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Process Evaluation on Crisis Services in Northern Idaho

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By

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Abstract

Background: Idaho ranks last of all states for per capita spending on mental health treatment (Kaiser Family Foundation, 2014). In Idaho, individuals in crisis who suffer from mental illness or Substance Use Disorder (SUD) have few options for care. They often utilize the most expensive treatment through the emergency department, inpatient services, or by going to jail. Idaho has the 7th highest suicide rate in the nation (Suicide Prevention Action Network of Idaho, 2015), while Region 1 of Idaho has the second highest suicide rate in the state from 2010-2014 (Suicide Prevention Action Network of Idaho, 2015).

Methods: This scholarly project uses process evaluation as a method to assist in the transformative work to improve crisis services in Region 1 of Idaho for the behavioral health population. This process evaluation focuses on three objectives: (1) to identify community goals and best practices from the international and national literature that have been shown to effectively respond to community behavioral health crises; (2) to determine how closely key stakeholders in the Region 1 behavioral health coalition agree with each other in addressing behavioral health crises and if they recognize community goals and best practices shown to effectively respond to behavioral health crises; and (3) to conduct a gap analysis that will identify the gaps and challenges in behavioral health crisis services and resources in Region 1.

Results: (1) The literature revealed that there are two best practice goals that are shown to effectively help communities address behavioral health crises; multi-sectoral and suicide prevention approaches; (2) Interview responses of key stakeholders reflect criteria that are associated with a multi-sectoral approach and each agency had long-term goals to address the

behavioral health population. However, there was not full agreement on the most urgent community-wide behavioral health crisis needs in Region 1; (3) Gaps in Region 1 were identified as lack of providers, lack of adequate transportation, lack of financial assistance for medications, and lack of housing for the behavioral health population. While most gaps are defined as a best practice in the literature, six gaps are unique to Region 1 and do not meet the definition of a best practice. This suggests that gaps and best practices may be unique to different communities and merits further exploration.

Recommendations: The findings of this process evaluation have the potential to shape the direction of Region 1 behavioral health crisis services. It can provide the foundation for prioritizing best practice strategies for the region. Ultimately, the goal is to decrease suicide by addressing the identified gaps and lack of related best practices in Region 1 for the behavioral health population in crisis.

Key words: behavioral health crisis best practices, behavioral health crisis services, behavioral health gaps in crisis services, multi-sectoral approach, process evaluation, suicide prevention.

Problem

Individuals with mental illness and substance use disorders (SUD) are woefully underserved in Idaho. This is evidenced by Idaho's ranking as last of all states for per capita spending on mental health treatment (Kaiser Family Foundation, 2014). The national per capita average for state spending on mental health services is $120—Idaho spends $36. In Idaho, individuals in crisis who suffer from mental illness or SUD have few options for care. They often utilize the most expensive treatment through the emergency department, inpatient services, or by going to jail. Those individuals with mental illness or SUD may be defined as part of the "behavioral health population" (Peek, 2013).

An extreme crisis state for an individual with mental illness or SUD is a life-threatening situation where an individual is threatening harm to themselves or others. This is a fact that adds urgency to the expanding problem of behavioral health services in Idaho. Idaho has the 7th highest suicide rate in the nation, which was 47 % higher than the national average in 2013, according to Suicide Prevention Action Network (SPAN) of Idaho (2015). Region 1 of Idaho, which is comprised of Boundary, Bonner, Benewah, Kootenai, and Shoshone counties, has the second highest suicide rate in the state from 2010-2014 according to the latest county statistics from SPAN of Idaho (2015). There has also been an identified lack of behavioral health services in Region 1 (Delio, Dupree, Malek, & Romero, 2013; Follow-up Gap Analysis Survey on Region 1 Crisis Services – Summer 2015 Results, 2015; Moehrle & Whalen, 2013, 2014; Region 1 Behavioral Health Board, 2015;) (see Appendices A, B & C).

Community stakeholders in Region 1 sought solutions for the past twenty years to address the behavioral health population in crisis. Due to a lack of services, regional emergency departments and jails have become the de facto settings utilized by individuals who experience a

behavioral health crisis. The regional medical center experienced almost 4,000 behavioral health admissions to the emergency department during 2014. Fifty-seven percent of these individuals were discharged with a safety plan and did not require inpatient admission, yet they sought services due to personal crisis. Additionally, the number of individuals placed on involuntary detention has incrementally increased over the past six years with the majority initiated by law enforcement in 2015 (Kootenai Health, 2015).

For the last twenty years, the coalition of stakeholders in Region 1 has been comprised of leaders of the region's hospitals, law enforcement, the local federally-qualified health clinic, the District 1 Health Department–Panhandle Health District, Region 1 Mental Health of the Idaho Department of Health and Welfare, and other entities (see Appendix D). In 2014, the 62nd Idaho legislature enacted the Behavioral Health Community Crisis Centers Act (2014), a bill that allows for crisis centers to be established by the Idaho Department of Health and Welfare as voluntary 23-hour crisis centers. The coalition saw the 23-hour crisis center as an opportunity to assist this population and decrease unnecessary use of emergency department visits and incarceration. While the initial attempt to bring a crisis center to northern Idaho was unsuccessful in 2014 due to the political landscape, the award was made to Region 1 of Idaho for a crisis center to be established in northern Idaho in 2015.

The Northern Idaho Crisis Center (NICC) opened in December 2015 and has been a robust step toward aiding behavioral health clients in crisis, but it is only part of the solution. Region 1 experiences a high suicide rate, a lack of behavioral health services, and crowding in jails (where there is a lack of mental illness and SUD treatment). Accordingly, a process evaluation has been identified as a method to assist in the transformative work to improve the inadequate crisis services in Region 1 and ultimately impact the rate of suicide in Region 1.

Process evaluation is an aspect of program evaluation theory (Issel, 2014). It is the systematic collection of information about a program or strategy's inputs, activities, and outputs, as well as the program's context and other key characteristics (Centers for Disease Control and Prevention, 2008). Process evaluation provides for analysis of the early development and actual implementation of a strategy or program, assessing whether strategies were implemented as planned and whether expected outputs were actually produced. It also provides the information needed to make adjustments to strategy implementation in order to strengthen effectiveness of the strategies (Issel, 2014) (see Appendix E for a rendering of the *Elements of the Process Theory Included in a Process Evaluation*). This process evaluation will focus on identifying best practices in crisis intervention services and community action strategies that can be added to the strategies beyond the NICC to address the behavioral health population in crisis in Region 1.

The objectives of this process evaluation are as follows:

- **Objective #1:** Identify community goals and best practice interventions from a comprehensive review of the international and national literature that have been shown to effectively respond to community behavioral health crises.
- **Objective #2:** Determine how closely key stakeholders in the Region 1 behavioral health coalition agree with each other in addressing behavioral health crises goals and do they recognize and incorporate these goals into their long-term goals, policies, and interventions.
- **Objective #3:** Identify gaps and challenges in behavioral health crisis services and resources in Region 1 that must be resolved in order to effectively respond to community-based behavioral health crises goals and best practices based on the review of international and national literature.

Problem Change

This process evaluation was designed to assist the behavioral health coalition of key stakeholders in Region 1 to determine the strategies required to improve crisis intervention services in Region 1, thus decreasing extreme crisis situations of suicide attempts and completions in Region 1. This will be accomplished through the three objectives of this process evaluation and the analysis of outcome data to identify best practices, community goals that address crisis interventions, and the gaps of best practices that are missing from Region 1. Recommendations on the basis of the results will be disseminated to the coalition for direction in developing a plan for crisis intervention services in Region 1.

Background

A review of the international and national literature was conducted to identify the current state of practices regarding crisis services. In keeping with the objectives of this process evaluation, the literature review focused on best practices, community goals, and the ramification of gaps in best practices related to crisis services in communities.

Crisis Intervention Best Practices

Best practices in behavioral health are described as strategies that have consistently shown results superior to other methods or techniques, and are used as a benchmark (National Gerontological Nursing Association, n.d.). An extensive review of the literature conducted by Substance Abuse and Mental Health Services Administration (SAMHSA) (2014a) identified the primary goals of crisis services. They are to stabilize, improve psychological distress, and engage individuals in appropriate crisis intervention treatment services. In the SAMHSA (2014a) report, *Crisis Services: Effectiveness, Cost-effectiveness, and Funding Strategies,* best practices included: 23-hour crisis stabilization/observation beds, short-term crisis residential services,

mobile crisis services, 24/7 crisis hotlines, peer-run listening lines run by trained mental health consumers (called "warm lines"), peer support, psychiatric advance directive statements, and peer crisis services.

Another model that identifies best practice for crisis care is the *Practice Guidelines: Core Elements in Responding to Mental Health Crises* (The U.S. Department of Health and Human Services [USDHHS], 2009). The practice guidelines consist of the ten essential values and fourteen essential principles that are recommended regardless of the nature of the crisis, the situations where assistance is offered, or the individuals providing assistance (see Appendix F for a complete list of the values and Appendix G for a list of principles). Underpinning the interactions that clinicians have with clients should be trauma-informed care. Trauma-informed care is a best practice and organizational framework that involves understanding, recognizing, and responding to the effects of all types of trauma (SAMHSA, 2014b).

Community Goals

The review of the best practice literature associated with behavioral health crisis intervention identified two broad goals that have shown a positive impact for addressing behavioral health community crises. These two community goals are defined as a multi-sectoral approach needed to effectively address community-based behavioral health crises (World Health Organization [WHO], 2014b) and a suicide prevention approach (Mann, et al., 2005; Suicide Prevention Resource Center, n.d.).

Multi-sectoral strategies.

The multi-sectoral approach encompasses a comprehensive and coordinated effort between partnerships in the public and private sectors that can impact crisis intervention services and ultimately prevent suicide (WHO, 2014b). To effectively meet behavioral health crisis

goals, a comprehensive, multi-sectoral strategy is needed—which includes involvement from but not limited to—health care, social welfare, education, judiciary, and employment sectors (WHO, 2014b).

The multi-sectoral approach has been successful in Great Britain. The work from multiple sectors was examined in a 2012 study that specifically linked changes in suicide rates to the implementation of nine suicide prevention recommendations. The recommendations were: (1) providing 24-hour crisis teams; (2) removing ligature points (environmental angles that materials can be affixed to for hanging); (3) conducting follow-up with patients within 7 days of discharge; (4) conducting assertive community outreach, including intensive support for people with severe mental illness; (5) providing regular training to frontline clinical staff on the management of suicide risk; (6) managing patients with co-occurring disorders (mental illness and substance use disorder); (7) responding to patients who are not complying with treatment; (8) sharing information with criminal justice agencies; and (9) conducting multidisciplinary reviews and sharing information with families after a suicide (Cox, Robinson, Nicholas, Lockley, Williamson, Pirkis, et al., 2013).

Findings indicate that implementation of seven or more of these multi-sectoral recommendations can significantly lower suicide rates (Cox et al., 2013). Among all recommendations, providing 24-hour crisis care was linked to the largest decrease in suicide rates (Cox et al., 2013; Mishara & Weisstub, in press). These findings suggest that communities must have the capacity to respond to crises with appropriate interventions, and those individuals in a crisis situation must have access to emergency mental health care.

Another successful multi-sectoral initiative noted by the WHO (2014b), was the *Choose Life* initiative developed in Scotland in 2002 in response to a suicide rate of 27 per 100,000 men.

It was part of broader Scottish policy to improve population mental health and stimulate change regarding lack of social justice and inequalities, which contribute to the stigma of mental illness. Recommendations from the *Choose Life* initiative include the following three key goals:

- Coordinated efforts for suicide prevention across health care services, social care services, educational institutions, housing, police, welfare, and employment services.
- Multi-professional training programs to increase provider capacity for supporting suicide prevention.
- Financial support for local community and neighborhood interventions.

Scotland has reported an 18% decrease in the suicide rate between the years 2000 and 2012 due to the *Choose Life* strategy (Scottish Government, 2013).

Communities that serve the mentally ill should incorporate models that integrate law enforcement with behavioral health services. They are often the first responder in crisis situations with the mentally ill or SUD population (McKenna, Furnass, Oakes & Brown, 2015). The Crisis Intervention Team (CIT) model is a collaborative approach to safely and effectively address the needs of persons with mental illnesses, link them to appropriate services, and if appropriate, deter them from the criminal justice system. While this model has not undergone sufficient research to be recognized as an evidence-based practice, it is a recommended approach and has been effectively utilized in many law enforcement agencies nationally and internationally (Kohrt et al., 2015; Watson & Fulambarker, 2012).

The Comprehensive Continuous Integrated System of Care (CCISC) model (Minkoff & Cline, 2004) has been identified as a best practice for crisis intervention services for individuals who experience both a mental illness and SUD, also known as “co-occurring” disorders. The model focuses on engagement and treatment of the co-occurring disorder population. Through

addressing the individual holistically, suicidality can decrease. It has been successfully employed nationally and internationally.

As crisis intervention strategies have been shown to require a coordinated community approach, building a strong coalition of key stakeholders is vital. The Community Coalition Action Theory (CCAT) propositions developed by Butterfoss & Kegler (2002) are community action strategies relevant for addressing crisis interventions from a community perspective. According to CCAT, a core group of community stakeholders must be committed to the prioritized issue and reflect a broad constituency of diverse groups and organizations.

Suicide prevention strategies.

The suicide prevention approach is comprised of best practices from suicide prevention programs that have been identified to have a positive impact on the reduction of suicide and may influence some combination of one's psychological state, physical environment or cultural norm (Mann, et al., 2005; Suicide Prevention Resource Center, n.d.).

According to the WHO in *Preventing Suicide: A Global Imperative* (2014b), the first WHO international report on suicide prevention, approximately 804,000 suicide deaths occurred worldwide in 2012. This represents an annual global suicide rate of 11.4 per 100,000 people for those 18 to 65 years old (WHO, 2014a). For each adult who died of suicide, it is estimated that there may have been more than 20 others who attempted suicide. Many developing countries do not have robust data collection systems and identified prevalence may be lower due to this issue. The WHO data on suicides is rooted in clinical data and does not include terrorist acts of suicide (WHO, 2014a).

In the United States, a number of suicide prevention goals have been recommended that involve community and crisis response from local coalitions of stakeholders to promote and

implement comprehensive suicide prevention at the community level (USDHHS, Office of the Surgeon General and the National Action Alliance for Suicide Prevention, 2012). Increased collaboration and coordination among suicide prevention programs, mental health, substance use disorder agencies, and local crisis centers can help provide a continuum of care for individuals at risk for suicide.

Community goals noted from *Healthy People 2020* (2011) include a focus on reducing the number of adults who experience major depressive episodes and thus, the high incidence of suicide. To that end, the recommendation is that communities should strive to increase primary care facilities that provide onsite mental health treatment and depression screenings, increase dual diagnosis services that address serious mental illness and co-occurring disorders, and increase services for homeless adults with mental illness.

A community goal from the *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (USDHHS, Office of the Surgeon General and the National Action Alliance for Suicide Prevention, 2012) is the "Zero Suicide Initiative" which is an emerging best practice. An emerging best practice is defined as services that are promising but have fewer than five published research studies. They hold promise for the adoption of other organizations to also demonstrate effectiveness (National Gerontological Nursing Association, n.d.). "Zero Suicide Initiative" aims to improve care and outcomes for those who are at risk for suicide in health and behavioral health care systems. It also encourages the engagement of the broader community with involvement from suicide attempt survivors, family, policy makers and researchers. It is an evolving initiative with noted success in Michigan at the Henry Ford Health System (National Council for Behavioral Health, 2015).

In 2011, the Idaho Council on Suicide Prevention supported by the Governor developed the *Idaho Suicide Prevention Plan: An Action Guide* (Suicide Prevention, 2011). Ten goals were outlined which are in concert with other national goals such as community involvement, training for mental health professionals, access to care, and decreasing stigma.

The Impact of Best Practice Gaps

Examining the impact when best practice gaps exist in a community is the third focus of the literature review. Gaps are the absence of best practices for crisis services. In Great Britain, the Care Quality Commission (2015) conducted a study to identify gaps in crisis services for the mentally ill. The study noted that there should be services available to provide urgent help and care at short notice on a 24-hour basis. These services include advice from telephone helplines, assessment by a mental health professional, intensive support at home or urgent admission to a hospital. Training of mental health personnel was also noted as a gap. Due to the gaps in services and training, it was reported that individuals with "mental illness" are treated differently than those with a "physical disorder" (Care Quality Commission, 2015).

Clients suffer when there is a gap in crisis services. Gaps in services for the behavioral health population can result in police intervention rather than effective treatment. When a client is placed in a police vehicle, it can be a demoralizing and stigmatizing experience. Compounding the issue is when officers are not prepared to interact with a behavioral health client due to a lack of behavioral health crisis training. Some success has been noted however in Canada, when police officers have become a part of an Assertive Community Team working with mental health professionals to help the behavioral health population (Glauser, 2013). The direct communication and collaboration between law enforcement and mental health experts, has

resulted in police officers learning about mental illness and the de-escalation techniques to be used with the behavioral health population (Glauser. 2013).

There is high morbidity and mortality in the behavioral health population when there is poor access to care (WHO, 2010). The behavioral health population loses from 13 to 20 years of life compared with the non-psychiatric population due to poor health care habits, medication non-compliance and complications such as metabolic syndrome, that result from some psychotropic medications. The lack of access to health care compounds this reality (Vreeland, 2007). Additionally, pharmacologic treatment that often does not meet evidence-based standards of care is a gap (Mechanic, 2014) that effects the behavioral health population in crisis and contributes to poor health.

Implementation Process Analysis

Boise State University Internal Review Board reviewed this process evaluation proposal and granted exempt status in June of 2015, which allowed the process evaluation to proceed. This section includes the descriptions of the setting and target population for this process evaluation, outcomes, implementation strategies, the economic, political and social environment at the time of the implementation, project evolution and business plan analysis.

Setting and target population

The setting for this scholarly project was Region 1, which encompasses the five northern counties of Idaho. The five northern counties are Boundary, Bonner, Benewah, Shoshone, and Kootenai. According to the U. S. Census Bureau (2013), the total population of Region 1 is 217,550 individuals. Boundary, Bonner, Benewah, and Shoshone counties all have critical access hospitals. The hospital emergency departments become the primary referral source used by police, paramedics, and families to refer individuals with psychiatric emergencies for initial

triage. Individuals are either stabilized and released or transferred to a higher level of care (inpatient psychiatric unit) from the critical access hospitals. Inpatient psychiatric units are specialized to care for individuals who are a danger to themselves or others, or gravely disabled from their mental illness or SUD. The only unit is located in Kootenai County and most days it has a wait list. None of these counties have an existing crisis center or robust crisis intervention services that could assist in the prevention of behavioral health emergencies. The Northern Idaho Crisis Center opened in December 2015 and will serve northern Idaho.

The target population for this process evaluation includes all of the key stakeholders of the behavioral health coalition in Region 1 (see Appendix D), but most importantly the end users. These are the individuals who are suffering with mental illness and/or SUD and by nature of their illness, are more prone to crises. Families of the individuals in crisis are also impacted.

Program outcomes

As stated in the logic model (see Appendix H), the outcomes for this process evaluation are as follows:

- **Outcome #1: Best Practice Assessment**. A table was generated that categorizes community goals and best practices for behavioral health crisis intervention strategies identified from a thorough search of existing evidence from the international and national literature.
- **Outcome #2: Region 1 Community Stakeholder Report.** Interviews were conducted with key stakeholders. Data from interviews was generated that synthesized long-term goals, policies and interventions of key stakeholders of the Region 1 behavioral health coalition from the perspective of (1) how closely they agreed with each other to address behavioral health crisis community goals, and (2) how specifically they addressed

community goals recommended from international and national literature on how communities should effectively respond to behavioral health crises.

- **Outcome #3: Region 1 Crisis Intervention Best Practice Gap Analysis**. A gap analysis based on data from surveys and reports from Region 1 behavioral health stakeholders was conducted to determine whether the community goals and best practices identified in the literature that address behavioral health crises exist in Region 1 and what gaps need to be resolved to effectively respond to community based behavioral health crises.

Implementation strategies

Outcome #1 was met through conducting a comprehensive review of the international and national literature for community goals and best practice strategies regarding behavioral health crisis interventions. Community goals and best practices are listed in Table 1. Two community goals relevant to crisis intervention strategies that were identified include a multi-sectoral approach and a suicide prevention approach. Best practices from the literature were then categorized under either the multi-sectoral approach or the suicide prevention approach.

Data for outcome #2 was generated and synthesized from interviews conducted by this DNP student with key stakeholders from the Region 1 behavioral health coalition. The interviews focused on two areas: (1) how closely Region 1 stakeholders' long-term goals, policies, and interventions agree with each other in addressing community-based behavioral health crises; and (2) how closely key stakeholders' agree with community goals and best practices recommended from international and national literature on how to most effectively respond to behavioral health crises. Selection of stakeholder interviewees was based on their role in providing treatment and safety to the mentally ill and SUD population in Region 1. Interviews

were conducted with the director of the Panhandle Health District, the CEO of the federally qualified health clinic, Heritage Health, the manager of the NICC supported by Kootenai Health, the manager of the Department of Health and Welfare Region 1 Mental Health, the Kootenai County Sheriff, and the Coeur d'Alene Police Captain.

Data from stakeholder interview responses are summarized in Tables 2, 3 and 4. Table 2 provides a list of the six interview questions. Table 3 provides a listing of all stakeholders and their associated agency that participated in the interviews. Table 3 also summarizes the response of each stakeholder for each of the six interview questions and categorizes them according to one of the two goals that communities should attain to reduce behavioral health crises: multi-sectoral approach or suicide prevention. Table 4 further synthesizes the interview data by showing how closely Region 1 stakeholders' long-term goals, policies and interventions agree with each other in addressing community-based behavioral health crises and with community goals and best practices.

Outcome #3 identifies gaps in crisis intervention services and strategies in Region 1. Surveys and reports utilized were the *Executive Summary for Region 1 Survey of Behavioral Health Gaps* - Spring 2013 (Delio, Dupree, Malek, & Romero, 2013; the *2013 North Idaho Community Health Assessment* (Moehrle & Whalen, 2013), the *2014 North Idaho Community Health Improvement Plan* (Moehrle & Whalen, 2014), the *Gaps and Needs Analysis 2015* (Region 1 Behavioral Health Board, 2015), and the *Follow-up Gap Analysis Survey on Region 1 Crisis Services—Summer* 2015 (see Appendices A, B & C). Gap analysis findings are reported in Tables 5 and 6. Table 5 provides a compilation of Region 1 gaps identified from the gap analysis reports generated in Region 1 between 2013 and 2015. Table 6 illustrates how Region 1 gaps reflect the best practices from Table 1. Table 6 also notes gaps identified in the Region 1

gap analysis that do not pertain to a best practice from Table 1. While important to Region 1, these gaps do not appear to be defined as best practices in the literature.

Economic, social, and political environment

As noted, Idaho spends the least of any state on mental health services (Kaiser Family Foundation, 2014). Crisis services for the mentally ill in the state are beginning to improve with the initiation of the Idaho Suicide Hotline in 2014, and the passing of legislation to fund two crisis centers in the state. Gaps identified in Region 1 will necessitate additional funding, which may come through private or federal grant funding or state legislative appropriation. State legislative appropriation would entail a hard sell to taxpayers and conservative legislators, and would need to demonstrate a cost-benefit with savings to be offset by the benefit of the new services. The Behavioral Health Board and the NICC Board are committed to improving crisis services in the region through seeking grants and proposing changes in legislation if necessary.

Stigma regarding mental illness must be addressed on a societal level or initiatives will be slow to move forward. Stigma of the mentally ill is a significant social issue with deep roots in naiveté that mental illness is not biological in nature. Substance use disorders are also biological in nature (Volkow, Baler, & Goldstein, 2011) and individuals with SUD are also often stigmatized. Fear toward these populations occurs as a result of stigma and individuals often do not seek help due to being misunderstood. Corrigan, Morris, Michaels, Reface, and Rusch (2012) conducted a meta-analysis of 72 outcome studies regarding strategies to decrease the stigma of mental illness. The study results found that public education about mental illness and interaction with individuals who have a mental illness are the best approaches to decrease stigma. Educating elected officials, community leaders and the general public will help dispel some of

the myths regarding mental illness and SUD. This will hopefully open the door to those who suffer to participate in recovery services, while addressing the public health problem of suicide.

Project Evolution

Conducting this process evaluation has provided a framework for the planning of additional crisis services for Region 1. Initially the work of this process evaluation focused on the upstart of a crisis center for northern Idaho. However, while conducting this process evaluation, the scope of the issue was noted to be much broader. A process evaluation is fluid and dynamic (Issel, 2014). This fluidity allowed for the change in direction for this process evaluation to become more expansive to address behavioral health crisis interventions for Region 1 from a more comprehensive approach.

Identification of community goals and best practices from international and national sources has been a core focus of this process evaluation. The translation of the community goals and best practices into reality for Region 1 will be the transformative work of the coalition of key behavioral health stakeholders to address Region 1 gaps. It has been informally noted that the success of the coalition in securing funding and opening the NICC has bolstered the coalition to express interest in "taking on" other projects that can positively impact this population.

Business plan analysis

The business plan for this project involved minimal cost. The main costs were salaries for this researcher, and the time participants took to respond to surveys and individual interviews. There were also minor costs for copying and office supplies. Most participants were affiliated with large organizations and viewed this participation as part of their job duties for the welfare of the community. This time was counted toward the organization's community benefit contribution (see Appendix I for business plan proposed costs).

Results/Outcome Analysis

Data analysis and outcome indicators

Outcome #1: Community goals and associated best practices from the international and national literature are listed in Table 1. Best practices from the literature were categorized under the two community goals that the literature identified as being necessary to effectively address community behavioral health crises: a multi-sectoral approach and a suicide prevention approach.

Outcome #2: Results generated from interviews with key Region 1 stakeholders indicates that there was agreement among stakeholders on three of the six questions that were asked. There was agreement among all stakeholders for question one, "What are your agency's long term goals in working with the mentally ill and substance use disorder (SUD) population in crisis?" and question three "Describe your agency's process for long-term planning? Are the mentally ill and SUD population included as part of this planning?" All stakeholders interviewed identified the mentally ill and SUD population in their goals and long-term planning. Question five, "What crisis services or intervention does your agency currently provide to individuals with mental illness and SUD problems?" revealed that all stakeholders provide some type of crisis service or intervention. In response to question four, "What does your agency identify as the 3 most urgent community-wide behavioral health crises in Region 1?" five of six stakeholders identified access to care as an urgent community behavioral health crisis. Four out of six stakeholders cited suicide prevention as another urgent community behavioral health crisis and only two noted the lack of SUD services as urgent.

Reponses from the interview questions listed in Table 3 were categorized according to the two behavioral health community goals identified in the literature: a multi-sectoral approach,

or a suicide prevention approach. The analysis indicated that long-term goals, policies, and interventions identified by key stakeholders to address behavioral health crisis intervention in Region 1 were predominantly categorized as multi-sectoral approaches.

Results for outcome #3, which identifies the gaps and challenges in Region 1 with regard to crisis intervention services, indicates that the lack of mental health and SUD providers and lack of transportation are two critical gaps in Region 1 and were consistently noted in all of the gap analysis reports. Financial assistance for medications, lack of school based mental health and SUD services, housing, and residential care are noted as gaps in the majority of the gap analysis reports (see Table 5). Stigma was cited in three of four gap analysis reports as a barrier to behavioral health services. The majority of Region 1 gaps listed in Table 5 are associated with a best practice (see Table 6). Six gaps did not link to a best practice identified in the comprehensive literature review. Those gaps are: respite care, SUD education and prevention, telehealth, day treatment, foster care, and case management for specialty court clients.

Inferences relating to project objectives

In regard to objective #1, the comprehensive literature review identified two community goals associated with crisis intervention services—the multi-sectoral approach and the suicide prevention approach. The multi-sectoral approach has had a positive effect on behavioral health crises and suicide in Great Britain and Scotland (Scottish Government, 2013). This is based on the synergistic effect of all best practices identified in this approach being in play simultaneously at all possible sites that touch the mentally ill and SUD population (Cox, Robinson, Nicholas, Lockley, Williamson, Pirkis, et al., 2013; Scottish Government, 2013; World Health Organization, 2014a). The multi-sectoral approach strives to engage a larger network of the community than the suicide prevention approach which focuses on strategies that should be

embedded into direct care services for behavioral health clients (Mann, et al., 2005; Suicide Prevention Resource Center, n.d.). Replicating the multi-sectoral approach and applying identified best practices associated with both the multi-sectoral approach and suicide prevention approach in Region 1 could effectively impact community behavioral health crisis intervention strategies.

Examination of current community goals and best practices by Region 1 behavioral health key stakeholders may lead to the adoption of new best practices or the improvement of existing best practices for behavioral health crises. If these are in place to support the behavioral health population in crisis, there should be less use of high cost services such as the emergency departments, inpatient stays, and improper incarceration (SAMHSA, 2014a). The rate of suicide could also decrease (SAMHSA, 2014a).

Findings related to objective #2 focused on interviews with key behavioral health stakeholders. Two identified strengths noted among the stakeholder responses are (1) all agencies have long-term goals relative to the behavioral health population, and (2) strong partnerships exist between one another and with other stakeholders in Region 1. Stakeholders' responses are also related to many practices that are associated with elements of the multi-sectoral approach (see Table 3). Effective work on decreasing community crises and suicide rates have been linked to this approach (Cox, Robinson, Nicholas, Lockley, Williamson, Pirkis, et al., 2013; Scottish Government, 2013; World Health Organization, 2014a). Some stakeholder responses are associated with the suicide prevention approach such as referencing the "Zero Suicide Initiative" (National Council for Behavioral Health, 2015) and embedding mental health and SUD services in existing programs such as the plan for introducing mental health services at the Kootenai County Jail.

A challenge for the region is that stakeholders are not in full agreement on what the most urgent community-wide behavioral health crisis are in Region 1. Agreement on this is a necessary first step in unifying key stakeholders on action toward developing a cohesive plan for crisis intervention services for Region 1. Another challenge in Region 1 is the lack of a comprehensive approach and unified plan among stakeholders to address crisis intervention services. To adopt a comprehensive regional approach aimed at increasing crisis services and decreasing suicide, multiple new partnerships will need to be formed and existing ones strengthened (Community Tool Box, 2015).

Findings related to objective #3 revolve around the gap analysis that was created as a result of this process evaluation. Gaps are defined as best practices that are lacking in a community (WHO, 2010). Most of the gaps identified in Region 1 are associated with a best practice noted from the literature. Understanding the best practices can help assist stakeholders to prioritize which gaps need to be addressed first before other best practices can be implemented. The most critical gap noted in Region 1 is the lack of providers. Addressing this gap is crucial to the welfare and care of the behavioral health population (Mechanic, 2014). Without enough providers in place, services that are essential in ameliorating behavioral health crises gaps such as lack of mental health and substance use crisis services, telehealth, and prescribing of psychotropic medications, will not occur (SAMHSA, 2014a). The shortage of providers will continue to contribute to the lack of trust experienced by clients who are not receiving proper services. It will also continue the cycle of using unnecessary and more expensive levels of care.

Of interest are gaps identified in the Region 1 gap analysis that are not related to best practices recognized in the literature. They include respite care, SUD education and prevention, lack of telehealth and funding, day treatment, foster care, case management for specialty court

clients and client's lack of trust in services. This finding suggests that best practices may be somewhat subjective to specific communities and is worthy of further exploration. That these particular gaps were identified in all or most of the Region 1 gap analysis data sources, indicates that they are important to Region 1 stakeholders and should be addressed by the coalition for possible future planning.

Gaps and effectiveness

This process evaluation identified that Region 1 has many existing gaps and a lack of resources and strategies that need to be addressed to provide support and services for the behavioral health population in crisis. The most serious gaps such as having enough providers and financial assistance for medications are basic to the infrastructure of care for this population. There is a national shortage of mental health providers. It is estimated that 2,707 psychiatrists are needed to address the shortage areas in the United States. In Idaho, it is estimated that there is a need for an additional 24 psychiatrists to address the current shortage (Kaiser Family Foundation, 2016). Fortunately psychiatric nurse practitioners are helping to fill some of the gap. Low reimbursement and overhead remain barriers for practitioners to come to Idaho. Lack of housing and inadequate transportation are also fundamental gaps for the behavioral health population that contribute to behavioral health crises. Without these four gaps being addressed, the behavioral health population will remain in a destabilized state, placing this population at continued risk of being in crisis and at higher risk for suicide. The behavioral health coalition—a strength for the region—is positioned to do transformative work that needs to occur such as addressing low payer rates for providers and other gaps.

Unanticipated consequences

This process evaluation validated some issues already recognized in Region 1 regarding behavioral health crises interventions. It also identified a lack of agreement among stakeholders on what the most urgent behavioral health community crises needs are for Region 1. In addition, it identified gaps that were unrelated to best practices in Region 1.

Financial analysis

The estimated cost to conduct this process evaluation was estimated to be $17,111, with $15,360 designated as the author's labor investment. Interviews and completion of surveys with stakeholders were estimated at a total cost of $1,075 in salary and benefits for stakeholders. Dissemination of the process evaluation findings has not yet occurred. Estimated cost associated with dissemination is $576. To date total costs associated with this scholarly project has been approximately $16,535.

Recommendations

Informed decisions and recommendations

Impacting behavioral health crises and suicidality cannot be completed in silos. A much broader network must be engaged. Based on the findings of this process evaluation, recommendations are that Region 1 behavioral health coalition should develop short and long-term action plans that will: (1) work to eliminate gaps in best practice, (2) focus crises intervention strategies on a multi-sectoral and a suicide prevention approach as defined in the literature, and (3) help align agreement among key stakeholders as to long-term goals, policies and interventions regarding behavioral health crises. Prioritization of best practices will also need to be examined under a social, economic, and political lens to determine feasibility and sustainability.

Implementation of a multi-sectoral approach would address Region 1's most salient gaps such as a lack of providers, affordable medications, transportation, and housing for the behavioral health population. This will require a broad, well-integrated coalition of stakeholders to build a regional plan for crises intervention services and the greater goal of suicide reduction. Determining funding streams to support a multi-sectoral approach will be integral to the process.

Strategic plan congruence

The key stakeholders who were interviewed indicated that the behavioral health population in crisis has been a part of their agencies' long term planning process. The need for more crisis intervention services and a reduction in suicide is recognized, but there is not an overall strategic plan in Region 1 to address these two major needs.

Application to other settings

All communities are challenged with gaps in services and determining the best services for the population served. A process evaluation can assist with identifying best practices that communities should attain for effective crisis intervention services and suicide reduction. It can also help to determine the need for a coalition of stakeholders, and the identification of gaps in existing services. The objectives of this process evaluation could be replicated to determine the status of a region or community interested in planning for next steps to address the needs for the behavioral health population in crisis.

Maintaining and sustaining change

There is a committed group of behavioral health stakeholders in Region 1. If a plan were to be adopted that would have the possibility to effect behavioral health crisis and suicidality in the region, there would be significant support to begin the process and sustain the changes that would need to be implemented. Conflicts may arise if a key agency would not be willing to

become a part of the broader network required to implement a multi-sectoral approach. Another process evaluation should be crafted to evaluate the implementation phase if there is the adoption of a new, unified approach.

Lessons learned

Process evaluation is a powerful tool that can be used to assess large, complex community issues. It is also a fluid process that can allow for the development of a framework that can be tailored to address a community's specific needs. This process evaluation found that multi-sectoral and suicide prevention approaches to crisis intervention have been demonstrated to be successful. Findings also noted that most gaps identified in Region 1 have been linked to best practice, but a small number are not associated with a best practice. Gaps that were not linked to best practice may require further study.

Conclusion

The findings of this process evaluation have the potential to shape the direction of Region 1 behavioral health crisis services. They can provide the foundation for prioritizing best practice strategies the Region should support. Region 1 has identified some unique needs not linked to best practices that should also be addressed during a prioritization process. It will be for the coalition of Region 1 behavioral health stakeholders to decide how to utilize the findings and recommendations of this process evaluation. Ultimately, the goal is to decrease suicide by addressing the identified gaps and lack of related best practices in Region 1 for the behavioral health population in crisis.

References

Behavioral Health Community Crisis Centers Act, 62nd Idaho Senate. Senate Bill 1352 (2014). Retrieved from https://legislature.idaho.gov/legislation/2014/S1352.pdf

Butterfoss, F. D. & Kegler, M.C. (2002). Toward a comprehensive understanding of community coalitions: Moving from practice to theory. In DiClemente, R., Crosby, L., & Kegler, M.C. (Eds.), *Emerging Theories in Health Promotion Practice and Research* (pp. 157-193). San Francisco, CA: Jossey-Bass.

Care Quality Commission. (2015, June 12). *Public services must 'wake up' to gaps in mental health crisis care, warns CQC*. Retrieved from http://www.cqc.org.uk/content/public-services-must-%E2%80%98wake-up%E2%80%99-gaps-mental-health-crisis-care-warns-cqc

Centers for Disease Control and Prevention (CDC). (2008). *Best practices users' guide: Coalitions-state community interventions.* St. Louis, MO: U.S. Department of Health and Human Services, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Retrieved from http://www.cdc.gov/tobacco/stateandcommunity/bp_user_guide/pdfs/user_guide.pdf

Community Tool Box. (2015). *Creating and managing partnerships*. Retrieved from http://ctb.ku.edu/en/creating-and-maintining -partnerships

Corrigan, P.W., Morris, S.B., Michaels, P.J., Rafacz, J.D., & Rusch, N. (2012). Challenging the public stigma of mental illness: A meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963-973.

Cox, G.R., Robinson, J., Nicholas, A., Lockley, A., Williamson M., Pirkis, J. et al.

(2013). Interventions to reduce suicides at suicide hotspots: A systematic review. *BMC Public Health. 13*(1), 214. doi:10.1186/1471-2458-13-214.

Delio, A., Dupree, A., Romero, J., & Malek, L. (2013). *Executive summary for region 1 survey of behavioral health gaps–Spring 2013.* Coeur d'Alene, ID.

Glauser, W. (2013, November 19). Community partnerships fill mental health gaps, *Canadian Medical Association Journal, 185*(17). doi:10.1503/cmaj.109-4616

Issel, L.M. (2014). *Health program planning and evaluation.* Burlington, MA: Jones & Bartlett Learning.

Kaiser Family Foundation. (2014). *State health facts: State mental health agency per capita mental health expenditures*. Retrieved from http://kff.org/other/state-indicator/smha-expenditures-per-capita/

Kaiser Family Foundation. (2016). *Mental health care health professional shortage areas (HPSAs).* Retrieved from http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

Kohrt, B.A., Blasingame, E., Compton, M.T., Dakana, S.F., Dossen, B., Lang, F., Strode, P., & Cooper, J. (2015). Adapting the crisis intervention team (CIT) model of police-mental health collaboration in a low-income, post-conflict country: Curriculum development in Liberia, West Africa. *American Journal of Public Health 105*(3), 73-80. doi: 10.2105/AJPH.2014.302394.

Kootenai Health. (2015). Involuntary detentions, 2010-2014. *Involuntary Detention List 2010–2015.*

Luptak, M., Dailey, N., Juretic, M., Rupper, R., Hill, R.D., Hicken, B.L. & Bair, B.D.

(2010). The care coordination home telehealth rural demonstration project: a symptom-based approach for serving older veterans in remote geographical settings. *Rural Remote Health 10* (2) Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20518592

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., …Hendin, H. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association 294 (16), 2065-2074.* doi:10.1001/jama.294.16.2064.

McKenna, B., Furnass, T., Oakes, J., Brown, S. (2015). Police and mental health clinician partnership in response to mental health crisis: A qualitative study. *International Journal of Mental Health Nursing, 24*(5), 386-393. doi: 10.1111/inm.12140

Mechanic, D. (2014, August). More people than ever before are receiving behavioral health care in the United States, but gaps and challenges remain. *Health Affairs (Millwood), 33*(8). doi:10.1377/hlthaff.2014.0504

Minkoff, K. & Cline, C. (2004). Changing the world: The design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatric Clinics of North America, 27*, 727-743.

Mishara, B.L., Weisstub, D.N. (in press). Suicide laws: An international review. *International Journal of Law and Psychiatry.* Retrieved from: http://www.journals.elsevier.com/international-journal-of-law-and-psychiatry/

Moehrle, C. & Whalen, L. (2013). *2013 North Idaho community health assessment.* Retrieved from http://www.idahopublichealth.com/files/data/community -health-assessment/2013/Community-Health-Assessment-D1-D2-09-06-13.pdf

Moehrle, C. & Whalen, L. (2014). *2014 North Idaho community health improvement plan*. Retrieved from http://www.idahopublichealth.com/files/data/chip/5-22-2014-CHIP-FINAL

National Gerontological Nursing Association. (n.d.). *Editorial policy and submission guidelines*. Retrieved from http://ngna.org/_resources/documentation/events/Editorial-Policy-Submission-Guidelines.pdf

National Council for Behavioral Health. (2015). *Zero Suicide breakthrough series: Outcomes and recommendations*. Retrieved from http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/breakthrough%20Series.pdf

Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. (2011). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/

Peek, C.J. (2013). *Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus*. Publication No.13-IP001-EF). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Region 1 Behavioral Health Board. (2015). *Gaps and needs analysis 2015*. Coeur d'Alene, ID.

Scottish Government. (2013). *Suicide prevention strategy 2013-2016*. Edinburgh: Scotland. Retrieved from www.gov.scot/Publications/2013/12/7616

Substance Abuse and Mental Health Services Administration. (2014a). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. Retrieved from

http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

Substance Abuse and Mental Health Services Administration. (2014b). *Trauma-informed care in behavioral health services*. (Publication No. (SMA) 13-4801). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Suicide Prevention. (2011). *Idaho suicide prevention plan: An action guide*. Boise, ID. Retrieved from healthandwelfare.idaho.gov/Portals/0/.../DocumentsSrtView.pdf

Suicide Prevention Action Network (SPAN) of Idaho. (2015, August). *Suicide fact sheet*. Retrieved from http://www.spanidaho.org/idaho-suicide-facts

Suicide Prevention Resource Center. (n.d.). *Suicide prevention: the public health approach*. Retrieved from http://www.sprc.org/sites/sprc.org/files/library/phasp.pdf

U. S. Census Bureau. (2013). *Population statistics.* Retrieved from http://quickfacts.census.gov/qfd/states/16/16017.html

U.S. Department of Health and Human Services. (2009). *Practice guidelines: Core elements for responding to mental health crises,* pp. 5-12. (Publication No. SMA-09-4427). Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration.

U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 National strategy for suicide prevention: Goals and objectives for action.* Washington, DC: HHS, September 2012.

Volkow, N.D., Baler, R.D., Goldstein, R.L. (2011). Addiction: pulling at the neural threads of social behaviors. *Neuron 69.* doi:10.1016/j.neuron.2011.01.027

Vreeland, B. (2007). Bridging the gap between mental and physical health: A multidisciplinary approach. *Journal of Clinical Psychiatry, 68*(4). 26-33. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17539697

Watson, A.C., Fulambarker, A.J. (2012). The crisis intervention team model of police response to mental health crisis: A primer for mental health practitioners. *Best Practice in Mental Health 8* (2), 71-81.

World Health Organization. (2010). *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings: Mental Health Gap Action Programme (mhGAP*). Retrieved from http://www.paho.org/mhgap/en/

World Health Organization. (2014a). *World health statistics 2014*. Retrieved from http://www.who.int/gho/publications/world_health_statistics/2014/en/

World Health Organization. (2014b). *Preventing suicide: A global imperative*. Retrieved from http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

Table 1 - *Literature Review of Best Practices on Community Behavioral Health Crisis Interventions*

Table 1 represents community behavioral health crisis intervention best practices from the international and national literature. The table is organized according to two community goals that address these best practices - a multi-sectoral approach and a suicide prevention approach. Column 1 lists the best practices under the heading of either multi-sectoral approach or suicide prevention approach. Column 2 lists the international or national reference that supports the best practice literature source.

Community Goal: Multi-sectoral Approach	**International/National Literature Source**
Availability of 24 hour crisis teams for a geographic locale is key.	World Health Organization (2014a)
Remove ligature points in areas where the acutely mentally ill are treated.	World Health Organization (2014a)
Conduct follow-up appointments within 7 days of inpatient discharge for a behavioral health related admission.	World Health Organization (2014a)
Conduct assertive community outreach 24/7, which includes intensive support, e.g. medication monitoring, transportation to appointments, assistance with activities of daily living, etc., for people with severe mental illness by a multi-disciplinary team aimed at keeping the patient in the community and avoid hospitalization.	World Health Organization (2014a)
Provide regular training to frontline clinical staff on management of suicide risk.	World Health Organization (2014a)
Treatment of both the mental illness and substance use disorder for patient who experience co-occurring disorders (mental and substance use disorders experienced at the same time).	World Health Organization (2014a)
Respond to patients who are not complying with treatment with outreach services.	World Health Organization (2014a)
Share information with criminal justice agencies.	World Health Organization (2014a)
Conduct multi-disciplinary reviews of post suicide cases.	World Health Organization (2014a)
Community must have access to emergency mental health care.	Mishara & Weisstub (2014)
There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law	Scottish Government (2013)

Community Goal: Multi-sectoral Approach	**International/National Literature Source**
enforcement, affordable housing services, welfare, and employment services.	
Develop multi-professional training programs to build capacity for supporting the prevention of suicide.	Scottish Government (2013)
Financial support must be available for local community and neighborhood interventions.	Scottish Government (2013)
23 hour crisis stabilization/observation beds available.	Substance Abuse and Mental Services Health Administration (2014a)
Mobile crisis services available.	Substance Abuse and Mental Services Health Administration (2014a)
24/7 crisis hotlines available.	Substance Abuse and Mental Services Health Administration (2014a)
To prevent suicide, there should be participation from local coalitions of stakeholders to promote and implement comprehensive suicide prevention at the community level.	U.S. Department of Health and Human Services Office of the Surgeon General and the National Action Alliance for Suicide Prevention (2012)
Increased collaboration and coordination among suicide prevention programs, mental health and substance abuse agencies, and local crisis centers.	U.S. Department of Health and Human Services Office of the Surgeon General and the National Action Alliance for Suicide Prevention (2012)

Community Goal: Suicide Prevention Approach	**International/National Literature Source**
"Warm lines" (peer run listening lines) available.	Substance Abuse and Mental Services Health Administration (2014a)
Peer support incorporated into mental health and substance use services. Peers are individual who are in recovery from their mental illness.	Substance Abuse and Mental Services Health Administration (2014a)
Psychiatric advance directives used to direct care of the mentally ill individual.	Substance Abuse and Mental Services Health Administration (2014a)

Community Goal: **Suicide Prevention Approach**	**International/National Literature Source**
Peer crisis services available.	Substance Abuse and Mental Services Health Administration (2014a)
Crisis Intervention Team (CIT) training for law enforcement should be incorporated into routine training for police officers to prevent suicide.	Kohrt, et al. (2015); Watson & Fulambarker (2012)
Comprehensive Continuous Integrated System of Care (CCISC) model of treating individuals with co-occurring disorders – Dual Diagnoses services should be incorporated into available services to prevent suicide.	Minkoff & Cline (2004)
Access to supports to those in crisis are should be timely.	U.S. Department of Health and Human Services (2009)
Services are provided in the least restrictive manner when working with suicidal clients.	U.S. Department of Health and Human Services (2009)
Services should be congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the person being served in a behavioral health crisis.	U.S. Department of Health and Human Services (2009)
Services should be trauma informed.	U.S. Department of Health and Human Services (2009)
Recurring crises signal problems in the assessment or care and should be reviewed.	U.S. Department of Health and Human Services (2009)
To prevent suicide, services for homeless adults with mental illness be available.	Healthy People 2020 (2011)
Zero Suicide Initiative	U.S. Department of Health and Human Services (2012)
Trauma-Informed Care	Substance Abuse and Mental Services Health Administration (2014b)

Table 2 - *Process Evaluation Interview Questions Generated for Key Stakeholders in Region 1 Regarding Behavioral Health Crisis Services*

Table 1 lists the questions that were posed during stakeholder interviews. The questions were designed to identify how closely the long-term goals, policies, and interventions of agencies are in agreement with one another. The questions were also intended to clarify how closely the agencies' long-term goals, policies and interventions are in agreement with the best practices from the literature on behavioral health crisis services.

Interview Questions
1. What are your agency's long term goals in working with the mentally ill and substance use population in crisis?
2. Describe the written policies or guidelines reflecting your agency goals in working with the mentally ill and substance use population in crisis.
3. Describe your agency's process for long term planning? Are the mentally ill and substance use population included as part of this planning? Why or why not?
4. What does your agency identify as the 3 most urgent community-wide behavioral health crises in Region 1?
5. What crisis services or intervention does your agency currently provide to individuals with mental illness and substance abuse problems?
6. What prevention services does your agency currently provide to individuals with mental illness and substance abuse problems?

Table 3 - *Stakeholder Recognition and Agreement of the Two Community Goals: Multi-sectoral or Suicide Prevention Approach for Addressing Crisis Intervention Strategies in Region 1*

Table 2 reflects how stakeholder's long-term goals, policies, and interventions reflect the 2 goals identified in the literature as being necessary to effectively intervene in community behavioral health crises; a multi-sectoral approach or a suicide prevention approach. Paraphrased interview responses from Region 1 key stakeholders that pertain to one or both of these goals are shown in the Table. Comments obtained during interviews that did not directly pertain to crisis intervention concerns in Region 1 were omitted from this table.

Key stakeholders who were interviewed are listed in the first row. Each interview question is listed in a separate row in the table and responses to that interview question are categorized according to either a multi-sectoral approach or a suicide prevention approach. If a response pertains to both approaches, it is listed under multi-sectoral approach.

Panhandle Health District	**Heritage Health**	**Kootenai Health**	**Region 1 Mental Health (IDHW)**	**Kootenai County Sheriff**	**Coeur d'Alene Police Department**
Question #1: What are your agency's long term goals in working with the mentally ill and substance use disorder (SUD) population in crisis?					
Responses Associated with a Multi-Sectoral Approach					
We oversee disaster response preparedness for vulnerable populations which includes the mentally ill. Another goal is to support the Northern Idaho Crisis Center.	Main focus in working with this population is access into an integrated system where mental, medical, dental, and social issues can be addressed. When these are not all available it can push people into crisis.	Long-term goal is to continue to offer youth, and adult inpatient psychiatric services for the region. Another goal is to continue to develop outpatient services for the Region.	Regionally as a HUB which encompasses Regions 1 and 2, we want to have greater impact on individuals prior and post hospitalization with increased resources. Region 1 Behavioral Health Board can secure services that can help beyond Idaho	From the field aspect the goal is to train those officers dealing with those in crisis to recognize the crisis, de-escalate and channel them to right resources for help.	Long-term we continue to partner with Kootenai Health and agencies to get other individuals the services they need. Other partnerships include working with the fire department, the

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
We would like to offer direct mental health services, but do not at this time. Panhandle Health District 1 is supporting the Region 1 Behavioral Health Board via contract.	Mental health is a priority of Heritage Health. Another goal is to work together with community partners. Idaho Health Partners fills a gap to assist with doing things together.	Kootenai Health currently supports the Northern Idaho Crisis Center (NICC) which provides individual crisis intervention for those experiencing a behavioral health crisis. Kootenai Health will continue to grow regional partnerships and as a regional referral center.	Department of Health and Welfare (IDHW), which is supported by IDHW. Responsibility is shifting to the community long term. In Region 1 assignments have been given to supervisors to do an analysis to look at needs and gaps, e.g. a lack of housing options either pre post hospitalization.	In regard to the RFP for mental health services in the jail, we would prefer a local provider as the follow-up is better and reduces recidivism of those in custody. CIT is not consistently utilized as a training model. The hope is that trained officers will help to decrease multiple calls to the same individual.	homeless coalition, Heritage Health and their homeless outreach, and CDA Commons – it's about partnerships.
Responses Associated with a Suicidal Approach					
A goal of Panhandle Health District is to remain active with suicide prevention.			Suicide prevention rests with the community.	There will be a specific mental health component to health services at jail will now be	

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
				included; cost is $250,000.	
Question #2: Describe the written policies or guidelines reflecting the goals your agency has in working with the mentally ill and SUD population in crisis.					
Responses Associated with a Multi-sectoral Approach					
Panhandle Health District identifies and refers mentally ill and substance use population to regional providers. Panhandle Health District contracts with Health and Welfare for some individuals in need of mental health services, but Panhandle Health does not provide direct services. Panhandle Health District identifies and refers mentally ill and substance	In regard to policy Heritage is adopting into the core focus of the organization to have all in the community to have access to services including the homeless population.		IDHW goals were always very general. This year there will be a central vision. There will be a focus on recovery and housing expansion for the substance use population. Crisis was a #1 priority and IDHW will offer this.		There are not written policies – but the police department works with all of our partners through meetings. When responding to calls, officers provide handouts and flyers on how to access services such as the suicide hotline, NICC, and resource guides to citizens.

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
use population to regional providers.					
Responses Associated with a Suicidal Approach					
The policies regarding the mentally ill and substance use population are more informal than formal policies to serve mentally ill and substance use population. District wants to support suicide prevention.				The Sheriff Department is not a responder for mental issues except in the realm of protective custodies.	
Question #3: Describe your agency's process for long term planning? Are the mentally ill and substance use population included as part of this planning?					
Responses Associated with a Multi-sectoral Approach					
Strategies involve supporting Suicide Prevention Action Network (SPAN) Idaho and their work – bringing Dr. Rudd for Suicide Prevention	Heritage has partnered with a mental health agency and SUD treatment agency to meet those objectives.				The department planning involves continued education and increased education for officers on how to deal with mental health issues for

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
Training for the Region. Get the word out in the Region about the NICC. Supports the Region 1 Behavioral Health Board					citizens and collaboration with other relevant agencies. The plan is to continue partnerships with the community partners.
Responses Associated with a Suicidal Approach					
Strategies involve working with Suicide Prevention Action Network (SPAN) Idaho. Panhandle Health District has a 3 year strategic plan: Mental health and SUD population needs falls under "increase value to the community" and the priority is to strengthen services and how to	Those plans have to include mental health and SUD treatment.			For the jail we are planning for 40 hours per week for a Mental Health Professional. We already provide substance use services and peer support. The jail is planning for medical housing units in new expansion so inmates can be	

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
effect policy around suicide prevention. Get the word out in the community about the Zero Suicide Initiative.				isolated and there is improved observation for detox and suicide precautions.	
Question #4: What does your agency identify as the 3 most urgent community-wide behavioral health crises in Region 1?					
Responses Associated with a Multi-Sectoral Approach					
1) Access to care 2) Suicide prevention 3) Homeless	1) Suicide prevention 2) Social isolation is a huge driver for a lot of other problems; it's very quiet but all the steps lead to mental health and substance use issues. Kroc RX a program sponsored by Heritage at the Kroc Community Center focuses on wellness and helps with people being able to	1) Not enough psychiatric providers 2) Suicide prevention 3) Detox and follow-up services for the substance use population	1) Lack of appropriate housing for Substance use and mentally ill population 2) Lack of jobs that can sustain the mentally ill. Many have to use food bank. 3) Not enough providers. (6 weeks out to see a provider).	1) Access to affordable follow-up care 2) Lack of inpatient psychiatric beds in Region 1 3) Lack of public understanding regarding the impact mental illness and substance use has on community.	1) Teen suicide – get a handle on dealing with this from Law enforcement perspective. 2) Mental Health issues in the community – getting care. 3) How law enforcement can best help individuals in crisis.

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
	connect with each other. 3) Substance Use				
Question #5: What crisis services or intervention does your agency currently provide to individuals with mental illness and substance abuse problems?					
Responses Associated with a Multi-Sectoral Approach					
We have coordinated referrals to other agencies.	Heritage provides access to providers and services that is affordable and integrated with a medical system, outreach and connections with other agencies.	The Regional Emergency Department sees over 3500 individuals a year in a behavioral health crisis and refers to community agencies or the NICC. The Northern Idaho Crisis Center (NICC) is supported by Kootenai Health.	Region 1 is looking at high utilizers and strategies to keep them out of the hospital. We interacts with community providers to work on treatment plans. The Assertive Community Treatment team (ACT) serves those with chronic and persistent mental illness to keep them at baseline, e.g. med drops, take to appointments, the grocery store, etc. We serve 23 clients through the ACT team. 22 clients are served in Drug court.	The field side officers refer to the hospital, NICC; and Region 1 Mental Health.	Officers provide health resource guides, referrals to appropriate agencies for help, courtesy drop off to NICC.

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
			Region 1 Mental Health will assist law enforcement upon request.		
Question #6. What prevention services does your agency currently provide to individuals with mental illness and substance abuse problems?					
Responses Associated with a Multi-sectoral Approach					
		Kootenai Health staff participate in Mental health screenings at health fairs and coordinates referrals. Kootenai Health sponsors educational offerings to inpatients, the community and providers on mental health and SUD treatment and strategies.	Clinicians participate in annual health day at the County Fair.		Officers reach out to Region 1 Mental Health, provide resource guides to individuals when on a call. Also deal with a lot of homeless and transient population and work with homeless outreach at Heritage Health to get them help.
Responses Associated with a Suicidal Approach					

Panhandle Health District	Heritage Health	Kootenai Health	Region 1 Mental Health (IDHW)	Kootenai County Sheriff	Coeur d'Alene Police Department
	Kroc Rx assists with social isolation and helps people to connect with treatment to impact social isolation upstream. Heritage is committed to doing warm hand-offs and immediate access to treatment. Unexpected consequences of the shared medical appointments and Kroc Rx are people making connections and friends.	Kootenai Health has outpatient services where education occurs.	Staff participated in Suicide Prevention Action Network walk. All clinicians trained in Dialectical Behavioral Therapy.	We do not provide any prevention in the community. In 1992, I began budgeting for officers / staff to have mental health services by a specialist for PTSD after a psychological trauma care resulting from a case. Jail offers NA, AA and both faith based and non-faith based recovery programs for inmates to help prevent further substance use.	

Table 4 - *Stakeholder Agreement Regarding Long-Term Goals, Policies and Interventions Related to Crises Intervention Efforts in Region 1*

Column 1 lists the six interview questions asked of key stakeholders in Region 1.
Column 2 provides a summary of responses to the interview questions reflected in Table 3. Column 3 reflects agreement among stakeholders regarding long-term goals, policies and interventions related to crises intervention efforts in Region 1.

Interview Questions	**Summary of Stakeholder Responses**	**Agreement – Yes, No, or Unclear / Comment**
1. What are your agency's long-term goals in working with the mentally ill and substance use disorder (SUD) population in crisis?	All agencies had long-term goals to support crisis intervention and suicide prevention. Region 1 Mental Health noted that suicide prevention efforts are shifting to the community, but is working with clients pre- and post-hospitalization, which will support crisis intervention and suicide prevention. Law Enforcement's focus is on officer training in crisis situations and partnerships with community providers and agencies to get clients assistance when in crisis.	**YES** While each agency approaches long-term goals from a differently vantage point, there was agreement in the fact that they each had long-term goals related to the mentally ill and SUD population in crisis.

Interview Questions	Summary of Stakeholder Responses	Agreement – Yes, No, or Unclear / Comment
2. Describe the written policies or guidelines reflecting your agencies goals in working with the mentally ill and SUD population in crisis.	Three out of six agencies had written policies reflecting goals for working with the mentally ill and SUD population in crisis.	**NO** Only the three agencies that provide direct mental health and SUD treatment had policies.
3. Describe your agency's process for long-term planning? Are the mentally ill and SUD population included as part of this planning?	All agencies engage in a long-term planning process. All agencies had a component of their long-term plan involve an aspect of behavioral health crisis intervention or suicide prevention relevant to their interface with the community.	**YES** There was agreement between stakeholders in that they all have a long term planning process involving behavioral health crisis intervention.

Interview Questions	Summary of Stakeholder Responses	Agreement – Yes, No, or Unclear / Comment
4. What does your agency identify as the 3 most urgent community-wide behavioral health crises in Region 1?	Access to care was noted by five of six stakeholders as the most urgent behavioral health crisis identified through either noting 1) the need for access; 2) not having enough providers in the region; or 3) not having enough psychiatric beds in the region all of which encompass the access to care issue for the mentally ill and SUD population. Four out of six stakeholders cited suicide prevention as the most urgent behavioral health crisis. Two out of six stakeholders indicated lack of SUD services as the most urgent behavioral health crisis.	**NO** There was no consistent agreement between stakeholders on the three most urgent community-wide behavioral health crises in Region 1.
5. What crisis services or intervention does your agency currently provide to individuals with mental illness and SUD problems?	Two agencies deliver direct care for the mentally ill and SUD population were in agreement to receive and treat clients. The agencies that do not provide mental health	**YES** All agencies provide some type of crisis services or intervention. Heritage Heath, Kootenai Health and Region 1 Mental Health all

Interview Questions	Summary of Stakeholder Responses	Agreement – Yes, No, or Unclear / Comment
	services were in agreement with the responsibility to refer to the appropriate level of care.	provide direct crisis services. Panhandle Health District, Kootenai County Sheriff Department and Coeur d'Alene Police Department all intervene with the individual in crisis by referring them to the appropriate level of care.
6. What prevention services does your agency currently provide to individuals with mental illness and substance abuse problems?	Law enforcement noted some internal prevention programs for their officers and staff. Educational offerings that can influence prevention efforts were noted by two agencies. One agency noted a community-wide suicide prevention education: the ZERO Suicide Initiative.	**NO** There are no coordinated efforts regarding suicide prevention strategies among agencies.

Table 5 - *Compilation of Region 1 Gap Analysis Findings*

Column 1 in the first row identifies gaps by categorical themes. Columns 2 – 5 in the first row identifies the 5 data collection sources used to compile gaps in best practice in Region 1.

The subsequent rows describe how each gap was categorized and how that gap was described by each of the four data collection sources.

Column 3* represents combined data from the Districts 1 and 2 Community Health Assessment and the Health Improvement Plan.

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
Housing	Access to housing		Lack of safe and sober housing for all ages and genders	
Transportation	Access to transportation	Access to affordable transportation for health appointments; Winter driving and distance impact	Lack of transportation in rural areas; Limited City Link bus routes in Kootenai County	Lack of transportation in region

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
		access to health care.		
Access to health care	Access to health care	Access to health care is difficult	Lack of medical preventive care for mentally ill and substance use disorder (SUD) population especially if not insured	
Access to mental health providers and services	Access to mental health providers	Lack of mental health providers	Lack of general and intensive outpatient providers in outlying areas	Lack of access to services
Lack of funding for medications	Access to financial assistance for medications		Lack of aid from drug companies and complicated paperwork	
Access to respite care	Access to respite care			
Access to affordable mental health services	Access to affordable mental health services			
Access to affordable	Access to affordable			

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
substance use treatment	substance use treatment			
Access to legal assistance	Access to legal assistance			
Lack of school based mental health and SUD services	Access to school based mental health services		Lack of school based mental health and SUD services to include intervention and prevention	
Lack of mental health and SUD education	Lack of mental health education		Lack of parent and adult education for mental health and SUD issues.	
Lack of psychiatric providers	Lack of psychiatrists	Lack of physicians	Lack of access to psychiatric provider services for both adults and children	
Lack of mental health and substance use crisis services	Lack of mental health and substance use crisis services			

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
Lack of mental health residential treatment	Lack of mental health residential treatment			
Lack of school based substance abuse services	Lack of school based substance abuse services			
Lack of substance abuse education and prevention	Lack of substance abuse education and prevention			
Lack of substance abuse residential treatment	Lack of substance abuse residential treatment		No transitional or residential care settings	
General lack of mental health resources		General lack of mental health resources		
Stigma		Stigma is a barrier to care that impacts those seeking mental health services.	Stigma limits community acceptance of individuals with mental illness and SUD for both adults and children.	Stigma is perceived as a potential barrier to accessing crisis services.
Lack of crisis services			Lack of crisis services	No 23 hour crisis stabilization available.

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
Lack of critical access ERs able to identify/manage/address acute crisis needs			Lack of critical access ERs able to identify/manage/address acute crisis needs	
Lack of funding for telehealth/lack of insurance coverage.			Lack of funding for telehealth/lack of insurance coverage.	
PCPs not willing to prescribe psychotropic medications.			PCPs not willing to prescribe psychotropic medications.	
Lack of funding to provide training for respite care staff for both children and adults			Lack of funding to provide training for respite care staff for both children and adults	
Lack of day treatment			Lack of day treatment	
Lack of foster care			Lack of foster care	
Lack of trauma informed care			Lack of trauma informed care	

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
No system in place to identify kids at risk			No system in place to identify kids at risk	
Lack of standardized education for law enforcement and first responders about mental illness and SUD issues			Lack of standardized education for law enforcement and first responders about mental illness and SUD issues	
Difficulty referring a SUD client to a provider due to system constraints			Difficulty referring a SUD client to a provider due to system constraints	
Lack of case management for specialty court clients			Lack of case management for specialty court clients	
Lack of mobile crisis services				Lack of mobile crisis services

Gaps Listed by Categorical Themes	**Executive Summary Region 1 Survey – Spring 2013 Identified Gaps**	***2013 Community Health Assessment Idaho Public Health -Districts 1 and 2; &** **2014 Community Health Improvement Plan - Districts 1 and 2 Identified Gaps**	**Region 1 Behavioral Health Board Gaps and Needs Analysis – 2015**	**Follow-up Gap Analysis Survey on Region 1 Crisis Services -Summer 2015**
Lack of "warm lines" (talk lines run by peer support specialists)				Lack of "warm lines" (talk lines run by peer support specialists)
Lack of use of psychiatric advance directives				Lack of use of psychiatric advance directives
Lack of peer support involvement in crisis services				Lack of peer support involvement in crisis services
Lack of knowledge regarding available services				Lack of knowledge regarding available services
There is a client lack of trust in services.				There is a client lack of trust in services.

Table 6 - *Comparison of Region 1 Gaps with Best Practices*

This table illustrates how gaps identified in the Region 1 Gap Analysis have been linked to a best practice listed in Table 1. Also illustrated in Table 5 are services and interventions identified as gaps in the Region 1 Gap Analysis that do not pertain to any of the best practices listed in Table 1.

Column 1 of Table 5 lists Region 1 gaps that have been categorized by themes taken from Table 5.
Column 2 lists the best practice from Table 3 that defines the corresponding gap.
Column 3 lists gaps identified in the Region 1 Gap Analysis that do not pertain to any best practices listed in Table 1.
Column 4 provides a rationale to describe the link between Region 1 gaps and best practices.

Gaps Labeled as Categorical Themes as Noted in Table 4	Best Practices Identified from the Literature that are Associated with Region 1 Gaps	Gaps Not Related to Best Practice	Consequences and/or Explanation Resulting from Each Gap
Housing for the mentally ill and substance use populations.	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (*Choose Life Initiative* – Scottish Government, 2013).		When individuals do not have housing, mental health is difficult to maintain due to the stressors that ensue. This is a component of a coordinated suicide prevention action strategy.
Transportation	Conduct assertive community outreach 24/7, which includes intensive support, e.g. medication monitoring, transportation to appointments, assistance with activities of daily living, etc., for people with severe mental illness by a multi-disciplinary team aimed at keeping the patient in the community and avoid hospitalization (WHO 2014).		This is in reference to the work of the ACT team which interacts with a small segment of the mentally ill population. The ACT is not consistently available 24/7 in Region 1. Transportation when in crisis is not consistently available.
Access to affordable health care	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (*Choose Life Initiative* – Scottish Government, 2013).		When individuals cannot afford health care, they generally will not seek it out until it reaches crisis level which increases costs and exacerbates the illness. The coordinated actions in the community must include that providers are available, it is accessible through transportation, and affordable on all spectrums to include mental health and substance use disorder (SUD) care.
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
Lack of mental health providers	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (*Choose Life Initiative* – Scottish Government, 2013).		Coordination of health care services implies that there are enough providers to provide those services.
Financial assistance to obtain medication	There must be a coordinated action for suicide prevention across health-care services, social-care		Being able to obtain medication falls into the realm of coordinated health care and welfare. If a crucial part

	services, educational institutions, law enforcement, affordable housing services, welfare, and employment services; Financial support must be available for local community and neighborhood interventions (Scottish Government, 2013).		of the health care plan is not available it speaks to lack of coordination.
Respite care		Not Identified as a best practice	This is not distinctly defined as a best practice in the literature, however availability of respite care can decrease stress on families and possibly the need for hospitalization.
Affordable mental health and substance use care.	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		When individuals cannot afford health care, they generally will not seek it out until it reaches crisis level, which increases costs and worsening of addiction and associated symptoms and disease processes (World Health Organization, 2014b).
Legal assistance	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		The involvement of law enforcement often leads to the need for legal assistance. This must be a coordinated effort. Often individuals are in jail due to their mental illness. Legal assistance can assist individuals to get the help that they need.
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
School based mental health services	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		Suicide is the second leading cause of death for Idahoan males age 10-14 (Suicide Prevention Action Network of Idaho, 2015). School based services must be a component of the coordinated action.
Mental health education	Provide regular training to frontline clinical staff on management of suicide risk (World Health Organization, 2014b). Develop multi-professional training programs to build capacity for supporting the prevention of suicide (Scottish Government, 2013).		Mental health education is needed on three levels: individual, community and front line staff. This was not clarified in the surveys. There is a gap in Region 1 for all areas.

Lack of psychiatrists	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		Coordination of health care services implies that there are enough providers to provide those services.
Lack of mental health and substance use crisis services	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		Coordination of health care services implies that there are enough providers to provide those services.
Residential treatment for the mentally ill	Short-term crisis residential services are identified as a best practice (Substance Abuse and Mental Health Services Administration, 2014a).		Long-term residential care is not identified as a best practice. The type of residential care was not clarified in the survey – short-term or long-term.
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
School based substance use disorder (SUD) services	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		School based services must be a component of the coordinated action.
SUD education and prevention		Not identified as a best practice.	Programs that only focus on education have had few effects on the SUD population. Prevention programs must incorporate specific types of skill building such as resistance of peer pressure, impulse regulation, etc. (Committee on Prevention, Diagnosis, Treatment and Management of Substance Use Disorders in the U.S. Armed Forces, 2013).

Residential treatment for SUD population	Only short-term residential care is defined as a best practice (Substance Abuse and Mental Health Services Administration, 2014a).		Long-term residential care is not identified as a best practice.
23 hour crisis stabilization services	To prevent suicide, there should be 23 hour crisis stabilization/observation beds available (Substance Abuse and Mental Health Services Administration, 2014a).		Since the surveys were administered, the Northern Idaho Crisis Center has opened serving Region 1.
Critical access ERs unable to identify, manage and address acute crisis needs	Community must have access to emergency mental health care (Mishara & Weisstub, in press).		Critical access hospitals do not have mental health staff to manage, and address acute crisis needs for the mental health and SUD population.
Lack of telehealth and funding to support it		Not identified as a best practice.	Telehealth is not listed as a best practice at this time but is a viable way to deliver psychiatric care to rural areas that lack psychiatric providers and has been successfully done in this region (Luptak, Dailey, Juretic, Rupper, Hill, Hicken, & Blair, 2010).
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
Primary care physicians not willing to prescribe psychotropic medications	There must be a coordinated action for suicide prevention across health-care services, social-care services, educational institutions, law enforcement, affordable housing services, welfare, and employment services (Scottish Government, 2013).		Due to the lack of psychiatrists in Region 1 prescribing psychotropic medications falls to the primary care physicians. There is a hesitation by many primary care physicians to treat complex mental illness and SUD.
Funding to train respite care workers for child and adult population	Financial support must be available for local community and neighborhood interventions (Scottish Government, 2013). Provide regular training to frontline clinical staff on management of suicide risk (World Health Organization, 2014b). Develop multi-professional training programs to build capacity for supporting the prevention of suicide (Scottish Government, 2013).		Ongoing funding for trainings continues to be an issue. This is where a coordinated action approach by many sectors of Region 1 can possibly assist with educational endeavors.

Day treatment		Not identified as a best practice.	This is not distinctly defined as a best practice in the literature.
Foster care		Not identified as a best practice.	This is not distinctly defined as a best practice in the literature.
Trauma-informed care	TIP 57: Trauma-Informed Care in Behavioral Health Services (Substance Abuse and Mental Health Services Administration, 2014b).		There is a current movement within children's mental health in Region 1 to have providers trained in the understanding the impact of trauma-informed care and incorporating that into treatment. It is a best practice recognized by the Substance Abuse and Mental Health Services Administration (2014b).
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
System to identify children at risk	To prevent suicide, there should be participation from local coalitions of stakeholders to promote and implement comprehensive suicide prevention at the community level (U.S. Department of Health and Human Services Office of the Surgeon General and the National Action Alliance for Suicide Prevention, 2012).		Suicide prevention strategies should be conducted across the age continuum.
Standardized education for law enforcement and first responders about mental illness and SUD issues	Crisis Intervention Team (CIT) training for law enforcement should be incorporated into routine training for police officers to prevent suicide (Kohrt, et al., 2015); Watson & Fulambarker, 2012).		Not all law enforcement agencies in Region 1 participate in CIT training.
Difficulty referring a SUD client to a provider due to system constraints	To prevent suicide, there should be increased collaboration and coordination among suicide prevention programs, mental health and substance abuse agencies, and local crisis centers (U.S. Department of Health and Human Services Office of the Surgeon General and the National Action Alliance for Suicide Prevention, 2012).		Collaboration and coordination is not consistent for the SUD population.
Case management for specialty court clients		Not identified as a best practice.	This is not distinctly defined as a best practice in the literature yet it is a reasonable service to be affiliated with the Region 1 Drug and Mental Health Courts.

Mobile crisis services	To prevent suicide, there should mobile crisis services available (Substance Abuse and Mental Health Services Administration, 2014a).		Due to the rural nature of Region 1, mobile crisis remains a challenge.
"Warm lines" (talk lines run by peer specialists)	To prevent suicide there should "warm lines" (peer run listening lines) available (Substance Abuse and Mental Health Services Administration, 2014a).		Peer support is not consistent throughout the region and there is currently no funding for "warm lines."
Gaps Labeled as Categorical Themes as Noted in Table 4	**Best Practices Identified from the Literature that are Associated with Region 1 Gaps**	**Gaps Not Related to Best Practice**	**Consequences and/or Explanation Resulting from Each Gap**
Use of psychiatric advance directives	To prevent suicide, there should psychiatric advance directives used to direct care of the mentally ill individual (Substance Abuse and Mental Health Services Administration, 2014a).		Psychiatric advance directives can assist in driving care when a client is not able to provide informed consent. There have been no individuals in the past 10 years enter acute psychiatric care in Region 1 with an advanced directive.
Peer support involvement in crisis services	To prevent suicide, there should peer crisis services available (Substance Abuse and Mental Health Services Administration, 2014a).		Peer support will be incorporated into the Northern Idaho Crisis Center staffing plan in the future.
Lack of knowledge regarding available services	To prevent suicide, there should be increased collaboration and coordination among suicide prevention programs, mental health and substance abuse agencies, and local crisis centers (U.S. Department of Health and Human Services Office of the Surgeon General and the National Action Alliance for Suicide Prevention, 2012).		There is a lack of knowledge on the part of clients and providers regarding all of the services available. Collaboration efforts have been underway in part of Region 1 (Kootenai County) to address this through a monthly meeting of providers to share new services. There is also a resource guide that has been created by St. Vincent DePaul's social services that is provided to clients by police and various social service agencies in Kootenai County.
Trust issues among behavioral health population		Not identified	This area could be addressed through focus groups with clients from the Region 1 National Alliance of Mental Illness chapters (NAMI).

clients regarding available services.		as a best practice.	

Appendix A

Executive Summary for Region I Survey of Behavioral Health Gaps, Spring 2013

To evaluate gaps in services throughout Region I, the Regional Mental Health Board and Regional Advisory Committee on Substance Abuse conducted a survey in the spring of 2013 of 100 providers, non-profits, and other stakeholders. The following groups responded to the survey: Health and Welfare, Hospitals, Law Enforcement, Not-for-Profit Agency, Primary Care Provider, Probation, Prosecuting Attorney/Public Defender, Schools, Private Provider/HW Contractor, Consumer, and Other.

The following situations were rated at the end of the spectrum as ***Severely Lacking*** in Region I: *Access to Housing, Access to Transportation, Access to Health Care and Mental Health Providers, Access to Financial Assistance for Needed Medications, Access to Respite Care, Access to Affordable Mental Health Services, Access to Affordable Substance Abuse Treatment, Access to Legal Assistance, School Based Mental Health Services, Mental Health Education, Psychiatrists, Mental Health Crisis Services, Mental Health Residential Treatment, School Based Substance Abuse Services, Substance Abuse Education and Prevention, Substance Abuse Crisis Services, and Substance Abuse Residential Treatment.*

Surveyors had the opportunity to provide comment, in which there were a couple positive comments, such as in the fiscal years of 2010 and 2011, only about 5% of children mental health crisis were substance abuse related, during this same time frame, the Department of H&W added therapeutic foster care and the juvenile mental health docket, agencies in the Silver valley have joined together with medical staff in order to provide solutions, and many comments provided for positive solutions and alternatives.

On the other hand, one surveyor quoted, "The best mental health therapy in the State of Idaho is a bus ticket out of the state", indicating the dire need of supports and resources in our communities that are currently lacking. Idaho ranks one of the lowest in the nation for behavioral health treatment, and has one of the highest suicide rates. Many comments focused on lack of funding, lack of collaboration, outcomes resulting in the justice system instead of prevention, lack of affordability to meet people's needs, lack of psychiatry, lack of treatment facilities, education needed for law enforcement, lack of crisis assistance and access to crisis care. Rural communities report they are struggling more than ever in meeting needs and accessing resources. Hospitals reports over 60% of medical patients have mental health issues, while an average of 40% have substance abuse issues. Providers mention low reimbursement rates resulting in not being able to ensure living wages, not being reimbursed for things that highly administratively burdensome, and the elimination of services that were once billable. Many comments urge our representatives to look at Medicaid Redesign to assist families who cannot currently afford the treatment they need.

We understand this document is lengthy, but we urge you to please read through the issues Region I is facing with regards to the needs and gaps in our region, the issues we face with behavioral health needs for our people, and to identify possible solutions.

Amika DuPree, ACES Community Services, MH Board Secretary/Private Provider Representative to the MH Board, and RAC member

Jennifer Romero, Restored Paths, RAC Co-Chair, and RAC representative to the MH Board
Matthew Malek, Angie Delio

Appendix B

Follow-up Gap Analysis Survey on Region 1 Crisis Services – Summer 2015 Results

Appendix C are the results from the "2015 Follow-up Gap Analysis Survey" conducted during the summer of 2015. The questions were focused on identifying any further gaps in Region 1 of best practices identified from the literature regarding crisis intervention services. It also focused on identifying any new barriers to accessing crisis services.

The survey was sent to 18 stakeholders and 12 responded. Results are outlined below. Questions 1 through 6 are listed with responses of no, yes, or I don't know and the corresponding percentage of responses.

Question 7 asked about barriers that could impact an individual from accessing crisis services. Barriers were rank ordered and those identified by most stakeholders were assigned #1. The next barrier most identified was assigned #2, and so forth.

1. **Does northern Idaho have any 23 hour crisis stabilization / observations beds?**

No	81.82%
Yes	0.00%
I do not know	18.18%

Comments:

- I don't believe there is anything outside of KBH services.
- Crisis Center is pending.

2. **Does northern Idaho have any mobile crisis services?**

No	41.67%
Yes	25.00%
I do not know	33.33%

Comments:

- Not in Bonner or Boundary County.
- Heritage Health has a mobile medical clinic several days a week at different locations
- Region 1 Mental Health at times does do community home visits for established clients.

3. **Does northern Idaho have any 24/7 crisis hotlines?**

No	0.00%
Yes	91.67%
I do not know	8.33%

Comments: Respondents listed the following:

- Idaho Suicide Prevention Hotline
- Most major mental health agencies have crisis lines. Actual available crisis help is lacking and pretty non-existent in northern Idaho.
- San Idaho, 611 Care Line (State, ID)
- Suicide hotline
- 800-273-TALK and local 664-1443
- Region 1 Mental Health and suicide hotline
- DHW has 24/7 crisis line.

4. **Does northern Idaho have any warm lines (peer supported talk lines)?**

No	36.36%
Yes	18.18%
I do not know	45.45%

Comments:

- For domestic violence, AA, and NA. General peer support warm lines – no
- There are some agencies who do have peer support services.
- Through Optum there is a hand-off to peer supports.

5. **Do clients of northern Idaho use any psychiatric advance directives?**

No	25%
Yes	25%
I do not know	50%

Comments:

- I have only seen one in 17 years of mental health work.

- It is the hospital's practice to ask if a patient has a psychiatric advanced directive.
- Information is provided at KBH.
- DHW behavioral health staff asks the client and if they don't have one, they are referred.

6. Does northern Idaho have any crisis services led by peer support?

No	50.00%
Yes	0.00%
I do not know	50.00%

7. What do you see as the potential barriers that exist which would prevent individuals from accessing crisis services?

Ranking of Barriers Most Often Identified by Respondents
1. Lack of transportation
2. Lack of knowledge regarding available services
3. Stigma
4. Housing
5. Access to services
6. Client lack of trust in services

Appendix C

Region 1 Behavioral Health Board Gaps and Needs Analysis, 2015

Identified Regional Service Needs and Gaps (relating to prevention, treatment, and rehabilitation services)	Shortfalls and Challenges	Project Proposals, Progress, and Accomplishments (including those related to family support services and recovery support services)	Improvement and Strategy Measures
Mental Health/ Substance Use Disorder (SUD) Crisis Services and Detox	• Lack of crisis services with healthcare status • Lack of general and intensive outpatient providers in outlying areas • Lack of capacity for local ERs to identify, manage, address acute crisis needs	• Legislation passed Idaho House and Senate HB 264	• Coeur d'Alene selected as site of crisis center 23-hour crisis center
Access to Psychiatric Services for Adults & Children	• Funding for Tele-health/Insurance • Best use of existing TH facilities • Primary Care Provider not willing to prescribe psychotropic Rx • Lack of psychiatric providers who can subscribe	• Increased use of Psych Nurse Practitioner • Legislation passed to offer loan repayment to psych MDs to work at state hospitals	• Accountable Care Act (ACA) increased access • Change IDAPA SUD regulations to allow clinical supervision vie Tele-health
Financial Help with Medications for Children and Adults	• Person to apply for aid from drug companies • Complicated paperwork requiring assistance to prepare	• Use a 340 B drug program for the community	
Sustainable Housing for the Homeless and Transitional Population	• Community acceptance, stigma • Limited funding for housing • Lack of Safe and Sober for males/females for adults and juveniles • No transitional or residential care facilities in Bonner, Boundary, Shoshone, or Benewah counties	• Kootenai Co had two organizations present to Behavioral Health Board about group homes • Apply for Idaho housing monies • Housing for felons	Develop sustainable housing for men, women, youth (male & female); group homes or secure homes

Identified Regional Service Needs and Gaps (relating to prevention, treatment, and rehabilitation services)	Shortfalls and Challenges	Project Proposals, Progress, and Accomplishments (including those related to family support services and recovery support services)	Improvement and Strategy Measures
Respite Care for Children and Adults	• Funding to provide training	• Train volunteer families to accept referrals on temp basis	
SUD/MH Parent Education and Training for Children and Adults	• Family education needed • Community resistance, stigma	• National Alliance of Mental Illenss (NAMI) Family to Family • Idaho Federation of Families Children's Mental Health (IFFCMH) Building Stronger Families; online courses, seminars • Children's Mental Health Adverse Childhood Experiences (ACE) training in April	• Use resources of advocacy groups to start: NAMI, IFFCMH Provided 5 scholarships to Idaho Conference on Alcohol and Drug Dependency (ICADD) for providers
School-Based MH/SUD Services, to Include Intervention and Prevention	• Community acceptance, stigma • Individual SD resistance • Funding from MH and SUD groups	• QPR suicide prevention training • ACE (Adverse Childhood Experience) workshop, 4/30/2015	• Question, Persuade, Refer (QPR) training in Silver Valley
CMH Day Treatment/Therapeutic Foster Care	• Funding for services • Licensure for day treatment • Volunteers to train for foster care		
Transportation for MH/SUD Clients	• Currently no transportation in rural areas • Limited City Link bus routes in Kootenai County		
Trauma Informed Care	• Inform, educate community service providers	• April 10th presentation Building a Trauma Informed Community at Kroc	

Identified Regional Service Needs and Gaps (relating to prevention, treatment, and rehabilitation services)	Shortfalls and Challenges	Project Proposals, Progress, and Accomplishments (including those related to family support services and recovery support services)	Improvement and Strategy Measures
Drug Endangered Children's Protocol	• Increase/start education and training • Idaho does not have DEC Alliance protocol in place; need system in place to identify kids at risk	• Behavioral Health Trainings • Address needs of children in dangerous drug environments • Formation of community-based partnerships with agencies across multiple disciplines • Support state services and local communities to develop efficient/effective strategies for avocation of victims	• Identify drug endangered children the dangers they face. We will: • Offer ongoing education, support, and linking services
Medical Preventative Care for MH and SUD	• Lacking for clients not on Medicare, Medicaid, or private insurance	• State Health Improvement Program to focus on Patient-Centered Medical Home • Expand community collaboration	• ACA • SHIP Program
Education for Law Enforcement and First Responders about MH and SUD issues	• Monies for Crisis Intervention Training (CIT) Training • Time for officers to attend training • Resistance by LE Administration	• CIT Training in April	• More CIT Training
SUD Referrals within the Medicaid System	• Currently no path in place within contractors referral system to refer clients to a SUD provider when a need is identified • Issues with co-occurring referrals	• Develop system to track co-occurring client referrals • Increase SUD provider network • Service provider contractors should reflect sub-categories being treated	
Specialty Court Clients Issues	• No case management for these clients • Housing is an issue	• Offer housing and case management	

Identified Regional Service Needs and Gaps (relating to prevention, treatment, and rehabilitation services)	Shortfalls and Challenges	Project Proposals, Progress, and Accomplishments (including those related to family support services and recovery support services)	Improvement and Strategy Measures
Lack of Payment to Providers to Create Process Paperwork	• No reimbursement from contractors for paperwork required from providers		• Reimbursement rates are below average
Opiate Replacement Therapy	• Lack of protocol in place between physicians and courts		• Implement and train statewide: SAMHSA's Opiate Replacement Treatment Model

Appendix D

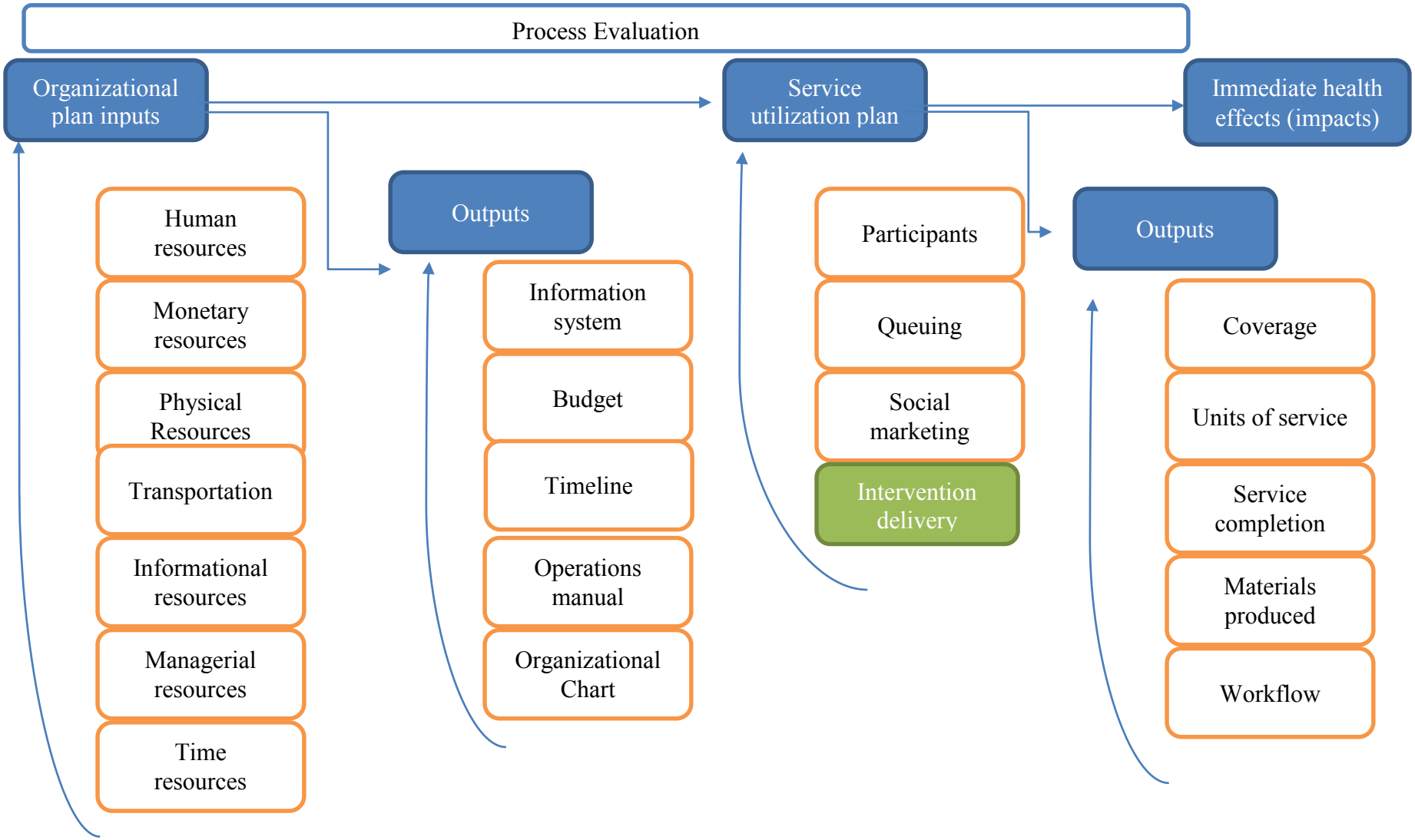
List of Coalition of Stakeholders for Region 1 Process Evaluation

- Individuals with Mental Illness and/or Substance Use Disorders
- Kootenai Health
- Boundary Community Hospital
- Bonner General Hospital
- Shoshone Medical Center
- Benewah Medical Center
- Heritage Health, Federally Qualified Health Clinic
- Panhandle Health District
- Idaho Health Partners
- Kootenai County Sheriff's Department
- Coeur d' Alene Police Department
- Post Falls Police Department
- Bonner County Sheriff's Department
- County Commissions of Region 1
- Mayors of Region 1
- Region 1 Mental Health – Idaho Department of Health & Welfare
- Kootenai County Prosecutor Office
- NAMI Coeur d'Alene and NAMI Far North
- Region 1 Behavioral Health Board
- Region 1 Judges
- Idaho State Legislators

Appendix E

Elements of the Process Theory Included in a Process Evaluation

[Note. Adapted from *Health Program Planning and Evaluation* (p. 306), by L.M. Issel, 2014, Burlington, MA: Jones & Bartlett Learning. Adapted with permission.]



Appendix F

Ten Essential Values in Responding to a Mental Health Crisis

1. Avoiding harm includes an appropriate response that establishes physical safety for the individual and responders and the individual's psychological safety.
2. Intervening in person-centered ways includes interventions that include the individual's personal preferences and goals that can be incorporated into the crisis response.
3. Shared responsibility involves interventions that focus on person-centered plans and honors an individual's role in crisis resolution; doing interventions with the individual not to the individual.
4. Trauma must be addressed with individuals in crisis. People with serious mental illness have a high probability of having been victims of abuse or neglect. It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by qualified individuals.
5. Establishing feelings of personal safety for an individual in a behavioral health crisis is crucial. Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security and what interventions increase feelings of vulnerability.
6. Assessment of the individual's strengths is an important crisis intervention. Reinforcing the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.
7. The whole person must be taken into account. While the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, and absence from work, etc.

8. Often individuals with mental illness are not seen as a credible source. There is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the 'telling of one's story' may represent an important step toward crisis resolution .
9. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person. Principles of recovery, resilience and natural supports should be incorporated into interventions that support the individual.
10. An appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse.

Adapted from "Practice Guidelines: Core Elements for Responding to Mental Health Crises," U.S. Department of Health and Human Services, 2009, Publication No. SMA-09-4427, pp. 5-7. Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration.

Appendix G

P*rinciples for Enacting the Essential Values of Responding to a Mental Health Crisis*

1. Access to supports and services is timely.
2. Services are provided in the least restrictive manner
3. Peer support is available.
4. Adequate time is spent with the individual in crisis.
5. Plans are strengths-based.
6. Emergency interventions consider the context of the individual's overall plan of services.
7. Crisis services are provided by individuals with appropriate training and competence to evaluate and effectively intervene with the problems being presented.
8. Individuals in a self-defined crisis are not turned away.
9. Interveners have a comprehensive understanding of the crisis.
10. Helping the individual to regain a sense of control is a priority.
11. Services are congruent with the culture, gender, race, age, sexual orientation, health literacy and communication needs of the individual being served.
12. Rights are respected.
13. Services are trauma-informed. It is critical to understand how the individual's response within the current crisis may reflect past traumatic reactions and what interventions may pose particular risks to that individual based on history. (U.S. Department of Health and Services, 2009).
14. Recurring crises signal problems in assessment or care. There should be a fresh and careful reappraisal of interventions and approaches if there are recurring crises.

Adapted from "Practice Guidelines: Core Elements for Responding to Mental Health Crises," U.S. Department of Health and Human Services, 2009, Publication No. SMA-09-4427,

pp. 7-12. Rockville, MD: Center for Mental Health Services, Substance Abuse, and Mental Health Services Administration.

Appendix H

Logic Model for Process Evaluation on Crisis Services in Northern Idaho

Inputs	**Activities**	**Outputs**	**Objectives**	**Outcomes**		**Impact**
What we invest	**Action**	**What we do**	**Measurable**	**Short-term**	**Long-term**	
Conducted a comprehensive review of the international and national literature for community goals and best practice strategies regarding behavioral health crisis interventions.	Developed a list of best practices identified from the international and national literature regarding behavioral health crisis interventions.	Categorized the list of best practices according to two main community goals that address crisis intervention strategies identified from the international and national literature: 1) Multi-Sectoral Approach 2) Suicide Prevention Approach	Identify community goals and best practices from a comprehensive review of the international and national literature that have been shown to effectively respond to community behavioral health crises.	Table 1 was generated that identified community goals and best practices for behavioral health crisis intervention strategies identified from the international and national literature.	Region 1 behavioral health coalition of stakeholders will adopt identified community goals and incorporate identified best practices into a community-wide strategic action plan that will address behavioral health crisis intervention services.	New crisis intervention services based on community goals and best practices identified from the literature that will reduce the suicide rate of Region 1.

Inputs	Activities	Outputs	Objectives	Outcomes		Impact
What we invest	**Action**	**What we do**	**Measurable**	**Short-term**	**Long-term**	
Region 1 behavioral health coalition of stakeholders are committed to see improvement in the management of behavioral health crises and suicide prevention.	Developed a set of interview questions to ask key stakeholders within the Region 1 behavioral health coalition (see Table 4). Questions were focused on organizational strategies in place to support the goals and best practices identified from the international and national literature that have been shown to effectively respond to community behavioral health crises. Identify at least six key	Conducted interviews with key stakeholders of the Region 1 behavioral health coalition regarding their existing long-term goals, policies and interventions that address behavioral health crises services.	Determine how closely key stakeholders in the Region 1 behavioral health coalition agree with each other in addressing behavioral health crises and how they address international and national community goals and best practices that outline the effective response to behavioral health crises.	Generated two tables: Table 3 – How key stakeholders address community-based goals and best practices recommended from international and national literature on how communities should effectively respond to behavioral health crises. Table 4 - how many key stakeholders were in agreement with each other with regard to their	Information from the interviews will be used to formulate a community-wide strategic action plan regarding crisis intervention services whereby Region 1 stakeholders' agencies are in agreement on long-term goals, policies, and interventions that addresses crisis services. Region 1 behavioral health coalition of stakeholders	Key stakeholder agencies working together will result in more resources for behavioral health clients experiencing crises. Development of a Region 1 community-wide strategic action plan regarding crisis intervention services will reduce the suicide rate of Region 1.

Inputs	Activities	Outputs	Objectives	Outcomes		Impact
What we invest	**Action**	**What we do**	**Measurable**	**Short-term**	**Long-term**	
	stakeholders within the Region 1 behavioral health coalition to interview.			existing long-term goals, policies and interventions that address behavioral health crises services.	will incorporate community goals and best practices identified from the literature into their long-term goals, polices and interventions.	
Data from Region 1 Survey of Behavioral Health Gaps – Spring 2013 Data from 2013 North Idaho Community Health Assessment and the 2014 North Idaho Community Health	Compiled all gap analysis and report findings from identified sources listed in the "input" column of this Logic Model to be listed in one table (see Table 5).	Data from the gap analyses and reports were synthesized to reveal gaps in Region 1 regarding crisis interventions and identified what were the most prevalent gaps.	Identify gaps and challenges in behavioral health crisis services and resources in Region 1 that must be resolved in order to effectively respond to community-based behavioral health crises goals and best practices based on the review of	Table 6 represents the synthesis of data regarding Region 1 gaps to 1) identify best practices that are associated with Region 1 gaps and to 2) Identify gaps that were not associated with a best practice.	Use the synthesis of gap analysis data to develop community-wide strategic action plan that will address and resolve identified gaps.	Development of new services and resources to support clients in crisis. Reduction of the suicide rate in Region 1.

Inputs	Activities	Outputs	Objectives	Outcomes		Impact
What we invest	**Action**	**What we do**	**Measurable**	**Short-term**	**Long-term**	
Improvement Plan Data from the Region 1 Behavioral Health Gaps and Needs Analysis – 2015 Data from the Follow-up Gap Analysis Survey on Region 1 Crisis Services – Summer 2015 Results			international and national literature.			

Appendix I

Business Plan

This plan outlines the projected expenses to complete the process evaluation.

Source of Expense	Expense Description	Dollar Value	Type of Cost	Description of Cost	Estimated Volume	Expense per Visit
Author's Time (Labor)	Time to conduct process evaluation; analysis of best practices; gap analysis in Region 1	$50.00 @ 240 hours = $12,000 + 28% (Benefits) = **$15,360**	In-Kind Salary and Benefits	Salaries and Benefits	N/A	N/A
Coalitions Time 6 Members (Labor) Time	Interviews with coalition members	$50.00 @ 1 hour X 6 members = $300 + 28% (Benefits) = **$384**	In-Kind Salary and Benefits	Salaries and Benefits	N/A	N/A
Region 1 Behavioral Health Board and other coalition members (18) survey participation (Labor)	Survey Completion	$30 @ 1 hour X 18 members = $540 + 28% (Benefits) = **$691**	In-Kind Salary and Benefits	Salaries and Benefits	N/A	N/A
Dissemination To coalition members 30 members (Labor)	Author will attend two board meetings to present gap analysis for future regional planning	$30 @ 30 minutes X 30 members = 15 hours = $450 + 28% (Benefits) = **$576**	In-Kind Salary and Benefits	Salaries and Benefits	N/A	N/A
	Total Labor Expenses	**$17,011**				
Office Supplies		$100				
	Grand Total	**$17,111**				