

**Appendix B**

Thriving Mind South Florida (“Thriving Mind”)

Mobile Response Team Requirements

**Purpose:** To ensure the implementation and administration of Mobile Response Team (MRT) services, Thriving Mind shall require that the MRT Provider adheres to the service delivery and reporting requirements referenced in the Department of Children and Families **Appendix A, Guidance Document 34,** Mobile Response Team (MRT), dated August 1, 2022, or the latest revision thereof. Additional requirements established by Thriving Mind in this document must be adhered to and will be contractually required.

1. **Authority**
2. The Marjory Stoneman Douglas High School Public Safety Act, Ch. 2018-3, Laws of Florida, created a statewide network of MRTs. The Florida Legislature appropriated recurring funds to ensure reasonable access to MRT services in all Florida counties. In 2020, s. 394.495, F.S., to include MRTs in the child and adolescent array of services and outlined programmatic requirements included herein.
3. Contract KH225 between Department of Children and Families and South Florida Behavioral Health Network d/b/a Thriving Mind South Florida.
4. Thriving Mind South Florida Mobile Response Team Requirements described in this Appendix B.

**B.** **Minimum Staffing Requirements**

Mobile Response Team (MRT) services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Most MRT programs utilize teams that include both professional and paraprofessional staff. Below is the minimum pattern for staffing the Mobile Response Team required by Thriving Mind. It is expected that there is a minimum of at least one of these positions at each individual MRT Team offering services in the four (4) quadrants of the county (North, South, East, and West). Thriving Mind will allow for negotiation with the MRT Provider to go beyond the minimum staffing pattern indicated below for this program, including the scheduling of staff and whether each staff member works from an office setting or remotely during their scheduled hours. At minimum there must be a Licensed Mental Health Clinician and a Certified Peer Specialist staffed on each team and there must be 24/7 access to a Board-certified or Board-eligible Psychiatrist or Nurse Practitioner.

1. ***Board-certified or Board-eligible Psychiatrist or Psychiatric Nurse Practitioner (1.0 FTE*** ***for all four teams)***

The MRT Team must have access to a Board-certified or Board-eligible Psychiatrist or Psychiatric Nurse Practitioner. These positions may be subcontracted and must be On-Call and able to be reached 24/7.

1. ***Program Manager-(1.0 FTE for all four teams)***

Minimum Qualifications: Master’s degree in Psychology, Social Work, or related Human Services field. Minimum of two (2) years of related administrative experience in a behavioral health setting. Minimum two (2) years of experience in a supervisory role.

Role and Function: Directs day-to-day clinical operations of the Mobile Response Teams within a geographic region. Conducts supervision, monthly reporting, outreach, completed qualitative audits of clinical record documents, and scheduling.

1. ***MRT Administrative Assistant (1.0 FTE for all four teams)***

Minimum Qualifications: Must have at minimum Associates Degree in Arts/Science or have at minimum two (2) years of administrative experience, particularly in mental health or related field. Must completed the required trainings listed in Section. L, Trainings.

Role and Function: Assist the Program Manager with administrative tasks including maintaining clinical records, completing quantitative audits of files, scheduling meetings, and submitting monthly reporting.

1. ***Licensed Mental Health Clinician- (3.0 FTE minimum or more per team or 2.0 per team each with 12 hour shifts)***

Minimum Qualifications: Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage/Family Therapist. Minimum of two (2) years of experience of in behavioral health crisis services.

Bilingual: English/Spanish, English/Creole

Role and Function: Responds to calls 24/7, meeting the individual in-person, conducts risk assessments, and completes safety planning over dedicated crisis phone line, and provides therapy and counseling to individuals, couples, and families at the time of the crisis. Complete required Assessments/Evaluations and Baker Acts when appropriate. May be required to transport individuals to designated receiving facilities under a voluntary or involuntary status when deemed safe to transport, if the individual does not have other transportation options available, and agrees to be transported by the MRT.

1. ***Certified Peer Specialist-(1.0 FTE per team)***

Minimum Qualifications: Have a high school diploma or general equivalency diploma. Minimum two (2) year demonstrated recovery time from a significant mental health and/or substance use disorder at the date of application. Be at least 18 years of age. Within the last year have either maintained at least 12 months of successful work or volunteer experience.

Training and Certification: Be Certified recovery peer specialists or certified recovery support specialists who are certified by the Florida Certification Board. Recovery support specialists and recovery peer specialists are allowed one year from the date of their employment to obtain certification through the Florida Certification Board.

Role and Function: Serves as a positive role-model to individuals and their families, sharing experiential knowledge and skills. The Peer Specialist must have experience and training in Crisis Intervention and be able to work with individuals experiencing crisis. Peer Specialists may be part of the in-person response team during the initial crisis event. Peer Specialists also provide follow-up services, as needed.

1. ***Master’s Level Dispatcher-* *(1.0 FTE per shift with 24/7, 365 day coverage)***

Minimum Qualifications: Master’s Level Social Worker, Master’s Level Mental Health Counselor, Minimum of two (2) years of experience of in behavioral health crisis services.

Bilingual: English/Spanish or English/Creole

Role and Function: The Master’s Level Dispatcher triage the call to the correct team depending on location and availability.  The dispatcher is trained to receive crisis calls and provide crisis intervention services. Dispatchers conduct initial screenings and determine if an in-person assessment is required by a Licensed Clinician. Screenings that meet the criteria will be forwarded by the Dispatcher to the licensed clinicians. Callers who need follow-up will be contacted by the Dispatcher when not answering initial calls.

1. ***Behavioral Health Technician -* *(3.0 FTE minimum or more per team or 2.0 per team each with 12-hour shifts)***

Minimum Qualifications: High School Diploma or GED. Minimum of one (1) to three (3) years of experience of in behavioral health crisis services. Registered Behavioral Technician Certification strongly preferred. They must receive trainings in Mental Health First Aide, de-escalation, cultural sensitivity, and any appropriate trainings that would benefit interactions with individuals served by the MRT.

Role and Function:

Behavioral Health Technicians operate as backup to the Licensed Mental Health Clinician that goes out to an in-person MRT crisis call. The Behavioral Health Technician transports individuals to designated receiving facilities under a voluntary or involuntary status, if deemed safe to transport, if the individual does not have other transportation options available and agrees to be transported by the MRT.

**C. Triage/Screening**

As most Mobile Response Teams are initiated via phone call to a hotline or provider, the initial step in providing Mobile Response Team services is to determine the level of risk faced by the individual in crisis and assess the most appropriate response to meet the need. In discussing the situation with the caller, the Master’s Level Dispatcher must decide if other first responders, such as law enforcement or emergency medical services, should be involved while understanding that this is not the preferred approach and one that should only be used when alternative behavioral health responders are not available, or the nature of the crisis indicates that EMS or police are most appropriate. For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm to self or others, the Mobile Response Team must determine if a coordinated response with law enforcement is appropriate. If it is determined that a coordinated response is appropriate, the Mobile Response Team in coordination with law enforcement will report at the site of the crisis and work together to resolve the situation.

Explicit attention to screening for suicidality must be part of the triage. The Licensed Mental Health Clinician will use the suicide risk assessment instrument adopted by the district school board pursuant to s. 1006.07(11), F.S., and approved by the Department of Education pursuant to s. 1012.583, F.S.

***211, 988, and 911 Calls***

Calls directly referred by 211, 988, or 911 to MRT if determined by the referral source to require MRT intervention, will receive direct MRT face-to-face assessments (e.g. level 1). Exceptions to direct face-to-face assessments would be expected to be infrequent.

Exceptions might include:

1. person-approved telehealth crisis intervention plus a next-day in person visit by MRT (e.g., level 2), or
2. person-approved telehealth assessment and a referral. The timeframe and follow-up model are to be proposed by the MRT Provider; e.g., level x,y,z.

Telehealth may not be utilized for calls for calls referred by 211, 988, or 911 unless defined exception conditions are met.

Thriving Mind requires the MRT Provider to have a separate dedicated line and referral protocols for 211, 988, 911, and other emergency/first responder calls.

The MRT Provider shall have a separate dedicated line for the community to call for MRT services. This number shall be advertised to the community and the number must be on the MRT Provider’s start page of its public-facing website.

**E. Assessments and Screenings**

1. Screenings

The Master’s Level Dispatcher will conduct the initial screening process once contact is made by the caller. All calls must have a screening completed on the individual being served and must be maintained by the MRT and accessible to Thriving Mind upon request. The Dispatcher may not have to do a screening if referred directly from 211/988 and must forward the call immediately to the Licensed Mental Health Clinician.

The screening should encompass the following:

1. Name and last name of the individual needing services
2. Reason for the call; is the person
3. Contact information for of the individual calling (if caller is not the individual needing services, contact information for the person experiencing crisis)
4. Is the person experiencing thoughts of self-harm or harm to others

1. Assessments

The Licensed Mental Health Clinician on the Mobile Response Team is responsible for completing an assessment. Assessments must be done for all in-person responses. All referred calls forwarded by the Dispatcher to the Licensed Clinician must have an assessment completed on the individual being served and must be maintained by the MRT and accessible to Thriving Mind upon request. Specifically, the Licensed Clinician should address:

* 1. Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, and legal factors; safety and risk for the individual and others involved; including an explicit assessment of suicide risk;
	2. Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports; a Crisis or Safety plan will be developed to assist the family and individual remain safe.
	3. Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
	4. Medications prescribed as well as information on the individual’s compliance with the medication regimen; and
	5. Medical history as it may relate to the crisis.

The Licensed Clinician must use the same suicide risk assessment instrument adopted by the district school board pursuant to s. 1006.07(11), F.S., and approved by the Department of Education pursuant to s. 1012.583, F.S. (As required in **Appendix A, Guidance Document 34**)

*Approved instruments are available at:* [*https://www.fldoe.org/schools/k-12-public-schools/sss/suicide-prevent.stml*](https://www.fldoe.org/schools/k-12-public-schools/sss/suicide-prevent.stml)

**F. De-Escalation and Resolution**

Mobile Response Teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary. The Dispatcher will make every effort to de-escalate or resolve the situation prior to referring the call to the Licensed Mental Health Clinician.

**G. Peer Support**

For Mobile Response Teams, Peers should not duplicate the role of Licensed Clinicians but instead should establish rapport, share experiences, and strengthen engagement with the individual experiencing crisis. They may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support. Peers should be certified or working towards certification but must be certified within one year of hire. Peer Specialists will engage with the caller during or after the initial crisis call based on necessity.

**H. Coordination with Medical and Behavioral Health Services**

MRTs, as part of an integrated crisis system of care, must focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services include but not limited to, crisis stabilization or acute inpatient hospitalization, substance abuse detoxification, and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, and therapeutic mentoring).

**I. Crisis Planning and Follow-Up**

An adequate crisis response requires measures that address the person’s unmet needs, both through individualized planning and by promoting systemic improvements. During a crisis intervention, the Licensed Clinician and other relevant MRT professional should engage the individual in a crisis planning process, resulting in the creation or update of a range of planning tools, including a safety plan. When agreed to with the caller, follow-up with individuals served will occur to assess the caller’s safety, determine if the services to which they were referred were provided in a timely manner and are meeting their needs. If necessary, the MRT will help facilitate the scheduling of in-person or telehealth appointment with a behavioral health provider. Follow-up services/activities is typically completed through telephonic outreach but there may be times when further face-to-face, in-person engagement may be warranted or even necessary when the individual cannot be reached by phone. The initial follow-up should occur within 24 – 72 hours or sooner of the initial interaction/contact, as determined by the MRT. Follow-up for individuals hospitalized for behavioral health reasons should occur within 7 days of discharge and again within 30 days of discharge.

The team must offer and provide short-term follow-up services if agreed to by the caller or the person experiencing the crisis. When requested, the MRT acts as a liaison and will link the caller, person experiencing the crisis, and/or family to community services.

**J. Licensed Mental Health Clinicians**

It is imperative that Licensed Mental Health Clinicians provide first contact for callers as it allows for initial understanding of the level of crisis. Licensed Mental Health Clinicians will take calls and complete the assessments as follows in **Section E. Screenings and Assessments** in this document. The Licensed Mental Health Clinician will also assess callers for potential Baker Act, if necessary.

**K. Reporting Requirements and Continuous Quality Improvement**

The MRT Provider will be required to submit several reports to the Thriving Mind as follows:

1. All reports required in Guidance 34, Mobile Response Team.
2. Data Report Template and instructions found in **Appendix C, Thriving Mind Mobile Response Team Data Report**.
3. Quarterly Outreach and Community Education Activities Log to Thriving Mind on a quarterly basis that documents the following information:
4. Name of the staff
5. Target/Intended audience (i.e., community behavioral health providers, schools, private sector providers, etc.)
6. Type of Activity (Event, Training, Community Fair, etc.)
7. Date of Activity
8. Location of Activity
9. Number of Attendees

Copies of the following documents must be maintained and available upon request from Thriving Mind:

1. Any social media posts about the presentation, if applicable
2. Attendance Sheets
3. Agendas or Handouts
4. PowerPoint Presentation(s)
5. Monthly/Quarterly Vacancy and Engagement Report

To ensure that MRT is actively working to obtain and maintain qualified staff, the MRT must submit a monthly Vacancy and Engagement Report until the MRT Teams are fully staffed. Once fully staffed, the MRT Provider will submit this report on a quarterly basis. Should the MRT Provider experience an increase in staff shortages, the reporting will revert to monthly submissions. This report must include a listing of all vacant positions, the date they became vacant, the date of expected hire, and any engagement efforts that have taken place to hire staff for the vacant role (tabling at job/recruitment fairs, utilization of job seeking websites, etc.).

1. Thriving Mind, at its discretion, may request additional reporting requirements in a specified alternate data system or manual reports. Thriving Mind may request call information from specific referrals such as those provided by 211 or 988. With a regional suicide prevention plan taking effect, data from the MRT will be crucial and Thriving Mind will request data on suicide related calls. The MRT is expected to engage in ongoing dialog with community affiliates (**see Section M. Collaboration for a list of affiliates**) to support continuous quality improvement and collaborative problem-solving. This may include quarterly meetings with aggregate data sharing as a part of their ongoing operations.

**L. Trainings**

1. Thriving Mind requires any and/or all the trainings listed below to be completed by MRT Staff prior to engaging individuals on MRT calls:
2. Mental Health First Aid (*Required*)
3. Motivational Interviewing (Required)
4. Gatekeeper suicide prevention training, such as Applied Suicide Intervention Skills (Required)
5. (ASIST) or Question, Persuade, Refer (QPR) (Required)
6. Crisis Intervention for Encounters with Mental Health Crises SAMHSA’s Practice
7. Guidelines: Core Elements for Responding to Mental Health Crises at (<https://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf>) (*Required*)
8. Critical Incident Debriefing (Required)
9. Grief recovery/counseling (Required)
10. HIPAA Confidentiality Training (Required)
11. Deaf and Hard-of-Hearing Training (Required)
12. Recovery Management (Required once available by DCF for ROSC)
13. Integrative Harm Reduction Therapy(Required)
14. Crisis Specialist Training and Certification (Required)
15. De-escalation Training (Required)
16. Optional training to consider but not required:
17. SafeTALK
18. Domestic Violence Training
19. Safety Assessment site
20. Simulation trainings
21. QI monitoring instrument
22. Lifeline training modules
23. NRC tools
24. Alliance of Information and Referral System (AIRS) Standards and the Network
25. Diversity, Equity, and Inclusion trainings

Optional Trainings may be negotiated with the Thriving Mind System of Care Department.

1. Training and Professional Development and Continuous Quality Improvement

The MRT Provider will evaluate the effectiveness of its training program and the performance of staff, making necessary adjustments to ensure staff are appropriately trained in crisis intervention, as well as having the appropriate skills on how to refer individuals to service and conduct triage effectively. This evaluation must occur on a quarterly basis and be documented in its Continuous Quality Improvement (CQI) process. Thriving Mind may request documentation of these evaluations, trainings, and other relevant information, which must be provided upon request by the MRT Provider.

**M. Collaboration**

The Network Provider must collaborate with various community entities including Jewish Community Services 211, National Suicide Prevention Lifeline center provider (988), Law Enforcement, Schools, Community Centers, Assisted Living Setting, Independent Living Facilities, Hotels/Motels, Shelters, and receiving agencies, substance abuse detoxification agencies, and Homeless Continuum of Care.

There should be consistent engagement with community agencies, government entities, first responders, providers, and businesses in order to provide outreach and linkage for potential users of the system. Outreach and Community Education Activities can be held at these locations. Thriving Mind, at its sole discretion, may ask the MRT Provider, and the MRT Provider will agree, to conduct outreach and community education activities that benefit and are in the best interest of the community.Thriving Mind may require cross-work between Miami Dade and the Monroe County MRT.

As required by the Department of Children and Families **Appendix A, Guidance Document 34, Mobile Response Team**, MRT Providers must maintain formal Memorandum of Understandings (MOUs) or agreements with the Miami-Dade County School District and with the 211/988 Provider. These must be submitted annually to Thriving Mind. The MRT Provider must establish response protocols with local law enforcement agencies, 9-1-1 dispatch, 211 call centers, suicide prevention lifeline member centers (988) local community-based care lead agencies, child protective investigators, the Department of Juvenile Justice, and local schools, including public K-12 schools, colleges, and universities.

MRT Teams must be able to work in collaboration with one another throughout the county, even if the Miami-Dade County quadrants (North, South, East, and West). Should one Team be responding to another call and unavailable to responding to a second call, another team must be able to take the call and provide face-to-face contact to the individual served within 60 minutes of the initial call.

**N. Promotion and Community Education**

The promotion of the services provided by the MRT is an important component of effectively increasing community access to MRT services. The following are elements of a successful marketing and communication plan:

1. Collaborating with other key stakeholders such as first responders, schools, shelters, and the ME for appropriate and community-centered marketing.
2. Distribution of materials based on the collaboratively developed marketing and communication plan;
3. Evaluation of educational and promotional material for targeted populations and most effective means of distributing materials;
4. Key metrics that can be used to assess the impact of the social marketing strategies/campaigns along with an evaluation plan to determine the effectiveness of the social marketing strategies/campaigns;
5. Assessment of effectiveness of the plan and adjustment of the approach as needed

Thriving Mind requires that all promotional materials created by the Network Provider on MRT services be submitted within thirty (30) calendar days prior to publication and receive written approval from Thriving Mind, and/or the Department of Children and Families Substance Abuse and Mental Health Office. At minimum, Thriving Mind requires that all flyers or ads be made available in English, Spanish, and Creole.

**O. Technology and Communication**

1. Mobile Response Teams must aim to include technology that allows for improved delivery of services including but not limited to:
* GPS-enabled mobile team dispatch
* Capability to coordinate telehealth services
* Access to an online communication mechanism or texting options
* Ability for calls to be forwarded to the next available MRT member answering calls when the Dispatcher is unavailable
* Ability for three-way calls to connect crisis calls to a language interpreter

Application of HIPAA compliant telehealth services must align with local regulations and should continue to involve other members of the MRT in face-to-face support as these advanced technologies are incorporated in crisis care practices.

1. Online Chat and Texting Options

It is encouraged that online chat options and texting options be utilized by the MRT Provider to receive communications from individuals in need. This will allow individuals who are in dangerous situations to communicate with the MRT Team in a safe way if they are unable to communicate their crisis telephonically.

1. Americans with Disabilities Act (ADA) and Preferred Language

MRT Teams must provide Auxiliary Aids and Services for the Deaf and Hard-of-Hearing and will make available the appropriate auxiliary aids and services at no cost to deaf or hard-of-hearing clients and companions. Additional ADA requirements may be found in the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. 12131, as implemented by 28 C.F.R. Part 35, and the Children and Families Operating Procedure (CFOP) 60-10, Chapter 4 entitled “Auxiliary Aids and Services for the Deaf and Hard-of-Hearing”.

Teams should be able to find means of communicating to callers in their preferred language, regardless of if the team member is fluent or not in the caller’s preferred language. Staff should communicate clearly regarding all options and offer services in the individual’s preferred language whenever possible. Interpreter services should be available for translation of all calls for non-English speaking individuals.

**P. Call Patterns**

The MRT must have standard protocols in place for answering phone calls and receiving training on how to respond to individuals experiencing crisis. Thriving Mind requires, at a minimum, the following Call Patterns:

1. Upon receiving a call, MRT staff must identify themselves and indicate that the individual is calling the MRT Phoneline. Once a call is received by the Dispatcher or MRT Staff answering the phone, they must provide a screening referenced in **Section. E, Screenings and Assessments of Appendix B**.
2. Screenings that meet criteria must be forwarded to the Licensed Mental Health Clinician (LMHC). If not forwarded, the Dispatcher must document why the call did not meet the criteria to be forwarded. It is the expectation that the Dispatcher will try to diffuse the situation before sending the LMHC. Calls must be forwarded to LMHC if the individual is a high risk. High risk calls can include but are not limited to individuals experiencing mental distress, behavioral outbursts, mental decompensation, experiencing or re-experiencing trauma. Calls involving children, whether as the individual being served or child of the caller, must be prioritized.
3. Dispatchers must offer a follow-up callto the caller, regardless of presence or level of suicidality/risk. The only exception is if the caller is abusive. The MRT must document why a follow-up was not offered when this occurs. Depending on the risk of the caller, the Dispatcher can decide if a high risk (experiencing mental distress, behavioral outbursts, mental decompensation, experiencing or re-experiencing trauma) or standard follow-up is needed. Follow-up should also be offered to the individual who called seeking services for the person in crisis, i.e. friend/family, teacher, physical health provider, etc.
4. Calls from 211, 988, 911 and other first responders must be forwarded directly to the Licensed Mental Health Clinician.
5. Licensed Mental Health Clinician must provide in-person responses to calls meeting the clinical threshold within 60 minutes. While in-person responses may be provided via telehealth (video conferencing), teams are expected to respond to the location where the crisis is occurring when determined safe. Telecommunication cannot be utilized to complete an assessment. MRT Providers must document in the **Thriving Mind Mobile Response Team Data Report** the reason why they did not engage with the caller in-person and utilized telehealth instead.
6. LMHC must complete an assessment for all calls that have been referred by the Dispatcher.
7. For calls other than referred to by 211, 988, or 911, the MRT LMHC may only utilize non-face-to-face communication (telehealth) under the following circumstances:
* **The caller poses a danger or threat to staff**.
* **All Licensed Mental Health Clinicians on all four (4) teams are currently serving other individuals**.
* **An emergency event has affected the LMHC from meeting the individual in the community within the 60-minute time frame.** All emergency events must be documented and reported to Thriving Mind within 24 hours of occurring. Thriving Mind may request documentation proving that such incidents took place (i.e. accident report, insurance claim).

**\*All of these circumstances would be expected to be infrequent.**

1. Should a call drop or the caller hang-up, the Dispatcher or LMHC must attempt to call back the individual and document the time and date of the call if unable to reach the caller. There must be, at a minimum, three (3) attempts for callback via by telephone or an in-person attempt if an address is provided. Though a call may not meet criteria for voluntary hospitalization or Baker Act, the LMHC must make an attempt to provide face-to-face in person calls if considered a high risk.
2. If the caller declines MRT services, MRT staff must provide options for community services from the **Resource Behavioral Health** **Directory** and document where they were referred.
3. If the crisis is resolved prior to MRT arrival, MRT must document the resolution of the crisis in the **Thriving Mind Mobile Response Team Data Report**.

**Q. Protocols to Address High Utilizers**

The MRT Team must work with Thriving Mind’s System of Care Department to develop protocols for High Utilizers of MRT services within the first month of contracting. The protocols must be approved by the Thriving Mind System of Care Department within sixty (60) days of contract execution.

**R. Resource Behavioral Health Directory**

The MRT provider shall develop and maintain an updated resource directory to include all Thriving Mind Network Providers under contract. This resource directory must be updated, at a minimum, annually, to provide appropriate referrals to individuals. Information on Network Providers can be found on the Thriving Mind Website: <https://thrivingmind.org/providers>

The directory must have at minimum:

* Name of Provider
* Phone
* Address
* Contact Person
* Contact Email
* Services Provided
* Locations Where Services are Provided