

988 Behavioral Health Crisis Care Continuum

Key themes from December 2020
working sessions and interviews

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1. Executive Summary

More than ever, this is the time for us to update the behavioral health system to meet the needs of people in crisis and emotional distress. Approximately one in five people above the age of twelve has a mental health condition in the U.S. Suicide is the second leading cause of death among young people, and the tenth leading cause of death overall. More Americans died from mental health crises and substance abuse in 2018 alone than have died in combat in every war combined since World War II.

But we can change this. Suicide is preventable, and mental health conditions are treatable. Annually in the U.S., for every person who dies by suicide, 280 seriously consider suicide but do not kill themselves. But the crisis care continuum must evolve to better meet needs of people in crisis and distress, as well as prepare for the future mental health impacts of the pandemic and other events that may occur.

Vibrant Emotional Health and the National Suicide Prevention Lifeline, in partnership with RI International and the National Association of State Mental Health Program Directors, convened a series of four 2.5 hour working sessions over the course of December 2020. McKinsey's Center for Societal Benefit through Healthcare provided technical support including conducting stakeholder interviews and facilitating working sessions.

The purpose of these working sessions was to gather input to support planning and preparation across the behavioral health (BH) crisis continuum for the launch of 988 – the new three-digit number for suicide prevention and mental health crisis, designated by the FCC in July 2020. Vibrant and its partners turned to leaders from health care, public health, and public safety to get a pulse on current barriers to and goals for successful crisis care implementation. The series brought together over 110 stakeholders from mental health authorities, service providers, and state and local leaders in four working sessions.

This document presents key themes that emerged from the December 2020 series, and collectively emphasizes the need to shift the existing behavioral health crisis care continuum toward a system that is **inclusive, people-centered, and cross-collaborative**. The behavioral health care continuum should aim to be inclusive of different communities and geographies, integrated more fully into the existing healthcare system, and held accountable with new metrics. The barriers to meeting these goals are often related to infrastructure, accessibility, and accountability. This document outlines domains of activity that more specifically address those concerns, with examples of current programs and activities across the country.

We hope that these key themes can be drivers of future policies across states as they examine their behavioral healthcare needs and prepare for the launch of 988. We recommend that stakeholders and policymakers incorporate these themes and goals into their work, and seek to address these barriers to create a behavioral health crisis care system that is more accessible, inclusive, equitable and effective for all. For more specific policy recommendations regarding 988's implementation, please visit www.vibrant.org/988.

2. Barriers facing the BH crisis system

- Most local BH crisis care systems are underdeveloped due to underinvestment.
- The current BH crisis care system can elect who and when to serve, leaving everything else to law enforcement and hospitals.
- The system is often not set up to meet the needs of historically marginalized groups, such as the BIPOC population, LGBTQ+ population, and others.
- Peer support is often not fully integrated across the BH crisis care continuum.
- Lack of infrastructure makes it difficult for BH crisis providers to access many funding streams.
- Commercial payors often do not see a clear need to cover BH crisis care.
- Funding and services dedicated to children, youth, and families often sit outside of the BH system.
- Public safety processes and protocols are often not built with BH crisis providers in mind.
- Non-BH entities can be hesitant to refer outside of normal pathways for fear of liability.
- Metrics that demonstrate the effectiveness of the BH crisis system are often not tracked or communicated consistently across stakeholders.
- Accountability for a comprehensive BH crisis system varies widely.

3. Shared goals for a BH crisis system that meets community needs

- Individuals feel supported, respected, and in control of their own care.
- Lived experience is taken into account in every aspect of the system.
- Historically marginalized groups have a voice in the system and it is set up to meet their needs, with a specific focus on the BIPOC population, LGBTQ+ populations, and others.
- All involved entities work together in a trusted relationship.
- Solutions address the needs of the child and youth population, and the role of families is acknowledged and valued.
- Solutions address the varying starting points of different localities.

- Solutions address the needs of different geographies, including rural, frontier, and tribal communities.
- BH crisis care is viewed and funded as an extension of the healthcare system.
- High quality and evidence-based crisis care is delivered across the BH crisis care continuum.
- BH crisis care providers uniformly acknowledge accountability for outcomes.
- Emergency rooms and detention facilities are not the de facto solutions to BH crises – people are treated in the most collaborative environment possible.

4. Domains of activity

Note: Examples provided are non-exhaustive

4.1 Enhancing the capacity and robustness of the BH Crisis Care Continuum

- Building capacity across the BH crisis continuum to ensure the system can identify and meet demand in line with SAMHSA's National Guidelines for Behavioral Health Crisis Care, e.g.,
 - Arizona's crisis response model, which has crisis call center hubs, mobile crisis units, and crisis stabilization facilities linked and working in coordination with local first responders. *Contact: David Covington, RI International; Erica Chestnut-Ramirez, La Frontera Arizona, Shelley Curran – Aetna/Mercy Care Health Plan, Alex Herrera – AHCCCS*
- Creating accountability structures at all levels to incentivize coordination, connection, and outcomes measurement
- Creating system-wide mechanisms for involving and effectively integrating the perspectives of specific groups, including:
 - Individuals with lived experience, e.g., building off the work of:
 - California Peer-Run Warm Line. *Contact: Eduardo Vega, Humannovations, formerly of Mental Health Association of San Francisco*
 - NYC Well's large network of available Peer Support Specialists. *Contact: Kelly Clarke, NYC Well*
 - Utah Mobile Crisis Outreach Teams, which pair clinicians with individuals with lived experience. *Contact: Kim Myers, Utah Division of Substance Abuse and Mental Health – Crisis Expert, Leanne Huff - Program Administrator, Utah Division of Substance Abuse & Mental Health – Mobile Crisis Outreach Team Expert, Doug Thomas, Utah Mental Health Commissioner, Steve Eliason – UT State Representative*
 - Caregivers and family support systems

- Historically marginalized populations, such as BIPOC, LGBTQ+, rural, and others, e.g., building off the work of:
 - Trans Lifeline, which is dedicated to building and maintaining trust with the transgender community with a model anchored on lived experience and empowerment. *Contact: Elena Rose Vera, Trans Lifeline*
 - The Gathering of Native Americans and Gathering of Alaska Natives training and technical assistance offered through the Tribal TTA Center, which provides a potential model for a culture-based planning process. *Contact: Pamela End of Horn, Indian Health Services*
- Integrating substance use prevention and addiction treatment into the BH crisis support structure, e.g.,
 - Baltimore Crisis Response, which provides services for detoxification as part of the crisis stabilization model. *Contact: Edgar Wiggins, Baltimore Crisis Response, Inc.*

4.2 Coordinating effectively across entities involved in crisis care

- Working with relevant entities – including hospital emergency rooms, 911¹, schools, and law enforcement – to create protocols (including shared definitions) and incentives that support coordination, e.g., building off work such as:
 - Embedding BH resources into 911 call centers in Harris County, TX. *Contact: Jennifer Battle, The Harris Center for Mental Health and IDD*
- Embedding crisis response into the school system, both operationally and financially, e.g.,
 - Baltimore County School System, which implements mental health training for school security officers and funds an Expanded School Mental Health Network in coordination with Behavioral Health System Baltimore. *Contact: Sharon Hoover, Co-director of the Center for School Mental Health (CSMH) at the University of Maryland School of Medicine*
- Integrating with social supports and community resources such as support for housing and food security, e.g., building off the work of:
 - Washington Foundational Community Supports, a supportive housing and employment benefits program that coordinates closely with the BH crisis system. *Contact: Kevin Martone, TAC*
- Establishing mechanisms for effective coordination.
 - Establishing a group to plan for 911 and crisis response coordination and 988 scale up across Federal, state, and local entities.
 - Putting in place technology that connects entities across the crisis care continuum, e.g.,
 - SAMHSA, through NASMHPD's TTI project, has funded 23 state mental health agencies to build or expand crisis bed registry systems. Crisis bed registries are databases designed to show “real-time” availability of psychiatric crisis services, including inpatient beds, and

¹ E.g., Major 911 protocol providers include ATCO, Power Phone, and IAED. Contact: April Heinze, NENA

often also include less intensive crisis services. NRI has been working closely with the funded states to assist their work and document their progress and lessons learned. A NRI/NASMHPD report highlighting this initiative will be available in the Spring of 2021. *Contact: Ted Lutterman, NRI; Brian Hepburn, NASMHPD*

- Behavioral Health Link in Georgia uses an electronic bed registry to enable crisis line staff to see available beds and refer individuals. *Contact: Wendy Tiegreen, Georgia Department of Behavioral Health and Developmental Disabilities; Debbie Atkins, Georgia Department of Behavioral Health and Developmental Disabilities*
- Creating regular cross-system convening points within communities, e.g.,
 - Arizona Crisis Community Collaborative weekly meeting to support cross-system planning for 988. *Contact: David Covington, RI International*
- Organizing ongoing cross-sector trainings to increase awareness of BH crisis services and build relationships across entities, e.g., building off the work of:
 - Crisis Intervention Team (CIT) training for law enforcement. *Contact: Ron Bruno, CIT International*

4.3 Financing BH crisis care continuum services and supports

- Making strategic investments in BH crisis services
 - Developing guidance and approach to braiding funding across different sources
 - Using state and local dollars to primarily fund infrastructure, not ongoing services
- Removing barriers to billing insurance for BH crisis care
 - Establishing standard codes and processes to bill Medicaid, Medicare, and commercial insurance, e.g., building off the work of:
 - Developing guidance for other states on Medicaid billing. *Contact: David Covington, RI International*
 - Investing in third-party billing capabilities, including infrastructure and personnel, e.g.,
 - Funding support provided by the Colorado Department of Human Services to enable ongoing billing to support Colorado Crisis Services. *Contact: Michael Allen, Rocky Mountain Crisis Partners*
 - Accelerating accreditation process for BH crisis providers
- Increasing available funding streams
 - Establishing 988 coordinators in every state to work with the 988 Administrator and SAMHSA to assess resources that exist in the community and identify gaps
 - Investing in research and technology to build the evidence base around realized savings
 - Building relationships with state, community, and healthcare associations to educate stakeholders and increase financial support

- Creating additional funding streams to cover operational costs associated with 24/7 crisis care
- Disseminating example legislation for states interested in implementing 988 cell phone fees
- Developing shared perspective on how philanthropy can invest strategically in the BH crisis care continuum, e.g., building on large philanthropic investments such as:
 - Philanthropic investment in the Crisis Text Line by Melinda Gates, Balmer Foundation, Pierre Omidyar, and others. *Contact: Ken Zimmerman, The Mental Health Strategic Impact Initiative*



5. Appendix

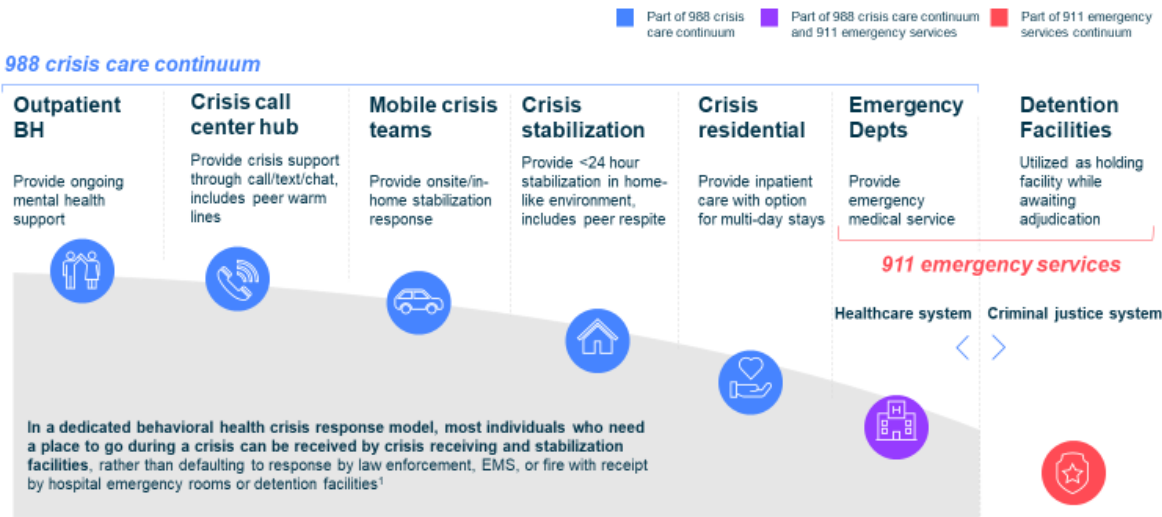
Exhibit 1: Participants vision for how people will feel using future 988 system

of responses: 39

The size of the word corresponds to the number of individuals who shared that word.



Exhibit 2: Crisis and emergency services care continuum



1. For both 988 and 911, a share of calls will be resolved without need for a receiving facility. In some cases, individuals receiving care through a dedicated mental health crisis response model will need receipt by non behavioral health facilities, but this will not be a default response
Source: Milbank Memorial Fund, "The '988' Opportunity: Improving Our Response to Behavioral Health Crises", published Nov 2020. CrisisNow, "Mental Health Care Shouldn't Come in a Police Car", published Dec 2019.

Exhibit 3: Exemplars

3.1 Arizona AHCCCS Crisis System

Arizona AHCCCS Crisis System

Summary: Crisis services, including 24/7/365 crisis telephone lines, mobile crisis teams, and facility-based crisis stabilization centers, are available to any Arizona resident, regardless of health insurance coverage

● Available across relevant geography and population

◐ Partially available across relevant geography and population

○ Unknown or unavailable across relevant geography and population

	Core element:	Mobile response teams	Receiving & stabilization facilities	Funding
<p>Select detail:</p> <p>Additional detail found at website below</p> <div style="background-color: #008000; color: white; padding: 5px; margin-top: 10px;"> <p>SAMHSA Nat'l Guidelines</p> <p>◊ Minimum Expectations</p> <p>★ Best Practice</p> </div>	<ul style="list-style-type: none"> ◊ Offers 24/7/365 crisis telephone lines operated by trained crisis specialists ◊ Links electronically to mobile crisis units and crisis facilities. • Works with other components of the system to connect individuals to facilities through warm hand offs, where appropriate. 	<ul style="list-style-type: none"> ◊ 24/7 mobile teams are staffed by a mix of clinicians, behavioral health technicians, and peers. ◊ Teams travel to the individual experiencing a crisis and provide assessment, stabilization and may triage the individual to a higher level of care, as appropriate. ★ Fewer than 5% of dispatches require law enforcement involvement 	<ul style="list-style-type: none"> • Offer crisis stabilization and observation, including access to Medication Assisted Treatment. ★ Accept all police referrals with zero rejections, no hospital "medical clearance" ★ Dedicated first responder drop off area and 5 to 10 minute turn around 	<ul style="list-style-type: none"> • In 2019, AZ spent \$163M on crisis hotlines, mobile crisis response, and crisis stabilization services <ul style="list-style-type: none"> – \$134M funded by Medicaid – \$28M funded through state revenues, county funds and grants (to serve individuals who were not Medicaid eligible)
<p>Crisis Now has measured the impact of these BH crisis services in the 4-million-person community of Maricopa County (Phoenix, Arizona):</p> <ul style="list-style-type: none"> – 37 FTE Police Officers Engaged in Public Safety Instead of Mental Health Transportation/Security – Reduction of 45 Cumulative Years of Psychiatric Boarding (aka Waiting in the ED) Creating a savings to hospitals of \$37 million in avoided costs/losses – Reduced Potential State Acute Care Inpatient Expense by \$260 million – The cost avoidance represents the net savings of a \$100 million investment in a full, integrated crisis continuum 				
<p>Source: AZAHCCCS website, AZ Central News Website: https://www.azahcccs.gov/BehavioralHealth/crisis.html</p> <p>Confidential and proprietary. Document intended to provide insight based on currently available information for consideration and not specific advice. Any use of these materials without specific permission if strictly prohibited.</p>				

Contact:

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Shelley Curran – Aetna/Mercy Care Health Plan

3.2 Colorado Crisis Services

Colorado Crisis Services



- Available across relevant geography and population
- Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: Colorado Crisis Services is the state's first statewide resource for mental health, substance use or emotional crisis help, information and referrals.

Core element:

Crisis call center



Select detail:
Additional detail found at website below

- ◇ 24/7/365 state-wide centralized support line (call and text) that serves anyone affected by a mental health, substance use or emotional crisis
- ◇ Callers choose to be connected with a mental health professional or peer support specialist who will provide immediate support and connections to further resources
- ★ Robust follow up programs focus on hospital ED discharges, substance use callers, safety planning and veteran support

Mobile response teams



- ◇ Mobile crisis response teams are dispatched by the call center and have response times ranging from 1h (urban areas) to 2h (rural areas)
- Training for mobile crisis response teams is standardized across the state

Receiving & stabilization facilities



- 12 walk-in crisis service centers are open 24/7, and offer confidential, in-person crisis support, information and referrals to anyone in need
- ◇ Walk in locations provide access to crisis beds for 1-5 days, for either voluntary or involuntary treatment
- ~24,000 visits and ~4,000 admissions in 2019
- ★ Additional crisis respite resources available regionally for voluntary services up to 14 days

Funding

- Funded through an annual state budget of \$31M
- Crisis line contract awarded as a state wide contract with Rocky Mountain Crisis Partners. Face to face services awarded per each of the state's 7 Medicaid regions to 4 ASOs in 2019.
- Full budget breakdown provided on the CDHS website

SAMHSA
Nat'l Guidelines

- ◇ Minimum Expectations
- ★ Best Practice

Website: <https://coloradocrisisservices.org/>

Source: [EM Crisis Partners](#), [Colorado Sun](#), [Colorado Government](#)

Confidential and proprietary. Document intended to provide insight based on currently available information for consideration and not specific advice. Any use of these materials without specific permission if strictly prohibited.

Contact:

Michael Allen, Rocky Mountain Crisis Partners - MICHAEL.ALLEN@CUANSCHUTZ.EDU

3.3. Crisis Center of Tampa Bay

Crisis Center of Tampa Bay



- Available across relevant geography and population
- Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: The Crisis Center of Tampa Bay offers phone and chat support for any mental health crisis, as well as general information and referrals. They partner with Veterans Affairs at the federal and state level to provide services to veterans in crisis.

Core element:

Crisis contact center



Select detail:
Additional detail found at website below

- ◇ Operates 24/7/365 through 211, with functionality by internet chat available as well
- Provides immediate and confidential short-term crisis intervention, as well as general information and referrals to over 4,000 community resources
- ◇ Staffs Care Coordination Teams that provide support for select individuals
- ◇ Collaborates with the U.S. and FL Depts. of Veterans Affairs to run the FL Veterans Support Line, which connects veterans in crisis with certified veteran counselors

Mobile response teams



- Partners with Gracepoint Mobile response and local law enforcement to provide mobile response services
 - Licensed team members are trained to clinically evaluate, de-escalate crisis situations, provide supportive counseling, and referrals

Receiving & stabilization facilities



- TransCare transports individuals to all Baker Act and Marchman Act receiving facilities in Hillsborough County, when appropriate

Funding

- The Crisis Center of Tampa Bay received ~\$15M in funding in 2019
 - 41% program service revenue
 - 27% federal grants
 - 18% county and local grants
 - 13% individual contributions
 - 3% other
- Received ~\$1M grant from VA through collaboration effort in 2018

SAMHSA
Nat'l Guidelines

- ◇ Minimum Expectations
- ★ Best Practice

Website: <https://www.crisiscenter.com/what-we-do/>

Source: [Crisis Center Website](#), [Grace Point Wellness Website](#)

Confidential and proprietary. Document intended to provide insight based on currently available information for consideration and not specific advice. Any use of these materials without specific permission if strictly prohibited.

Contact:

Eric Hebert, Crisis Center of Tampa Bay- ehbert@crisiscenter.com

3.4 Baltimore Crisis Response

Baltimore Crisis Response



- Available across relevant geography and population
- ◐ Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: Started in 1992, Baltimore Crisis Response, Inc. (BCRI) is the city's first and only comprehensive crisis center. Representative diversity is a key focus of the program which serves a community with a 70% Black population

Core element:

Crisis call center



Select detail:
Additional detail found at website below

- ◇ Started with limited hours (3p-11p) in 1992 as Maryland's first hotline – expanded to 24/7/365 coverage over time through foundation funding
- Currently partner with Lifeline to operate crisis line services

Mobile response teams



- Mobile crisis response teams part or original model and have expanded over time
- Outpatient license allows fee for service reimbursement
- Respond to ~2,700 mobile crisis calls each year
- ★ Accompanied by local law enforcement only when necessary
- CRT co-responder model includes specially trained officers and BH clinician for requests that come through police dispatch
- ◇ Agreements with every hospital and RNs on mobile team can ease transition into hospital if needed

Receiving & stabilization facilities



- ◇ Operate residential beds used primarily for short-term detox
- ◇ Staffed through a medical model with around the clock nursing and daily psychiatric visits for all patients
- Operating both short term crisis stabilization beds and detox beds allows them to move individuals between the two without changing their clinical condition
- Do not have drop-off crisis receiving facilities for first responders

Funding

- \$9M annual budget funded through two major block grants (federal and state), contract grants, foundation, and fee for service
- Started in 1992 with \$350k budget for call center, mobile response team, and 3 detox stabilization beds

SAMHSA
Nat'l Guidelines

- ◇ Minimum Expectations
- ★ Best Practice

Website: <https://bcresponse.org/welcome.html>

Source: Interview on 12/2 with Edgar Wiggins, Executive Director, BCRI
Confidential and proprietary. Document intended to provide insight based on currently available information for consideration and not specific advice. Any use of these materials without specific permission is strictly prohibited.

Contact:

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3.5 Georgia DBHDD Crisis System

Georgia DBHDD Crisis System



- Available across relevant geography and population
- ◊ Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: Centralized, state-wide, tech-enabled behavioral health crisis care operated through a collaboration between the Georgia Department of Behavioral Health and Developmental Disabilities, Beacon Health and providers

Core element:	Crisis call center	Mobile response teams	Receiving & stabilization facilities	Funding
<p>Select detail: Additional detail found at website below</p>				<ul style="list-style-type: none"> • Funded primarily through state budget <ul style="list-style-type: none"> — ~\$10 million for the Georgia Crisis & Access Line — ~\$35 million for the statewide mobile crisis teams
<p>SAMHSA Nat'l Guidelines</p> <ul style="list-style-type: none"> ◊ Minimum Expectations ★ Best Practice 	<ul style="list-style-type: none"> ★ Statewide Georgia Crisis & Access Line provides 24/7 telephonic intervention and chat, dispatches mobile crisis teams, uses an electronic bed inventory for open crisis or detox beds, and electronically schedules individuals with urgent outpatient appointments. • BHL's centralized ATL location with 400 full-time employees • Also provides non-urgent appointment finding assistance 	<ul style="list-style-type: none"> ◊ 24/7 mobile teams staffed by clinicians and BH technicians, available to all 159 counties and all Georgia residents, MH, SU and IDD crises. ◊ Teams travel to the individual and may triage to a higher level of care, as appropriate. ★ Fewer than 5% of dispatches require law enforcement. ★ Dispatch software provides team with the ability to immediately locate and communicate with mobile teams in the field 	<ul style="list-style-type: none"> • Operate network of Crisis Stabilization Units and Behavioral Health Crisis Centers as emergency drop-off centers ("Medical Clearance" in a hospital is required prior to admission) • Provide "First Responder Pocket Guide" to educate law enforcement and other first responders on common mental health conditions and available resources 	

Website: <https://dbhdd.georgia.gov/>

Source: [BHL Georgia Collaborative](#), [Georgia Recorder](#)

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Contact:

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3.6 NYC Well

NYC Well



- Available across relevant geography and population
- Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: NYC's new crisis care system founded in 2016 as part of the city's \$250M plan to change the culture around mental illness and provide a full suite of crisis intervention services to its residents.

Core element:

Crisis call center



Select detail:
Additional detail found at website below

- ◇ 24/7/365 free and confidential crisis help offers ability to speak with a counselor via phone, text or chat
 - Interpreters for 200+ languages
- ◇ Offers suicide prevention and crisis counseling, peer support, referrals and warm transfer to other services, and a follow-up check to ensure individual has connected to care and it is working

SAMHSA
Nat'l Guidelines

- ◇ Minimum Expectations
- ★ Best Practice

Mobile response teams



- ◇ Mobile crisis response teams including nurses, social workers, and psychiatrists able to provide mental health services in individuals' homes
- ◇ Provide mental health engagement, intervention and follow-up support to help overcome resistance to treatment
- ◇ Services include assessment, crisis intervention, supportive counseling and information / referrals or transport to hospital psychiatric room (if required)

Receiving & stabilization facilities



- ◇ Crisis Respite Centers serve people who anticipate or are experiencing a mental health crisis and provide a temporary residential stay in a warm, safe and supportive home-like environment
 - ★ Centers offer 24/7 support by peers who have experience with mental health issues as well as Non-Peer/Traditional Mental Health Professionals
 - Current centers do not have a "no refusal" drop off location for first responders

Funding

- Funded through a combination of state and city budget
 - State: \$2M/yr
 - City: \$5.5M in first year and \$4.5M/yr thereafter
- Additional \$3M allocated to marketing the new services

Website: <https://nycwell.cityofnewyork.us/en/>

Source: [Gothamist](#)

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3.7 Utah Crisis Line

Utah Crisis Line



- Available across relevant geography and population
- Partially available across relevant geography and population
- Unknown or unavailable across relevant geography and population

Summary: Mental health crisis call center operated in partnership with Lifeline with ability to dispatch mobile response teams and connect individuals to local mental health resources

Core element:	Crisis call center	Mobile response teams	Receiving & stabilization facilities	Funding
<p>Select detail:</p> <p>Additional detail found at website below</p>				<ul style="list-style-type: none"> • Funding for the Utah Crisis Line, Utah Warm Line, Salt Lake County Mobile Crisis Outreach Teams (MCOT), SafeUT, and the Safe Care Transition Program comes from: <ul style="list-style-type: none"> – State of Utah – Salt Lake County – Utah Dept of Human Services – Optum – Univ. of Utah Health – UNI
<p>SAMHSA Nat'l Guidelines</p> <ul style="list-style-type: none"> ◇ Minimum Expectations ★ Best Practice 	<ul style="list-style-type: none"> ◇ 24/7 free and confidential crisis help & support line in partnership with National Suicide Prevention Lifeline <ul style="list-style-type: none"> • Interpreters for 150+ languages • Additionally allow non-crisis calls for anyone facing a mental health challenge 	<ul style="list-style-type: none"> ◇ Mobile Crisis Outreach Teams (MCOT) available in many areas offer in person or video consultation ★ Teams made up of two people, a masters level clinician and a certified peer support specialist who has lived through their own experiences with mental health challenges <ul style="list-style-type: none"> • Respond to ~300 calls / month • 20 minute average response time 	<ul style="list-style-type: none"> ◇ Short-term (up to 23 hours) secure center in Salt Lake City provides therapeutic crisis management, an assessment based on strengths and psychiatric needs, medication intervention, and wellness/recovery/discharge planning <ul style="list-style-type: none"> • Additional centers available through partnership network (e.g., ROC) 	
<p>Website: http://utahsuicideprevention.org</p>				

Source: [University of Utah Health, RUTV feature](#)
 Confidential and proprietary. Document intended to provide insight based on currently available information for consideration and not specific advice. Any use of these materials without specific permission is strictly prohibited.

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 Lianne Huff - Program Administrator, Utah Division of Substance Abuse & Mental Health – Mobile Crisis Outreach Team Expert;
 Doug Thomas, Utah Mental Health Commissioner;
 Rep. Steve Eliason – UT State Representative