Crisis Care Continuum Planning

IDHS/DMH is providing the following Q&A document in response to a set of questions curated by the National Alliance on Mental Illness- Illinois, and thank them for their continued partnership as we plan for the evolution of the crisis care continuum, consistent with national guidance from SAMHSA and "The Promise of 988." It is important to note that the transition to 988 as the three digit dialing code for the existing National Suicide Prevention Lifeline is considered a catalyst, and the beginning of a transformation across our country that is expected to take five years to fully realize. SAMHSA has offered the following in terms of an expected timeframe for the various goals to be realized:

2023: Lifeline Call Centers will develop the capacity to handle 90% of the calls routed to them as the "Primary Call Center."

2025: 80% of individuals across the nation will have access to mobile crisis response teams.

2027: 80% of individuals across the nation will have access to crisis receiving and stabilization units within their local area.

Preparation for each of these three pillars of a crisis continuum are currently in different phases of planning and implementation, and IDHS/DMH intends to meet or exceed these timelines within Illinois.

Someone to Call: 988 Call Center Implementation

Public-Facing Questions

Q: If people need help during a mental health emergency, who should they call, and what should they expect to happen? Members of the public need a clear message about who to call and what to do when they or a loved one need help. We need an Illinois-specific message that provides guidance about when to call 988 vs. 911, what happens next in each system, and how 988 might relate to mobile crisis teams.

A: The public will use the 988 system in the same way that they currently use the National Suicide Prevention Lifeline 10-digit number, 800-273-8255. This number has been in service for the nation since 2005. On July 16, 2022, the public gained access to a simplified, easy to remember number, 988, to use in the same manner. DHS/DMH issued a fact sheet that includes the following distinctions between the crisis lines:

988:

- Suicide prevention and mental health crisis lifeline
- Specialized intervention by trained call takers with advance training in de-escalation and clinical suicide prevention
- Confidential, free, and available 24/7/365
- Eventually, 988 call centers will function as access points to statewide community-based crisis resources such as mobile crisis response teams

911:

- Emergency line for public safety emergencies, medical emergencies and law enforcement
- Provides limited de-escalation or emotional support, staffed with public safety answering point dispatch workers
- If the public safety or medical emergency is pertaining to someone who has a mental health condition, or appears to be experiencing a mental health crisis, a crisis intervention team (CIT) trained officer with basic training in mental health crises may be available through 911 dispatch
- Free, and available 24/7/365

As the state further develops mobile crisis response in relation to the CESSA requirements, additional guidance will be provided to the public that will detail how Illinois' new community-based crisis response teams will operate. The earliest this is anticipated to occur is January 2023.

Q: What is the Illinois-specific messaging plan for the 988 roll out? Providers, leaders and advocates urgently need guidance and a simple script about what to say, who to say it to, and where and how to say it. The federal guidance provides a general framework, but it is vague - we need Illinois answers, and right now they could be provided with a level of simplicity that would not require a focus group. Once basic information is drafted, we are happy to mobilize our networks to engage and customize messages for every Illinois stakeholder community.

A: The public messaging for 988 will be slow and deliberate and directly informed by the capacity of our call centers to manage call volume following the July 16th launch. This approach is directly aligned with federal guidance on public messaging. We will be monitoring performance of our call centers in the months following the July launch and when we are assured that we have the appropriate resources within the state to manage calls from our state, we will begin our direct messaging campaigns to the public. We are currently working with the DHS marketing vendor to develop the message content for that campaign. Until that time, we will provide updates to state leaders and our partners in the form of E-newsletters and Frequently Asked Questions that will be distributed and posted regularly on the DHS/DMH website.

Q: What should the public know about how children and youth can use 988, versus how adults can use it? In addition to tailoring messaging to different age groups, we need to provide simple information about whether there are differences in the care and follow-up that 988 can provide to callers/texters who are minors versus adults. Both children and the adults who care about them will need this message.

A: Our Lifeline Call Centers will accept all calls, chats/texts no matter the age of the caller. Call Centers also follow up with individuals no matter the age and all have access to age- appropriate resources and referrals options. Lifeline Call Center specialists are taught to be selective in their word choices when talking to children. They are also trained to be cautious with any follow ups with children to assure their situation can remain confidential. Messaging campaigns will be designed using best practices in messaging youth and families.

Systems Questions

Q: Who will truly be answering our 988 calls, chats and text after the initial FY23 investment in Illinois' 988 call centers? While the addition of a statewide backup center in Bloomington is progress, more investment and system-building is needed to ensure that every Illinois 988 call will be answered regionally or by the backup center. Illinois is starting with a low baseline - in the first

quarter of 2022, 80% of our National Suicide Prevention Lifeline calls were answered out of state. We need an accurate sense of what 988 capacity will look like in FY23 to help inform our state's preparation.

A: The current statewide response rate is the result of a lack of Lifeline Call Centers assigned primary coverage for 67 counties in Illinois. In January, Illinois issued a Notice of State Award as noted in the question to PATH, Inc, who is charged with developing primary coverage responsibility for all areas without existing coverage as well as serving as a back-up for areas with existing primary coverage. Illinois submitted an updated routing request to Vibrant that will provide for primary and backup coverage for the entire state of Illinois for the first time since the Lifeline was established in 2005. We were notified by Vibrant on 7/5/22 that the routing requests had been completed, and PATH confirmed a significant increase in calls following this change.

All Lifeline call centers have received funding to hire staff to provide full coverage based on available projections. The DMH expert financial consultants have received data from Vibrant including hourly call rates by county that are being used to better understand the needs across the state, and this information has been utilized to analyze the proposed staffing plans of each call center. We will be monitoring the actual call rates with the routing changes with the intention of staffing adjustments as needed to meet the call demands. All staff in all Lifeline Centers will continue to go through an extensive training curriculum in accordance with contract standards. (Note: Vibrant Emotional Health is the administrator of the National Suicide Prevention Lifeline as authorized by the Substance Abuse and Mental Health Services Administration.)

Q: How are we preparing Illinois 988 call centers to provide local care connections to their callers, especially if Illinois is forced to rely on the statewide backup center to manage most of the state's calls? Each of Illinois' 6 call centers should not be on their own in researching local resources and building MOUs and partnerships. The State should provide frameworks and resources across the 988 system to help these centers connect callers to local in-person crisis services and longer-term resources.

A: DHS has an intergovernmental agreement with the University of Illinois, Jane Addams College of Social Work and has created a "Crisis Hub" in the Center for Social Policy and Research. The Crisis Hub is staffing a unit with responsibility for assisting the Lifeline call centers in building those local relationships, partnerships and agreements with organizations that will provide on-going supports for the crisis caller. This work will build on the existing relationships and networks that currently exist in communities across the state. In addition, call center accreditation standards require the curation of information contained in databases for the call takers to utilize, and PATH has completed this initial development of the statewide database, which will continue to be reviewed and updated consistent with requirements.

Q: How is 988 preparing to provide care to children and youth? Modalities for supporting children experiencing suicidality and mental health crises are different than adults. Also, the landscape and rules around in-person crisis services is different. What standardized training and guidance are 988 call centers receiving around this?

A: All populations will have access to calls, and chats and texts when available. All calls/texts are accepted, regardless of the age of the individual, and follow-up is also provided regardless of age. Call centers are provided with resources and referral options across the lifespan. In terms of training, call center specialists are trained to modify language/word choice as appropriate for different callers, including when talking to children. Additional measures

around confidentiality are also in place in regards to follow-up procedures for children, including ensuring the child has access to the phone again, and that it is their own phone they are using.

Q: What is the long-term vision to build out a more robust and hyper-local network of 988 call centers across the state? It is critical that every 988 call is answered near to where they originate, by a knowledgeable Illinoisan who is connected to local resources, especially once CESSA builds the capacity for 988 to coordinate with local 911 centers and mobile crisis services. For FY23, Illinois is primarily building capacity through our statewide backup center and the other 5 existing Lifeline Centers, but the July 16 launch should be just the beginning of building our state's infrastructure. We must continue working towards best practice, hyper-local crisis care in future years by sufficiently funding Lifeline centers, adding additional call centers and using the backup center as a true backup system.

A: The state will continue to monitor the effectiveness of the six Lifeline centers that are funded and charged to provide statewide coverage for 988 crisis calls. Any changes in approach will be considered only after careful monitoring and evaluation of the current approach. It is important to note that several states have embarked upon a similar approach (one statewide call center and a small number of local call centers who have historically served as National Suicide Prevention Lifeline Centers) and several states have only one call center serving the entire state. We will also be closely monitoring any Vibrant evaluations of statewide versus local coverage approaches used by states with an eye towards a reviewing all comparative analyses.

Someone to Respond: 590 & Mobile Crisis Teams

Public-Facing Questions

Q: How can the public access a mobile crisis team? There is significant confusion about what mobile crisis teams will do, and how they are connected to the 988 system. Many people assure that 988 will have the capacity to dispatch these teams. If that won't be true by the July 16 launch, the misinformation could be harmful. Our community needs an accurate, clear and consistent message, and advocates and providers need to know what to tell people.

A: Mobile Crisis Response teams have been funded statewide with 82 teams operating across the state. The teams are dispatched when individuals in crisis require an in-person response. The 82 teams are at varying stages of implementation however, all teams are to be dispatched by the provider for persons in their service system, or in response to a referral by a 988 call center. Any changes associated with the use of Mobile Crisis Response teams pursuant to the CESSA legislation will not occur until each jurisdiction has met the criteria for moving forward with full implementation. In the future, it is anticipated that 911 may transfer a behavioral health crisis call that requires a community-based Mobile Crisis Response to a 988 Lifeline center for dispatch. Development of risk matrices, updating of protocols and training of staff across the system must occur before CESSA is implemented.

Q: When people call for a mobile crisis team, who will respond, and what will the response look like? Mobile crisis teams are a powerful tool for a safe and appropriate response, but the public has very little information about how they look in Illinois, and most media narrative focuses on the dichotomy of police vs. social worker response. Advocates are aware that several models of mobile crisis response are operating in Illinois, and that more alignment work is ahead this year via CESSA.

To support these efforts, we need clear communications about the diversity of response teams operating in the state, the progress being made, and the work that is to come.

A: DHS/DMH is funding expanded crisis response capacity through Program 590, with teams being developed consistent with SAMHSA's model. The teams that are being developed as a part of Program 590 consist of mental health crisis counselors and engagement specialists who are trained to respond together to address a person experiencing a crisis at the location where they are located. This specific type of response should be viewed as a part of the continuum, which may also include other community resources such as CIT trained officers, co-responder models within police departments, etc. In addition, as we begin to anticipate what the coordinated system will look like once "The Promise of 988" is fully realized, the more likely scenario or appropriate question is, when someone experiencing a crisis calls for assistance, what will the response be? This is because the determination of whether or not mobile crisis response is needed is actually made by the call taker, rather than because it is what is requested by the caller. This type of determination will be guided by the development of protocols and procedures across 988, 911 and the greater emergency response system as a part of the CESSA work.

Systems Questions

Q: When can we expect a statewide map, list of services and phone numbers, for 590 and Medicaid mobile crisis teams (SASS/adults)? Mobile crisis providers do not know which other providers are operating in their regions, and call lines of all kinds are struggling to understand the landscape of mobile crisis. Illinois needs coordination and transparent information about the mobile crisis system, in order for it to be a viable alternative to police and fire/EMS.

A: DMH is currently working with the University of Illinois College of Urban Planning and Public Affairs to produce maps for Mobile Crisis Teams, PSAPS and Lifeline Centers within the 11 EMS Regions. These maps that will designed to allow for 'layering' of information from different systems will be shared in the Statewide and Regional CESSA meetings and will be publicly available at that time.

Q: How can we provide 590 teams with the flexibility needed to provide appropriate responses to people in crisis? 590 providers report that they need more discretion in how they staff teams to respond to different kinds of emergencies. Staffing flexibility can also help overcome hiring challenges. 590 providers also have concerns about CESSA's provisions restricting who can initiate involuntary petitions, which can sometimes be the only route available to getting care for a person in acute crisis.

A: DMH 590 providers have agreed to certain staffing models via contractual arrangements with DMH. Providers are able to request adjustments to all contractual requirements through their DMH contract manager and all requests will be considered. DMH will also work to clarify with providers how staff can be assigned to work in their agency. Again, discussions about specific staffing concerns routinely occur in discussions between providers and their contract manager. Providers concerns with CESSA requirements will be discussed during the CESSA implementation and any next steps will be discussed as part of that process.

Q: What is being communicated to help 590 teams understand their connection to 988, and to equip them with the best support possible in facilitating call center relationships? Many 590 teams are receiving the message that 988 will be their dispatch center, and if this centralized capacity will not be ready by the July 16 launch, providers need to understand that timeline. In the meantime, 590

teams need support in connecting to the 988 call centers that will serve people in their area, to discuss how warm handoffs will work.

A: DMH 590 providers are currently contracted to provide Mobile Crisis Response services. There is no expectation that their responsibilities will change effective July 16, 2022. Rather, a system that allows for routine referrals to Mobile Crisis Response Teams will occur over time as relationships are developed at the regional level between the Mobile Crisis Response Teams and the Lifeline Call Centers. This work is currently underway. CESSA requirements will also be implemented over time following the completion of specific requisites.

Q: As the connection between 988 and mobile response teams grows in the future, what will be the process for third-party providers and call lines to initiate a mobile crisis response? Call lines and providers must have access to a direct, centralized dispatch for mobile crisis teams with a different procedure than the general 988 call line. If the state tries to create a system where other call lines must hand off a person in crisis to general 988 call takers, who will in turn hand off to 590 providers, that creates too many intakes and screenings, and a significant potential for call drop-off.

A: Until such time as the new protocols are developed and technology exists to facilitate a more centralized dispatch, local crisis lines should continue to connect with their local resources through existing protocols that have been developed at the local level.

Q: How are we building for success in the integration of peers into mobile crisis teams and the larger crisis system? Peers and community health workers can play an important part in caring for people in crisis. Illinois should follow national best practices in how their leadership is incorporated into the crisis system, such as the recommendations that peers should not conduct intakes and evaluations. How is the State providing guidance to 590 and other providers on these best practices? Also, how can the State assist providers with peer workforce shortages by coordinating new peer workforce development programs with the new peer roles in the crisis sector?

A: The Division of Mental Health has provided training on the role of Engagement Specialists on Mobile Crisis Response Teams, including the instruction that ES staff engage in a range of non-clinical activities to support individuals or families of individuals in distress. Engagement Specialist activities follow national best practices and may include mentoring, advocating for people in recovery, and building non-hierarchical relationships with the individual in distress. They do not complete assessments, evaluations, or petitions for involuntary treatment. The role of the Engagement Specialist is unique in that it is based on the concept of mutuality—or sharing similar experiences. Engagement Specialists work in tandem with crisis counselors. The DMH training is available at 590 MCRT Engagement Specialist Training

Additionally, the DMH has coordinated quality training to be available to 590 providers through two vendors nationally renowned vendors (Humannovations and RI International). Lastly, the regular 590 Learning Collaboratives have been and will continue to be a space where DMH provides guidance on best practices related to the role of Engagement Specialists on MCRTs.

Q: How can we work towards equitable mobile crisis team coverage in Illinois, once coverage maps are released? Preliminary maps coordinated by the City of Chicago suggest there will be mobile crisis coverage gaps that mirror our existing community mental health service deserts. This means that many Black, Brown and disinvested communities may lack access to mental health-focused crisis care. This knowledge, and an equity perspective, should guide future investments.

A: Coverage maps will be made available to the CESSA Committees and posted for the public at that time.

A Place to Go: Crisis Receiving & Stabilization Facilities

Public-Facing Questions

Q: What are we able to tell the public about what will happen after the initial crisis, including where people go to get follow-up treatment or support their recovery? Given long wait times in ERs, shortages of inpatient options, and wait lists for outpatient service, we can expect many questions about "what happens next." Since it will take time to build out the comprehensive crisis receiving and stabilization system, we will need to provide the best available answers about what exists now.

A: We will continue to build out supports for individuals needing care, including those individuals needing access care following a crisis. At the time of the crisis, every effort will be made to make referral to available services that do not have protracted waiting lists. These specific systemic improvements can not address all of the current gaps in care, however we will work diligently to advance our vision on expanding crisis receiving and stabilization facilities to address this particular need.

Systems Questions

Q: What is the long-term vision for building out a continuum of crisis receiving and stabilization facilities in Illinois? "A place to go" is the third part of a comprehensive mental health crisis system: a statewide network of mental health-focused spaces where a person in crisis could walk in or be brought by a mobile crisis team or first responder, to receive immediate support without an appointment. In order to be a viable alternative to an emergency department, these facilities must be 24/7, equipped to handle first responder drop-off, and there must be a range of options in order to handle different types of crisis and provide different levels of support. This should also include peer-led and peer-supported crisis centers, including living rooms and other models.

A: The third pillar – somewhere to go – is recognized as an important part of a full crisis continuum, consistent with SAMHSA's model. IDHS/DMH has begun a needs assessment and includes this piece of the continuum within internal planning discussions. Consistent with SAMHSA's guidance and timelines for expected development of the full continuum (again which is projected to take five years), IDHS/DMH will be working towards this capacity and considering how development of these resources may be included in future program design.

Sustainable Funding & Infrastructure

Q: How can Illinois build towards a sufficient, sustainable funding structure for 988 call centers, so we are not in crisis when federal ARPA funding ends in 2024? The Trust Fund legislation and FY23 budget have created a structure to get started, but a much larger and sustained investment is needed. FY23 federal and state funding is already not enough to build a best-practice, hyper-local network of 988 call centers that can accept 100% of Illinois' 988 calls - and call volume will grow each year. We need a sustainable funding source and plan for FY24 and beyond.

A: Consistent with guidance from SAMHSA and Vibrant, IDHS/DMH will be closely monitoring the performance of the Lifeline Call Centers on a set of Key Performance Indicators, and our planning work will be further informed by evaluation performed by the University of Illinois-Chicago of

operations of both call centers and 590 providers. Discussions at both the state and federal level will continue on funding strategies and diversification/sustainability of the system. It is important to remember that the full realization of the crisis continuum is likely to take five years, and so the understanding of the necessary levels of funding will be informed by this continued expansion as well, and will need to be further refined from projections.

Q: How can we ensure appropriate capacity is in place in state and local government and in partner organizations to effectively implement 988, 590/mobile crisis, CESSA and other programs? With so many rapid changes all happening at once in mental health, Illinois needs an intensive level of coordination, planning and strategy that the State government is perfectly positioned to provide. We should consider investing in a dedicated team to manage this work, if the State agencies desire it, to equip ourselves to do this implementation right. When the Affordable Care Act rolled out, the State built a full team of dedicated staff to manage it, and these new mental health crisis programs are arguably even more complex.

A: DHS has an intergovernmental agreement with the University of Illinois, Jane Addams College of Social Work and has created a "Crisis Hub" in the Center for Social Policy and Justice. The Crisis Hub is being staffed to assist with 988 implementation, CESSA implementation and 590 training and evaluation. In addition, the state has contracts with two independent consulting firms to assist with strategy and implementation of all of the above-mentioned programs. Through a separate contract with UIC Jane Addams College of Social Work, program evaluations will be conducted by independent researchers. At this time, we believe that we have sufficient resources to conduct all required work and will seek other resources in the future as needed.

Q: How can providers and advocates help shape the work of the new UIC best practice center, to ensure it has the most positive possible impact on our system? Investing in a university partner for Illinois' mental health crisis system is an excellent step forward. The State should heavily weigh the input of the most involved system stakeholders (such as crisis providers and system advocates) in determining the most pressing needs and gaps that the center should address.

A: The UIC Crisis Hub was designed to provide support to the state infrastructure in the following areas:

- Statewide Community Linkages and Regional Supports
- Training and Staff Development
- Community Engagement and Messaging
- Information Systems Coordination

We expect that the university will engage all appropriate and necessary resources to meet the requirements of their agreement.