crisis Team (CMCT)

CMCTs provide short-term crisis response and case management services to children and adolescents up to age 18, except for instances where an individual is registered with Intellectual Disability Services, attending high school, and served by the Department of Human Services as well as case-by-case discussion by PCL/dispatcher. All Children and adolescents residing in Philadelphia are eligible for CMCT; as such, triage to funded services for non-Medicaid eligible individuals must be provided during the initial response to the crisis referral.

Suppose CMCTs receive a referral for a family currently enrolled in services that include a 24/7 crisis response component as a parallel process to addressing the child and family crisis. In that case, the agency (i.e., a home agency with a 24/7 crisis response component) should be contacted within one to three hours and requested to engage the family and support the family through crisis resolution. CMCTs will receive referrals from the DBHIDS Philadelphia Crisis Line (PCL) dispatch center. CMCTs should be equipped to work with children and families experiencing crises stemming from, but not limited to, family conflict, youth substance abuse, and the youth's intense behaviors, symptoms, and emotions that raise concern for potential harm to self or others.

1.3. Quality Improvement

The CBH Quality Department monitors and assesses the quality of care and member experience. This includes the collection and evaluation of data and participation in CBH's Quality Improvement (QI) activities. CBH collaborates with providers related to such activities, including, but not limited to:

- Providing the information requested through **Provider Bulletins and Notices**
- Adhering to practice guidelines and performance standards
- Participating in Quality Management/Improvement activities, including chart reviews, root cause analyses, action plans, quality improvement plans, and the complaints and grievances processes

Providers of services evaluated by performance evaluation processes, including, but not limited to, the pilot/demonstration program process, pay-for-performance, and value-based purchasing, will receive operational definitions for relevant performance measures and quarterly performance data. Providers should use this data to inform quality improvement activities/interventions. More information about these performance evaluation processes can be found in the **CBH Provider Manual**.

1.3.1. Network Improvement and Accountability Collaborative (NIAC)

NIAC Review Network Improvement and Accountability Collaborative (NIAC) is the primary mechanism for accomplishing site reviews (i.e., monitoring) across various funding streams in the Philadelphia County Behavioral Health System. NIAC promotes the ongoing improvement of behavioral health providers regarding quality of care. NIAC assesses the quality of services delivered by Mobile Crisis provider agencies through their scoring instrument, the Network Inclusion Criteria (NIC). Therefore, all Behavioral Health Case Management providers are expected to meet the core standards identified in the NIC.

2. DISPATCH AND RESPONSE

Mobile crisis response teams will contact individuals within 15 minutes of the referral from PCL and arrive on the scene within at least 45 minutes of phone contact. This timeframe follows the required timely access standards per **CBH Provider Bulletin 20-12** to ensure that 85% of the emergency service's mobile crisis response occurs within 45 minutes. Rapid response occurs in person for all referrals received 24 hours a day, seven days a week.

The purpose of the initial phone call should be treated as a follow-up from PCL and the team being en route to the caller in crisis, communicating an ETA, building rapport, and screening any imminent/current risk concerns. Most assessment, intervention, and crisis resolution should occur during an in-person intervention. Based on the response to the intervention and continued need, the response staff, in collaboration with the individual, will determine whether expedited access to other services is needed. Strategies are to be collaborative rather than coercive. Engagement with other emergency services during imminent safety concerns is documented. A person in crisis is determined to be at imminent risk of harm to self or others if mobile crisis staff responding believes, based on information gathered, that if no actions are taken, the person in crisis is likely to seriously harm or kill themselves, or others in the very near future.

2.1. Dispatch and Response Standards

Standards	Monitoring
Communication	
Mobile crisis response teams should maintain clear and effective communication with clients by calling within 15 minutes of the referral being sent by the PCL.	DBHIDS/CBH will review corresponding data elements, team communication logs, staff schedules, and client feedback to assess the effectiveness of team communication.
Prior to engagement with other emergency services during imminent safety concerns, the mobile crisis team will ensure the caller is notified of other emergency services and/or law enforcement and document the attempt to obtain consent.	PCL will track engagement with emergency services and analyze data to identify trends or areas that need improvement in partnership with CBH Provider Operations.
Response Time	
Mobile crisis response teams must provide face-to-face treatment intervention for all members within one hour for emergencies per CBH Bulletin 20-12, Mobile crisis response teams should aim to arrive at the crisis location within 60 minutes of receiving the dispatch being sent by PCL.	PCL will track response times for each call, assess compliance within the established time frame, and analyze data to identify trends or areas that need improvement in partnership with CBH Provider Operations.
Dispatch	
Mobile crisis response will be dispatched with interest of rapid response to the individual in crisis based on GPS location and proximity of the mobile team to the crisis location. When possible, PCL counselors will make all efforts to keep dispatches within catchment zip codes.	PCL will review dispatch assignments and mobile crisis team data to ensure fair and rapid dispatch process, and analyze data to identify trends or areas that need improvement in partnership with relevant CBH and DBHIDS departments.
Initial phone calls are limited to providing an estimated time of arrival for in-person crisis intervention services, triage of change since initial contact by the caller in crisis, review of potential safety concerns and not be categorized as a telehealth intervention.	PCL will monitor each dispatch, assess compliance with the established standard for initial phone calls, and analyze data to identify trends or areas that need improvement in partnership with CBH and DBHIDS.
Utilization of Dispatch Technology	
Mobile crisis teams will utilize the provided digital dispatch platform for live communication of their availability status for an incoming dispatch and tracking all case changes outlined below, as well as entering disposition of the case into the digital platform by the end of the current shift.	PCL will monitor the following live status data elements in addition to post-dispatch disposition data: ➡ Face-to-face: Pre-Dispatch, Dispatched, Accepted/In-transit, Arrived, Assessment Started, Assessment Completed, Completed or Transport ➡ Transport: Transport Started, Transport Completed, Completed

Standards	Monitoring
	➡ Telehealth: Pre-Dispatch, Dispatched, Accepted/Case in Review, Virtual Call Started, Call Completed, Completed

3. CRISIS ASSESSMENT

The initial step in providing community-based mobile crisis services is to engage the individual/system in crisis. This includes rapport building, providing them with a personalized crisis intervention that helps determine the level of risk faced by the individual in crisis and assess the most appropriate response to meet the need. In discussing the situation with the caller, the mobile crisis staff must decide if other first responders, such as police or emergency medical services, should be involved while understanding that there is an iatrogenic risk and one that should only be used when alternative behavioral health responders are not available, or the nature of the crisis indicates that EMS or police are most appropriate. All escalations to a first responder must be attempted collaboratively, with full transparency, and allow the individual/system in crisis to remain in control of the intervention. Involuntary emergency rescues should have clear criteria outlined and should be supported by a supervisor whenever possible.

A crisis assessment is a clinical interview to ascertain an individual's current and previous level of functioning, the potential for danger to self and others, physical health, and psychiatric and medical conditions to inform the individual's acute action plan and level of care. Conducting an assessment in an interview fashion should be utilized as part of an intervention aimed at stabilizing the crisis.

The assessment is an ongoing function of the mobile crisis team and is most effectively carried out when an individual feels the environment and treatment provider are safe. This includes addressing individual concerns, concerns of the family/natural supports, and fears about what led to the mobile crisis referral, as well as the individual's comfort with staff, the environment in which the service is being delivered, and how they are experiencing the treatment.

Assessment should be provided along with ongoing crisis intervention. Efforts to relieve the crisis should not be delayed for an assessment, and a formal assessment should not constitute entire contact with an individual. A structured tool can be administered to aid the initial understanding of the crisis when circumstances are complex. Keeping assessment strategies brief and focused on the clinical material related to the crisis is essential. A crisis assessment should be conducted from a holistic perspective, in addition to accounting for culture, development, experience, assets, trauma, and any known diagnoses or disabilities that may impact functioning in crises. Risk assessments are a helpful tool but have yet to be proven to predict future or near future risk. All assessments should be done in service of and with safety planning and other interventions that help the individual/system manage the crisis and reduce access to lethal means.

All staff are to regard family members and other natural support people as priority members in crises, such as but not limited to educators and other systems involved in child welfare. The mobile crisis team will demonstrate competency in the routine engagement of all people who provide collateral support to the

individual and gather information without a signed disclosure while having consistent positive regard for family members and other natural supports.

3.1. Crisis Assessment Elements

- Conducting a mental status exam
- Assessing crisis precipitants, including psychiatric, substance use, educational, social, familial, legal/court-related, and environmental factors that may have contributed to the current crisis (e.g., new school, home, or caregiver; exposure to domestic or community violence; death of friend or relative; or recent change in medication)
- Assessing the individual's behavior and the responses of parent/guardian/caregiver(s) and others to the individual's behavior
- Assessing parent/guardian/caregiver strengths and resources to identify how such strengths and resources impact their ability to care for the individual's behavioral health needs
- Obtaining behavioral health history, including past inpatient admissions or admissions to other 24-hour levels of behavioral health care
- Obtaining medication list and assessing medication compliance and past medication trials
- Assessing safety/risk issues for the individual and parent/guardian/caregiver(s)
- Acquiring a medical history/screening for medical issues
- Assessing current functioning at home, school, and in the community; identifying current providers, including state agency involvement
- Identifying natural supports and community resources that can assist in stabilizing the situation and offer ongoing support to the individual, including parent/guardian/caregiver(s)
- Information sharing with families and other communities and natural and professional support
    - All confidentiality regulations permit communication with collateral support people without release when such communication is necessary for assessment and intervention in a potentially harmful crisis or life-threatening emergency. Communication with collateral contacts is an expectation.
    - In the absence of a life-threatening emergency, crisis providers can facilitate receiving information from collateral contacts, even without permission to disclose information.

3.2. Crisis Assessment Standards

Standards	Monitoring
Clinical Assessment	
Teams must conduct a thorough clinical assessment of the individual in crisis and achieve successful resolution of the crisis, providing immediate support, referrals, and, when indicated, transportation as warranted.	➡ Review assessment reports to ensure completeness, accuracy, and that the disposition reflects identified needs. ➡ Evaluate key performance metrics of crisis interventions, ranging from response time and disposition to referrals and presentation within higher levels of crisis care.

4. SOCIAL DETERMINANTS OF HEALTH (SDOH)

Social Determinants of Health (SDOH) are the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."

Recognition of the role SDOH and racial inequities play in influencing health and quality of life requires attention in behavioral health care settings. SDOH are proven to impact health outcomes before and after a crisis incident significantly. Integrating a standardized and universal social needs assessment using a screening tool can predict the future use of crisis services and is an essential first step in facilitating more targeted interventions and avoiding repeated crisis episodes.

To address healthcare disparities, all mobile crisis teams are required to assess SDOH using a validated assessment tool. Mobile crisis teams are permitted to select a measure of their choosing. Still, they are strongly encouraged to consider The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) **Screening Tool**, which is a brief ten-item screener developed by the **Centers for Medicare and Medicaid Services (CMS)**. The Health-Related Social Needs (HRSN) screening tool includes items across five SDOH domains: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.

At a minimum, providers should consider the following regarding the SDOH assessment:

- The assessment is ideally administered during the initial visit, especially for SDOH that may increase the risk for overdose, such as homelessness. These SDOH should be addressed in the initial care management plan.
- Results can be shared with concurrent service providers for the individual or integrated into an ongoing care management plan to identify client needs and determine appropriate referrals for services and resources. To assist in this process, mobile crisis teams should maintain an accurate

and up-to-date resource referral list to connect clients to services in the community that address the needs identified through the SDOH assessment.

- Mobile crisis teams can use and share resources, such as PA 211 and PA Navigate when assessing and exploring SDOH needs.

4.1. SDOH Standards

Standards	Monitoring
Address SDOH as part of a crisis presentation, including working towards providing immediate relief and referrals as part of a holistic intervention.	➡ Conduct periodic reviews of case charts, client feedback, and clinical assessments. ➡ Use clinical audits to identify areas for improvement.

5. RESOLUTION-FOCUSED CRISIS INTERVENTION

An explicit goal is to reduce the use of involuntary commitment within the behavioral health service system. The mobile crisis team should prioritize assisting individuals in obtaining relief and regaining a sense of understanding and control. Mobile crisis teams should provide crisis stabilization through evidence-based/evidence-informed interventions that include but are not limited to, crisis intervention, crisis de-escalation, engagement, family-focused, and resolution-focused approaches. Evidence-based and evidence-supported approaches should effectively engage and stabilize the individual during a crisis. Strength-based engagement is foundational to creating a trusting climate, achieving effective crisis relief, and quickly activating adaptive coping and problem-solving capabilities. When sufficient relief/harm reduction is not forthcoming, a collaborative decision may be made to refer to the CRC.

If CRC referrals are necessary, CMCRT/CMCTs will accompany individuals and provide a warm hand-off to the CRC team, including all relevant information about the crisis to inform the CRC assessment and intervention. A warm hand-off transfers care and information from one service to another, ensuring continuity of care. CMCRT/CMCT staff will ensure the warm hand-off form accompanies the individual to the CRC as part of the intake process.

5.1. Resolution-Focused Crisis Intervention Standards

Standards	Monitoring
Intervention	
Mobile crisis response teams should provide evidence-based crisis intervention and mental health support that meets or exceeds established professional guidelines.	Conduct periodic reviews of case notes, client feedback, and clinical assessments to ensure the quality of care provided. Use clinical audits to identify areas for improvement.
Safety	
Mobile crisis response teams should prioritize the safety of both clients and team members during crisis interventions.	Track incident reports, injuries, or safety-related issues. Conduct regular safety drills and provide safety training to team members. CBH Compliance will periodically monitor staff files for training sessions. CBH Quality Management will monitor and follow up on incident reports.
Least Restrictive Intervention	
Mobile crisis staff should seek supervisory review and approval for every involuntary commitment petition that is initiated. Records should reflect supervisory review with the goal of support for the team in ensuring that all efforts have been exhausted prior to attempting a 302 commitment. Mobile crisis staff should seek supervisory approval for escalating a dispatch to a 911 intervention unless efforts to do so will delay a potentially life-saving intervention.	Track involuntary commitment application and 911/PSAP escalation via mobile crisis disposition data. Conduct periodic reviews of case notes, supervisory review, and clinical assessments to ensure the quality of care provided. Use clinical audits to identify areas for improvement.
The warm hand-off form will be completed in its entirety. CMCRT/CMCT staff will ensure the warm hand-off form accompanies the individual to the CRC as part of the intake process.	Philadelphia Crisis Line will review the disposition and analyze data to identify trends or areas that need improvement in partnership with relevant CBH and DBHIDS departments.

6. CRISIS STABILIZATION AND DISPOSITION

Mobile crisis services can and should be ended when clinically appropriate and mutually determined. Services should promote an individual's strength, resilience, autonomy, and ability to access community support. The crisis stabilization plan should be reviewed during the final contact to ensure the person is prepared to manage possible stressors and conflict. When another service has been recommended, the mobile crisis team should assist in understanding and addressing any apprehension or ambivalence that might prevent attending a first appointment or indicate that alternate service options should be explored.

A disposition is not complete until the involvement of support people and provision for their ongoing needs are identified. Families should also receive ongoing support following an acute crisis. This should include:

- Invitation to be part of crisis interventions, problem-solving, and disposition planning.
- Psychoeducation from the mobile crisis team includes answering family and natural support questions and connecting with community resources.
- Arranging for psychiatric consultation and urgent psychopharmacology intervention (if the current prescribing provider cannot be reached immediately or if no current provider exists), as needed, face-to-face or by phone, from an on-call psychiatrist or related medical specialist.

6.1. Crisis Stabilization and Disposition Standards

Standards	Monitoring
Documentation	
Mobile crisis response teams should maintain accurate and thorough documentation of all client interactions and interventions.	In accordance with the terms outlines within the CBH Provider Agreement, the CBH Compliance department may conduct scheduled or unannounced audits of documentation upon internal requests, or following referrals received from the CBH Compliance Hotline pertaining to allegations of fraud, waste and/or abuse (FWA) activity to ensure provider compliance with documentation standards.
Safety Planning	
When consent is provided, mobile teams should utilize a safety planning intervention for individuals who are at risk of suicide, using risk assessment elements to help create an individualized plan towards safety. Counseling on access to lethal means should be utilized for individuals in crisis who have access to means towards suicide.	In accordance with the terms outlined within the CBH Provider Agreement, the CBH Compliance department may conduct scheduled or unannounced audits of documentation upon internal requests, or following referrals received from the CBH Compliance Hotline pertaining to allegations of fraud, waste and/or abuse (FWA) activity to ensure provider compliance with documentation standards (see CBH Provider Manual).

7. FOLLOW-UP CARE

Follow-up to an initial stabilization is critical to ensuring safety in crisis care. Initial outreach should be within 15 minutes of receiving a dispatch from PCL. The goal of 72-hour follow-up is to develop an additional safety net post-intervention. This requirement is completed by, but not limited to, multiple therapeutic outreaches within 72 hours of the initial crisis intervention. While follow-up can be telehealth forward, there will be instances when face-to-face engagement may be warranted or necessary when the individual cannot be reached by phone.

When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, mobile crisis is an effective and efficient way to resolve mental health crises and prevent

future crises. During outreaches, mobile teams will check in to see how the individual has been doing since the initial dispatch, ask about progress (if any) towards connecting with referral resources, work to develop or update a safety plan, establish contacts/collaterals, provide additional resources, and assess/re-assess risk if needed.

If elevated risk is identified during follow-up, the mobile crisis team will reconnect the individual to appropriate services for immediate crisis support.

The components of the follow-up contact are:

- Conducting follow-up in a time frame that is sensitive to meeting the needs of the crisis (i.e., high risk of suicide, initial supportive contact within 1-24 hours of the intervention, low risk up to 72).
- Engaging the individual/system in a brief therapeutic encounter.
- Reassessing risk.
- Review/update safety plans.
- Confirmation of appointment completion or facilitation of linkages.
- Discussion and support of barriers to seeking care, such as but not limited to transportation or finances.
- Collaboration and support with connecting with immediate/available supports and community resources.

Priorities include helping the individual manage suicide risk, bolstering individual support after a crisis, and diverting individuals from further escalation through promoting engagement with the appropriate behavioral health care, social services, or natural supports in the community. This will aid in avoiding unnecessary placements into higher levels of care, such as inpatient hospitalization and involuntary commitments.

Follow-up will not end at the same point for everyone; therefore, a standardized “end goal” for individuals may not be feasible. Follow-up begins within 72 hours of intervention and terminates with the following dispositions:

- Significant reduction in suicidality/risk, connection to long-term treatment support
- Therapeutic mismanagement of the follow-up program (determined by leadership)
- No contact after three attempted outreaches (in-person contact should be attempted)
- Individual requests follow-up to stop.

If the individual remains in crisis at the conclusion of the 72-hour follow-up, PCL should be consulted.

7.1. Follow-Up Care Standards

Standards	Monitoring
Follow-Up Completion	
Teams must conduct a 72 hour follow up with the individual in crisis/family member/caller who initiated the dispatch to assist with achieving successful resolution of the crisis and/or providing additional supports if/when waiting for the recommended next level of care.	Review reports to ensure completeness and accuracy of the follow up encounters that were completed 72 hours following the dispatch. Evaluate outcomes of members and connections to appropriate services and supports following the dispatch.
Follow-Up Intervention	
Follow up should be, when possible, a therapeutic intervention that focuses on engagement of the individual or caller that requested the dispatch and helping meet all outlined components of the follow up contact.	Review clinical documentation of the follow-up contacts and components will be tracked through the dispatch software.

8. LINKAGES/COORDINATION OF CARE

Mobile teams will maintain updated information about treatment services, community support, and other relevant services, which will be utilized to connect individuals and families with needed and desired services. Linkages and warm hand-offs to services will be a component of mobile teams throughout the mobile crisis services.

It is best practice for crisis intervention staff to coordinate with natural and professional support to gather the necessary information to complete their assessment and make recommendations for medically necessary behavioral health services. Natural and professional support should also be included in the discharge planning, resource linkage, and transition processes. SAMHSA Best Practice Toolkit also notes that agreements or protocols for frequently used referral sources such as community behavioral health centers, police, hospitals, and other crisis intervention providers are recommended. Agency-to-agency collaboration is essential and may manifest through professional relationships of leaders, Memorandums of Understanding (MOUs), shared protocols, or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch and outpatient appointment setting through the call center hub (SAMHSA National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit, 2020).

8.1. Linkages/Coordination of Care Standard

Standards	Monitoring
Documentation of all referrals and linkages to all types of services and supports will be maintained in the individual's record. Teams will have policy, corresponding data tracking and a continuous quality improvement process to ensure care coordination and person-centered referrals.	Review case notes and documentation for completeness and accuracy. CBH Compliance will conduct periodic audits to ensure compliance with documentation standards.

9. TRANSPORTATION

Mobile Crisis teams will be required to have ADA-compliant vehicles appropriate for transporting individuals or family members. Transportation will be determined on a case-by-case basis, with consideration for other appropriate methods, such as providing public transportation passes or offering ride-share services. The transportation capabilities will guarantee a warm hand-off to the next level of care, if appropriate.

Each provider will have guidelines for providing transportation for individuals with:

- Co-occurring mental illness and SUD
- Co-occurring medical illness, including geriatric care.
- Cognitive disabilities (Intellectual/Developmental Disabilities, Traumatic Brain Injury, Dementia), including de-escalation strategies for people with cognitive impairment.
- People with hearing, visual, or physical disabilities.
- LGBTQIA+ individuals
- Veterans

9.1. Transportation Standard

Standards	Monitoring
Each provider will have a working ADA compliant vehicle that will provide transportation to individuals and their family members.	Review documentation that supports the transport of individuals as needed. In person quality assurance may request to see the vehicle to ensure ADA compliance.

10. COMMUNITY ENGAGEMENT

Regionalized services will provide a committed presence in a defined area and can engender stronger relationships between providers, families, and community-based entities. The mobile crisis providers will prioritize the creation of linkages to care at the community level through collaboration with the community at large and key stakeholders within the community. Collaboration and partnerships should be active with, but not limited to, public safety personnel, hospitals/medical care systems, schools, and local government entities. The mobile crisis providers will gain an understanding of cultural needs and distinctions in the communities. Becoming an inclusive member of the assigned community(ies) ensures consideration of the diversity within the community(ies). Mobile crisis teams will engage, collaborate, and coordinate with community-based agencies to address social determinants of health that contribute to negative behavioral health outcomes when not involved in crisis work/calls.

Collaborative partnerships, at minimum, should include:

- Culturally appropriate provision of covered services during a crisis.
- Information about the use and availability of crisis response services.
- Jail diversion and safety.
- Strengthening relationships between public safety personnel and providers when support or assistance is needed to work with or engage members.
- Procedures to identify and address joint training needs.
- Strategies to address provision or post-crisis services.
- Develop post-crisis care and a safety plan to reduce future crisis events.

10.1. Community Engagement Standards

Standards	Monitoring
Community Engagement	
Mobile crisis response teams should collaborate effectively with other emergency services, mental health providers, and community resources.	Monitor the frequency and quality of interactions with other service providers. Ensure that team members attend regular meetings with relevant stakeholders.
Client Satisfaction	
Mobile crisis response teams should strive for a high level of client satisfaction with their services.	Collect feedback from clients through surveys or interviews to measure their satisfaction. Use this feedback to make continuous improvements.

11. LANGUAGE/CULTURAL/LINGUISTIC/IMMIGRANT ACCESS

Services are provided by multilingual staff in the community's primary languages, with 24-hour language line access for languages not served by staff.

- Ability to serve Deaf/hard-of-hearing people using clinicians or peers who are fluent in ASL, use of a Deaf Interpreter, video relay system or video remote interpreting, and/or speech-to-text/captioning services.
- Respect for communication preferences and acknowledge the spectrum of language use and variation in hearing and literacy levels.

Mobile crisis providers should ensure access to care for all individuals and families seeking mobile crisis services. All providers are expected to have access to qualified interpreters, including for the Deaf and Hard of Hearing, to provide services if they need to access interpretation services outside of their organization. Because staff with linguistic capacity prefer to use interpreters, providers are expected to offer a staff person who speaks their language of choice whenever possible or refer to a provider who can do so. Suppose there are no providers with staff who talk about the individual/family language of choice within a reasonable distance from the family's residence. In that case, the family's preferred provider is expected to use qualified interpreters/interpreters and interpretation services experienced in behavioral health care appropriate to the needs of the local population. Interpretation services should be used in a manner that enables participation.

11.1. Cultural Competence Standard

Standards	Monitoring
Mobile crisis response teams should demonstrate cultural competence and sensitivity when serving diverse populations.	Assess team members' cultural competence through training evaluations and client feedback. Provide ongoing cultural competency training as needed.

12. STAFFING REQUIREMENTS

All employees and contracted individuals providing mobile crisis services must comply with current and future revisions of the Title 55. Public Welfare Part VII Mental Health Manual Chapter 5240. Crisis Intervention Services, Staffing 5240.31. The number of staff provided has been estimated and can be expanded to meet regional capacity needs. Teams will be comprised of:

- Clinical Director (LCSW, LSW, LMFT or LPC)
- Clinical Supervisor (LCSW, LSW, LMFT, LPC, or license eligible)

- Crisis Worker (BS, BA, MS, MA)
- Medical Professional (LPN)
- Certified Peer Specialist/Family Advocate

Mobile crisis teams are mandated reporters in Pennsylvania; they must follow the reporting laws and report abuse and neglect of children and vulnerable adults.

12.1.1. Certified Peer Specialist/Family Advocate

Certified Peer Specialists (CPS) and Family Advocates are core crisis team members. Including peers and family advocates in the crisis workforce can increase engagement while reducing distress and addressing the need for resources and referrals upon SDOH screening.

Peer specialists are equipped to navigate Philadelphia's robust system of SDOH resources and use their unique power of bonding over shared experiences while adding the benefits of peer modeling that recovery is possible. Peers can support individuals in seeking housing, transportation, employment, food, or other community-based resources.

Family Advocates will engage the caregivers during the crisis response and provide resources as needed. Family engagement is an essential component of crisis intervention. Through a shared experience and understanding of managing a child or adolescent facing difficulties, the family advocate will serve as an added support for the caregiver during an intervention. Family advocates will facilitate parent support groups to build skills and mutual support among caregivers. Family advocates should have a significant role in working with families to provide advice and help the family understand and select behavioral health resources for the young person. Family voice should be a significant determining factor for continuing or ending services.

12.2. Implementation Guidance

- Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible.
- Develop support and supervision that aligns with the needs of the team members.
- Emphasize engagement as a fundamental pillar of care that includes peers and advocates as a vital part of a crisis program's service delivery system.

12.3. Staff Requirement Standards

Standards	Monitoring
Staff Requirement	
Mobile Crisis providers should have a clear plan and policies for onboarding, training, and continued professional development.	Review of Human Resources employee files to ensure adequate onboarding and training is being provided and documented.
Peer Specialist/Family Advocate	
Mobile Crisis providers should have a clear plan for onboarding and maintaining inclusion of the Peer Specialists and Family Advocates.	Review of Human Resources employee files to ensure adequate onboarding and training is being provided and documented. Review of chart notes to ensure engagement of individuals and/or families in addition to resource connections.

12.3.1. Staff Onboarding and Training

Training for crisis team members must include training on the National Guidelines for Crisis Care Best Practice Toolkit by SAMHSA with a strong emphasis on essential structural elements of a crisis system and the crisis care principles and practices that follow:

- Trauma-informed care, de-escalation strategies, and harm reduction
- Resolution Focused Crisis Intervention
- Self-care/preservation
- Motivational Interviewing
- Cultural awareness/competency trainings
- Training on performance standards (including services for special populations)
- Suicide Prevention and Suicide Safer Care
- Safety/security for staff and consumers

All training must be presented and learned within the context of embracing the crisis system's responsibility to serve as a no-wrong-door path to accessing care for all community members in need of immediate access to mental health and substance use care. Providers must ensure that non-licensed staff deliver services within the scope of their allowed practice with supervision that supports best-practice care.

12.4. Onboarding and Training Standards

Standards	Monitoring
Onboarding and Training	
Mobile Crisis providers should have a clear plan and policies for onboarding, training, and continued professional development.	Review of Human Resources employee files to ensure adequate onboarding and training is being provided and documented.
Supervision	
Mobile Crisis providers will maintain all supervised documentation and schedules. Review of supervision notes should show a supportive and strength-based dialogue between the supervisee and supervisor.	Employee files will be reviewed to determine if adequate supervision is being documented.

12.4.1. Supervision

Mobile crisis providers should have a supervision policy that supports the professional development of each member of the mobile crisis team. Crisis services are unique to other community-based services where the potential of transference and vicarious trauma can be an occupational challenge due to the continuous exposure to victims of trauma and violence. Supervisors should meet individually with team members regularly, at least monthly, to support and guide mobile crisis team members. 302 petitions initiated by mobile crisis should be reviewed live by a mobile crisis team supervisor and discussed to ensure all efforts have been made to provide an intervention and engage the person in voluntary help-seeking. If a live supervisor is unavailable, all 302 decisions should be reviewed by a supervisor and incorporated into continuous quality improvement. Supervision must be standardized and documented to support the team members' success.

13. SYSTEM MONITORING AND ACCOUNTABILITY

- Established a set of system and program performance metrics and ensured they were measured and reviewed regularly.
- Regular, system-wide performance review process to identify system breakdowns and access barriers.
- Conduct collaborative problem-solving to address the identified challenges, improve consumer care, and ensure that residents are served in an equitable and developmentally appropriate manner.
- Consumers and family members of consumers will be involved in the system-wide performance review process.

- Collaborative review process to analyze aggregate data on involuntary commitments, conduct case reviews, and review sentinel events to look for inequities and opportunities for system improvements.
- Ensure regular contract audits and programmatic monitoring processes.
- Ensure routine consumer quality oversight process (customer satisfaction surveys) to assess the satisfaction of individuals and families with the services they've received to improve the quality of care.
- Ensure there is an opportunity for referral sources and other system partners, such as law enforcement and hospitals, to give feedback on the quality of care.
- Data Collection on the following metrics will be received through the electronic database used for dispatching:
  - Average response time for mobile crisis intervention
  - The percentage of individuals who receive follow-up within 72 hours post-intervention.
  - Disposition (CRC, 302, community stabilization, etc.)
  - Number and percentage of mobile responses with law enforcement involvement.
- CBH will also evaluate service quality for certain Mobile Crisis services using claims data for the following metrics:
  - Seven-day follow-up after Mobile Crisis Service
  - Seven-day readmission to Crisis Service or Acute Inpatient Hospital
- CBH will share performance reports with providers of the Mobile Crisis services evaluated using these metrics.

13.1. Continuous Improvement Standard

Standards	Monitoring
Mobile crisis response teams should engage in ongoing performance improvement efforts to enhance their services.	Establish regular performance review meetings to identify areas for improvement based on data analysis, client feedback, and incident reports. Implement action plans to address identified issues.

APPENDIX: REFERENCES

- **Mental Health Advance Directives Instruction for Providers**
- **CBH Provider Manual**
- **CBH Provider Bulletin 21-12: Provider Access to Timely Treatment**
- **Centers for Medicare and Medicaid Services: Accountable Health Communities Health-Related Social Needs Screening Tool**
- **PA 211**
- **PA Navigate**
- *Resolution-Focused Crisis Intervention.* Kappy Madenwald, M.S.W.