

National Guidelines for Behavioral Health Crisis Care

National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit

Knowledge Informing Transformation

Introduction

Like a physical health crisis, a mental health crisis can be devastating for individuals, families and communities. While an individual crisis cannot be fully predicted, we can plan how we structure services and organize approaches to best meet the needs of those individuals who experience a mental health crisis. Too often that experience is met with delay, detainment and even denial of service in a manner that creates undue burden on the person, law enforcement, emergency departments and justice systems.

Given the ever-expanding inclusion of the term “crisis” by entities describing service offerings that do not truly function as no-wrong-door safety net services, we must start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime**. Examples of crisis level safety net services seen in communities around the country include (1) 911 accepting all calls and dispatching support based on the assessed need of the caller, (2) law enforcement, fire or ambulance personnel dispatched to wherever the need is in the community *and* (3) hospital emergency departments serving everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**.

Similarly, crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**.

With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the “crisis system” has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and suicide.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This toolkit will delineate how to estimate the crisis system resource needs of a community, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care and the community-changing impact that can be seen when services are delivered in a manner that aligns with this *Best Practice Toolkit*. Readers will also learn how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices.

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Perhaps the most potent element of all, in an effective crisis service system, is relationships. To be human. To be compassionate. We know from experience that immediate access to help, hope and healing saves lives.

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Overview

Crisis mental health care in the United States is inconsistent and inadequate when it falls short of aligning with the best practice. This is tragic in that good crisis care is widely recognized as:

1. An effective strategy for suicide prevention;
2. An approach that better aligns care to the unique needs of the individual;
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis;
4. A key element to reduce psychiatric hospital bed overuse;
5. An essential resource to eliminate psychiatric boarding in emergency departments;
6. A viable solution to the drains on law enforcement resources in the community; *and*
7. Crucial to reducing the fragmentation of mental health care.

Short-term, inadequate crisis care is shortsighted. Imagine establishing emergency services in a town by purchasing a 40-year-old fire engine and turning the town's old service shop into the fire station. It will work until there is a crisis. True no-wrong-door crisis care is needed and anything short of full implementation will fall short of meeting the needs of the community.

Our country's approach to crisis mental health care must be transformed. Addressing crisis is the most basic element of mental health care because it immediately and unconditionally accepts everyone seeking care. It represents real-time access to services that align with the needs of the person when the person needs it most. In many states and communities, crisis care is nonexistent, limited or simply an afterthought viewed as an additional expense that was not included in the local budget. We cannot afford to pay the exorbitant price of not offering crisis care; including:

- The human cost of emotional pain of families struggling to access care;
- The opportunity cost of lost community contribution as mental illness represents our nation's largest source of disability;
- The costs of law enforcement and the justice system teams dedicating a disproportionate amount of resources to address issues that result from a person's untreated crisis; *and*
- The ever-escalating cost of inpatient healthcare for individuals who are unable to access needed community-based services in a timely manner.

In many communities, the current crisis services model depends primarily upon after-hours work by on-call therapists or in space set aside within a crowded emergency department (ED). These limited and fragmented approaches are akin to plugging a hole in a dike with a finger.

This toolkit is designed to bridge the unacceptable gap that currently exists in our continuum of care by solidifying national best practice guidelines that reflects SAMHSA's view of the standard of care we must expect in our communities. Core elements of a crisis system must include:

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; *and*
4. Essential crisis care principles and practices.

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These elements are discussed in more detail later in this toolkit. Effective crisis care that saves lives and dollars requires a systemic approach, and these key elements must be in place. In this report, we will review the proven key components of good crisis care and demonstrate that piecemeal solutions are unacceptable.

Many communities across the United States have limited or no access to true “no wrong door” crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. The available alternatives represent systemic failures in responding to those in need; including incarceration for misdemeanor offences or drop-off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis. Unacceptable outcomes of this healthcare gap are (1) high rates of incarceration for individuals with mental health challenges, (2) crowding of emergency departments that experience lost opportunity costs with their beds and (3) higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person’s needs are not available. For many others in crisis, individuals simply fail to get the care they need; contributing to mental illness’s designation as the most prevalent disability in the United States and one of the greatest causes of lost economic opportunity in communities throughout the nation.

The purpose of this publication is to establish a solitary set of national guidelines for crisis care and offer a toolkit that supports program design, development, implementation and continuous quality improvement in systems of care throughout the nation.

Core Services and Best Practices

In this section, we define essential elements of effective, modern, and comprehensive crisis care along with the actions needed to bring those services to communities across the United States. The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

1. **Regional Crisis Call Center:** Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control (ATC) - quality coordination of crisis care in real-time;
2. **Crisis Mobile Team Response:** Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*
3. **Crisis Receiving and Stabilization Facilities:** Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Although there are many other services that will be incorporated into the continuum of a comprehensive system of care, these three programmatic components represent the three true crisis service elements when delivered to the fidelity of the *Crisis Service Best Practice* guidelines defined in this toolkit. However, crisis systems must not operate in isolation; instead striving to fully incorporate within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed need of the individual.

A good way of looking at crisis system flow is to examine on the stratification of assessed need of individuals in crisis. The Level of Care Utilization System (LOCUS) is a tool designed to assess level of care needs of individuals experiencing psychiatric and addiction challenges for over a decade with broad utilization in many states around the country. Developed by the American Association of Community Psychiatrists, LOCUS provides a single easy-to-use instrument that can be used in a multitude of settings to clarify an individual's needs and identify services appropriate to address those needs.

An analysis of over a decade of Level of Care Utilization System (LOCUS) data in Georgia from individuals who were engaged by a face-to-face crisis response service by facility-based or mobile team providers was recently completed; offering insight into what service types would best align with the needs of a community in a fully efficient crisis and acute care system. The statewide crisis line data set used in the analysis included a total of 1.2 million records, 431,690 of which met the criteria described above. This review resulted in the following breakdown that can be used to inform optimal initial referral paths within a system of care that includes a continuum of crisis services:

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- 14% (59,269 of 431,690) LOCUS Level 6 – Direct Referral to Acute Hospital;
- 54% (234,170 of 431,690) LOCUS Level 5 – Referral to Crisis Receiving and Stabilization Facility; *and*
- 32% (138,251 of 431,690) LOCUS Levels 4-1 – Evaluation by Crisis Mobile Team with Referral to Care as Needed.

Crisis mobile teams are projected to serve a broader range of individuals in less acute crisis situations. A survey of higher-performing mobile crisis teams shows that approximately 70% of those engagements result in community stabilization. The remaining 30% should be connected to facility-based care that aligns with their assessed needs; including referrals, when indicated, to crisis receiving and stabilization facilities, respite or residential treatment programs. Crisis service providers should be prepared to support all individuals seeking their care and then connect them to care in a manner that truly aligns with the needs of the person.

Crisis systems must work within the larger system of care to address the needs of community members. The true test of whether there is adequate capacity to meet the needs of the community is whether individuals are able to access needed services in a timely manner. Psychiatric boarding in emergency departments and an over-representation of people with mental health and substance use challenges within the justice systems would suggest insufficient capacity within that community; warranting further analysis of flow within that system.

The true test of whether there is adequate capacity to meet the needs of the community is by assessing whether individuals are able to access needed services in a timely manner.

In addition to the essential structural or programmatic elements of a crisis system, we have established a list of the following essential qualities that must be “baked into” comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. “Suicide safer” care;
3. Safety and security for staff and those in crisis; *and*
4. Law enforcement and emergency medical services collaboration.

The subsections of this *Core Services and Guidelines for Care* chapter that follow contain the information the user of this Toolkit will need to align service delivery with the *Crisis Service Best Practice* guidelines.

Core Elements of a Crisis System

The good news is that there are really only three core elements to a crisis system. Unfortunately, few communities have them and even fewer have them operating in a manner consistent with the *Crisis Services Best Practice* guidelines defined in this Toolkit. The three-core structural or programmatic elements of a crisis system defined in this section are:

- (1) Regional Crisis Call Center,
- (2) Crisis Mobile Team Response *and*
- (3) Crisis Receiving and Stabilization Facilities.

Regional Crisis Call Hub Services – *Someone To Talk To*

Regional crisis call services offer real-time access to a live person every moment of every day for individuals in crisis. Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational guidelines regarding suicide risk assessment and engagement and offer air traffic control (ATC) quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Analogous to a 911 call for most emergencies, mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

At the time of this publication, Congress is considering a national 988 behavioral health crisis number to serve as a dedicated crisis call center line in a manner that generates better access to care through a more broadly recognized and remembered number than the local options that exist at this time.

Minimum Expectations to Operate a Regional Crisis Call Service

Regional, 24/7, clinically staffed call hub/crisis call centers must:

1. Operate every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
5. Coordinate connections to crisis mobile team services in the region; *and*
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.

Best Practices to Operate Regional Crisis Call Center

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Incorporate Caller ID functioning;
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

Implementation of the *National Suicide Lifeline Policy for Helping Callers at Imminent Risk of Suicide* is an expectation as these regional crisis line providers partner in Zero Suicide efforts around the country. **Direct crisis center staff are expected to:**

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1. Practice **active engagement** with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;
2. Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;
3. Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;
4. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
5. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
6. Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; and
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

Regional Crisis Call Center Technology

The incorporation of advanced technologies is essential to efficiently operating a regional crisis call center hub. We see the nation's air traffic control system (ATC) as one we can learn from as we work towards seamless connections to care in a mental health and substance use crisis system.

Air Traffic Control (ATC) Capabilities with Crisis Line Expertise

Virginia State Senator Creigh Deeds was stabbed by his son, Gus, who then took his own life by suicide. Shortly before this horrific outcome, Gus had been assessed at a local hospital and a magistrate had ordered an involuntary commitment. However, no beds were available at any nearby inpatient psychiatric hospitals so Gus was sent home. Sadly, it is far too common for individuals in mental health crisis to receive an initial assessment but then "fall through the cracks" due to a failure to make a connection to care that aligns with the unique needs of the individual. The cracks occur because of interminable delays in access to services based on an absence of:

1. Real-time coordination of crisis and outgoing services; *and*
2. Linked, flexible services specific to crisis response, namely mobile crisis teams and crisis stabilization facilities.

Because of these gaps, individuals walk out of a hospital emergency department (ED), often "against medical advice," and disappear until the next crisis occurs.

The nation's approach to crisis call centers received a significant upgrade starting in 2004 with creation of the National Suicide Prevention Lifeline (NSPL). Over time, the NSPL has demonstrated its effectiveness and raised the performance bar for crisis call centers. Recent SAMHSA initiatives include efforts to solidify real-time bed registries that can be used to more

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efficiently connect individuals to care during their times of greatest need. Air traffic control (ATC) systems provide a primary example of how access to real-time data and consistent standards lead to remarkable efficiency in complex systems. Adopting an ATC model for crisis services can significantly reduce the incidence of tragic and unacceptable outcomes for individuals in crisis.

Learning from Air Traffic Control (ATC) Safety

Air Traffic Control (ATC) works to ensure the safety of nearly 30,000 U.S. commercial flights per day. In the United States, this occurs with a very high success rate; making air travel remarkably safe today. Unfortunately, we have been less successful at supporting individuals who are navigating a mental health crisis.

The advancements in ATC that have helped transform aviation safety are two vitally important objectives and, without them, it is nearly impossible to avoid tragedy:

- Objective #1: Always know where the aircraft is (in time and space) and never lose contact; *and*
- Objective #2: Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

These objectives easily translate to behavioral health and our evolving crisis systems of care. Always knowing where an individual in crisis is and verifying that the hand-off has occurred to the next service provider seem like relatively easy objectives to fulfill. However, they are missing from most U.S. behavioral health and crisis systems despite the existence of technology that is working in some regions. Individuals and families attempting to navigate the behavioral health system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that ATC provides.

The Air Traffic Control (ATC) Model for Crisis Services and Functional Targets

Air traffic control (ATC)-type technology is being applied by some crisis call center hubs in the country; offering real-time connection to GPS-enabled mobile teams, true system-wide access to available beds and outpatient appointment scheduling through the integrated crisis call center. These exceptional practice centers serve as a true hub for whole, integrated crisis system of care.

Status Disposition for Intensive Referrals

In an effective ATC-based model for crisis services, there must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels; including requirements for service approval and transport, shared protocols for medical clearance algorithms and data on speed of accessibility (average minutes until disposition). An effective program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. For example, some systems display names on a pending linkage status board that highlight names in green, white, yellow, or red to reflect how long an individual has been waiting for connection to care.

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24/7 Outpatient Scheduling

Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the region while providing data on speed of accessibility (average business days until appointment) by provider/program.

Crisis Bed Registry

An intensive services bed census is required; showing the availability of beds in crisis stabilization programs and 23-hour observation chairs, as well as beds in private psychiatric hospitals, with interactive two-way exchange (such as through an individual referral editor and inventory / through-put status board).

High-Tech, GPS-enabled Mobile Crisis Dispatch

Mobile crisis teams should use GPS-enabled tablets or smart phones to support quick and efficient call hub determination of the closest available teams, track response times, and ensure clinician safety (*e.g.*, time at site, real-time communication, safe driving, etc.).

Real-Time Performance Outcomes Dashboards

Effective crisis service models utilize outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency created through these reports provides an extra layer of urgency and accountability.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. Emergency medical services (EMS) should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services

Mobile crisis team services must:

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

Best Practices to Operate Mobile Crisis Team Services

To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's- or Bachelor's-level clinician may be paired with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians who are on-call as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

SAMHSA's 2014 *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* report stated:

The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional

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objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.

In summary, mobile crisis care:

1. Helps individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible;
2. Meets individuals in an environment where they are comfortable; *and*
3. Provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization.

The same report confirmed previous evidence on the effectiveness of mobile crisis service:

Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.

The cost-effectiveness of mobile crisis services is noted as well:

Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was \$1,520 for mobile crisis program services, which included \$455 for program costs and \$1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was \$1,963, which consisted of \$73 for police services and \$1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.

SAMHSA asserts that mobile crisis team care is one of three essential elements of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center. Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;

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- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Triage/Screening

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis 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 mobile crisis staff must decide if other first responders, such as police 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, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, legal factors and substance use;
- Safety and risk for the individual and others involved; including an explicit assessment of suicide risk;
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
- Medications prescribed as well as information on the individual's compliance with the medication regimen; *and*
- Medical history as it may relate to the crisis.

De-Escalation and Resolution

Community-based mobile crisis 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.

Peer Support

SAMHSA's 2009 report (p.8) asserts that mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers

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can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis” (see Significant Role for Peers in Section 4).

For community-based mobile crisis programs, incorporating peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs 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.

Coordination with Medical and Behavioral Health Services

Community-based mobile crisis programs, as part of an integrated crisis system of care, should 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 may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA’s essential elements of responding to mental health crisis include prevention. “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. *Hence, an adequate crisis response requires measures that address the person’s unmet needs, both through individualized planning and by promoting systemic improvements*” (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support 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 indicated, mobile crisis service providers should also follow up with individuals served to determine if the services to which they were referred were provided in a timely manner and are meeting their needs. This activity is typically completed through telephonic outreach but there may be times when further face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone.

Crisis Mobile Service Summary

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations.

Crisis Receiving and Stabilization Services – A Place to Go

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions (such as serious emotional disturbances, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. As we will discuss later in this toolkit, it is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements and not shift responsibility to the initial referral source (family, first responder or mobile team). Law enforcement is not expected to do the triage or assessment for the crisis system and it is important that those lines never become blurred.

One of the phrases we have seen applied to programs around the country is ***“Thank you. Can I have another?”*** in reference to law enforcement bringing individuals to the program.

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

Crisis receiving and stabilization services must:

1. Accept all referrals;
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
3. Design their services to address mental health and substance use crisis issues;
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed;
5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
 - a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
 - b. Nurses
 - c. Licensed and/or credentialed clinicians capable of completing assessments in the region; *and*
 - d. Peers with lived experience similar to the experience of the population served.
6. Offer walk-in and first responder drop-off options;
7. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders;

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8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
5. Coordinate connection to ongoing care.

Many individuals in crisis brought to hospital EDs for stabilization report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who have little experience with psychiatric crisis care. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals; an experience they did not have at the hospital. In such an alternative setting, psychiatric crises can be de-escalated.

In the 2014 *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* report, SAMHSA defined crisis stabilization as:

A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services." (p. 9).

Data suggests that a high proportion of people in crisis who are evaluated for hospitalization (LOCUS levels 5 and 6) can be safely cared for in a crisis facility and that the outcomes for these individuals are at least as good as hospital care while the cost of crisis care is substantially less than the costs of inpatient care and accompanying emergency department "medical clearance" charges.

The Role of the Psychiatrist/Psychiatric Nurse Practitioner

Psychiatrists and Psychiatric Nurse Practitioners serve as clinical leaders of the multi-disciplinary crisis team. Essential functions include ensuring clinical soundness of crisis services through evaluation of need, continued monitoring of care and crisis service discharge planning.

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The role of the psychiatrist/psychiatric nurse practitioner during the evaluation is to:

- Clarify diagnosis and information within any existing psychiatric advance directive (PAD);
- Evaluate and define a course of care for substance use, mental & physical health needs;
- Collaborate with the team to assess risk and level of care needs;
- Participate in establishing patient-centered treatment goals and plans with the team;
- Educate about medications and care options; *and*
- Partner with the team to engage with the person's support system.

The role of the psychiatrist/psychiatric nurse practitioner in continued treatment is to:

- Monitor patient-centered needs and risk while adjusting treatment as needed;
- Collaborate to support movement towards recovery goals in a patient-centered fashion;
- Participate in the delivery of family education as applicable;
- Educate, train and model best practice care to team members during treatment; *and*
- Provide overall clinical leadership and oversight of patient-centered care.

The role of the psychiatrist/psychiatric nurse practitioner during the discharge process is to:

- Collaborate with the team and those served to develop PAD and discharge plan;
- Prescribe medication to bridge until the person's follow-up appointment; *and*
- Support persons served with education about discharge medications and any follow-up needs or recommendations for monitoring side effects.

Additional Elements of a System of Care

As noted previously, essential crisis system elements are limited to (1) the crisis call center hub, (2) crisis mobile response and (3) crisis receiving and stabilization services. A multitude of other resources that support a comprehensive system of care exist; including facility-based resources such as short-term residential facilities and peer respite programs that offer step down options for individuals following a crisis episode.

Short-Term Residential Facilities

Small, home-like short-term residential facilities can be seen as a strong step-down option to support individuals who do not require inpatient care after their crisis episode. In many communities, these are called crisis residential facilities. SAMHSA cautions that these are not actual crisis facilities given the criteria that a crisis facility must accept all referrals. However, they are an important part of a continuum that can be used to address the needs of individuals experiencing LOCUS assessed needs of 4 and 5 in a cost-effective manner. As such, staffing for these programs is far less intensive than a crisis receiving and stabilization facility. Short-term crisis residential programs should minimally have a licensed and/or credentialed clinician on location for several hours each day and on-call for other hours.

To maximize their usefulness, short-term residential facilities should function as part of an integrated regional system of care. Access to these programs should be facilitated through the air traffic control (ATC)-capable call center hub of the region to maximize system efficiency. This approach also centralizes data regarding program occupancy, lengths of stay, percentage of

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referrals accepted and time to make decisions on referral acceptance; offer valuable data on how each participate in the system of care is supporting the needs of the community.

Peer-Operated Respite

Another model of short-term facility-based care is a peer-operated respite program. These programs do not typically incorporate licensed staff members on site although some may be involved to support assessments. They provide peer-staffed, restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. Peer-respite offers a low-cost, supportive step-down environment for individuals coming out of or working to avoid the occurrence of a crisis episode. Program activities should focus on issues that have contributed to the escalation in challenges facing the individual and/or their support system and the skills needed to succeed in the community.

Crisis System Coordination

Crisis services should not be viewed as stand-alone resources operating independent of the local community mental health and hospital systems but rather an integrated part of a coordinated continuum of care. Services needs and preferences of the individual served must be assessed to inform the interventions of the crisis provider and the connections to care that follow the crisis episode. This is not easily achieved given the complex dynamics that are in play in many communities throughout the country that have complex health ecosystems influencing the care delivery system. Given the understanding that pieces of a continuum of care will not typically align and partner fully without a purposeful intent, regular communication between crisis services, local hospital and outpatient service leaderships must be coordinated in a thoughtful manner that focuses on the needs of the community served.

Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch and outpatient appointment setting through the call center hub. A modification of the Milbank collaboration continuum may be used to assess the degree to which crisis systems are meeting the expectation of community coordination and collaboration (*shown in Table 2 below*).

Table 1 - Continuum to Evaluate Crisis Systems and Collaboration

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM →				
<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>	<i>Level 5</i>
MINIMAL	BASIC	BASIC	CLOSE	CLOSE
<i>Agency Relationships</i>	<i>Shared MOU Protocols</i>	<i>Formal Partnerships</i>	<i>Data Sharing (Not 24/7 or Real-Time)</i>	<i>“ATC Connectivity”</i>

In this model, the highest level of care requires shared protocols for coordination and care management that are supported in real time by electronic processes. For a crisis service system to provide Level 5 close and fully integrated care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update and monitor available resources in the network of provider agencies.

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Psychiatric Advance Directives

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PAD creates a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities and listings of visitors.

Essential Principles for Modern Crisis Care Systems

A crisis provider's approach to care must include the incorporation of a philosophy that removes barriers to accessing care. Regional 24/7 clinically staffed crisis call centers must be equipped to triage and provide telephonic support to any caller, mobile teams must go to wherever the person in need is at the time of their crisis and crisis stabilization centers must accept all referrals that walk through their door or are brought in by first responders. To execute on this bold approach to care, a crisis provider must be staffed to meet these expectations. First responders and other community partners must know that they are able to connect every individual to care in a timely manner. Approaches that result in the rejection of even a small percentage of referrals translate into questioning whether crisis is really a viable alternative to emergency department and jail options that do not reject referrals.

There are many other levels of care that contribute to a comprehensive system of care and most of those will implement some form of admission criteria that restricts who is admitted to the program. This is appropriate for a vast majority of non-crisis programs but cannot be part of a crisis provider's practice. Much like 911, fire, police and emergency departments, the expectation is that crisis programs will respond to emergent appeals for support; never responding with an unwillingness to engage in addressing the emergent issue.

Core Principles

Best practice crisis care incorporates a set of core principles throughout the entire crisis service delivery system; offering elements that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that are defined as essential for modern crisis systems. These essential principles and practices are:

1. Addressing Recovery Needs,
2. Significant Role for Peers,
3. Trauma-Informed Care,
4. *Zero Suicide*/Suicide Safer Care,
5. Safety/Security for Staff and People in Crisis *and*
6. Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services (EMS).

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Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day. At the 2019 International Initiative for Mental Health Leadership (IIMHL) Crisis Now Summit, consumer Misha Kessler ended his description of his direct experiences with crisis services, “Mental illness is [just] one part of my tapestry.”

Recovery is possible and should not be viewed within the narrow definition of an absence of symptoms. In fact, many individuals develop meaning and purpose in life despite the continuation of symptoms. The report of the President’s New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be “recovery-oriented” and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The significance of a recovery-oriented approach is elevated for individuals in crisis and, thus, for crisis settings. In an outmoded, traditional model, crises reflect “something wrong” with the individual. Risk is seen as something to be contained; often through involuntary commitment to an inpatient setting. In worst-case situations, this obsolete approach interacts with inadequate care alternatives; resulting in people restrained on emergency room gurneys or transferred to jails because of their behavior.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one’s own recovery and ability to respond effectively to future crises. A recovery-oriented approach to crisis care is integral to transforming a broken system. Not only must we expand crisis care, but we must forge a better approach to crisis care by ensuring implementation of fidelity to these best practice guidelines.

Implementation Guidance

1. *Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options and offer materials regarding the process in writing in the individual’s preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align actions to those preferences.*
5. *Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.*

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6. *Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.*

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible.

Including peers—especially people who have experienced suicidality and suicide attempts and have learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11% to 50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following ED referral (Kessler et al., 2005). Peers can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement while reducing distress.

The role of peers—specifically survivors of suicide attempts as well as survivors of suicide loss—was bolstered when the National Action Alliance’s Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience*, in July 2014. The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*
2. *Develop support and supervision that aligns with the needs of your program’s team members.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program’s service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. The adverse effects of childhood trauma may present well into adulthood; increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance abuse, and poor medical health (Finkelhor et al., 2005). Persons with history of

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trauma or trauma exposure are more likely to engage in self-harm and suicide attempts and their trauma experiences make them very sensitive to how care is provided.

Mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, we find that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA set the following guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; *and*
6. Ensuring cultural, historical and gender considerations inform the care provided.

These principles should inform treatment and recovery services. If such principles and their practice are evident in the experiences of staff as well as consumers, the program's culture is trauma-informed and will screen for trauma exposure in all clients served, as well as examine the impact of trauma on mental and physical well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility of further trauma or crisis.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57).

Trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis and the vulnerability of people in crisis; especially those with trauma histories.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care

Crisis intervention programs have *always* focused on suicide prevention. This stands in contrast to other health care and even mental health services, where suicide prevention was not always positioned as a core responsibility. Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2)

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commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: “Promote suicide prevention as a core component of health care services” (p. 51).

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that health care organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC). The following seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

See more at <http://zerosuicide.sprc.org/about>

It should be noted that the elements of Zero Suicide closely mirror the standards and guidelines of the National Suicide Prevention Lifeline (NSPL), which has established suicide risk assessment standards, guidelines for callers at imminent risk, and protocols for follow-up contact after the crisis encounter. Zero Suicide also promotes collaborative safety planning, reducing access to lethal means, and incorporating, into the service provided, the feedback of suicide loss and suicide attempt survivors.

Since comprehensive crisis intervention systems are the most urgently important clinical service for suicide prevention and most parts of the country do not have adequate crisis care, we find a national and state-level commitment to implementing comprehensive crisis services to be foundational to suicide prevention; leading to an expectation that best practices in suicide care be required by health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare).

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Implementation Guidance

1. *Incorporate suicide risk screening, assessment and planning into the new employee orientation for all team members.*
2. *Mandate completion of Applied Suicide Intervention Services Training (ASIST) or similar training by all team members serving individuals who receive crisis services.*
3. *Incorporate suicide risk screening, assessment and planning into the crisis provider's practices.*
4. *Automate the suicide risk screening, assessment and planning process, and associated escalation processes, within the electronic medical record of the crisis provider.*
5. *Commit to a goal of Zero Suicide as a state and as a crisis system of care.*

Safety/Security for Staff and People in Crisis

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised.

People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. The Department of Health and Human Services' (DHHS's) Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation and stabilization.

Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical

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Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of individuals under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers and peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to themselves or others (DHHS, 2006).

In some crisis facilities licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as punishment, an alternative to appropriate staffing of crisis programs, a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

Crisis providers must engage in person-centered planning and treatment while assessing risk for violence to collaboratively develop de-escalation and safety plans for individuals served by the program. Staff and individuals involved in those interventions should be debriefed after a seclusion/restraint event to inform policies, procedures, and practices; reducing the probability of future use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the mental health division of the state's Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals.

According to SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device;
- Mental health workers dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness on the client they are visiting.

Ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the *perception of safety* is also essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly “Job One” in all crisis settings.

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Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. As first responders, they are often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis.

Police officers are critical to mobile crisis services as well; either (1) providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995) when the need is assessed or (2) as a referral source delivering warm hand-offs to crisis mobile teams. Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves;
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns;
- Address many incidents informally by talking to the individuals with mental illness;
- Encounter a small subset of “repeat players”; *and*
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call often escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between mental health and law enforcement, found the alliance

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between first responders and mental health professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to mental health crisis included police-based specialized police response, police-based specialized mental health response, and mental health-based specialized mental health response. These forms of collaboration share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as “moderately effective” or “very effective” in addressing the needs of persons in crisis.

Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker *et al.*, 2008). Lord *et al.* (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and mental health programs that includes the availability of a crisis setting where police can drop off people experiencing a mental health crisis. CIT has been cited as a “Best Practice” model for law enforcement (Thompson & Borum, 2006). Crisis programs should engage in ongoing dialog with local law enforcement agencies to support continuous quality improvement and collaborative problem-solving. Top crisis systems report facilitating monthly meetings with aggregate data sharing as a part of their ongoing operations.

Strong partnerships between crisis care systems and law enforcement are essential for public safety, suicide prevention, connections to care justice system diversion and the elimination of psychiatric boarding in emergency departments. The absence of comprehensive crisis systems has been the major “front line” cause of the criminalization of mental illness and a root cause of shootings and other incidents that have left people with mental illness and officers dead. Collaboration is the key to reversing these unacceptable trends.

Implementation Guidance

1. *Have local crisis providers actively participate in CIT training or related mental health crisis management training sessions.*
2. *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
3. *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

Unique Challenges of Rural and Frontier Communities

Rural and frontier communities face unique workforce and geographic challenges that make it more difficult to deliver high quality crisis services that meet the needs of the region. System leaders should evaluate opportunities to leverage technology and existing program capacity to deliver care to maximize access to timely services. Approaches should include:

1. Learning how other first responder services like law enforcement, fire and emergency medical services operate in the area.
2. Leveraging existing first responder transportation systems to offer access to care in a manner that aligns with emergency medical services in the area.
3. Incorporating technology such as telehealth to offer greater access to limited licensed professional resources.
4. Developing crisis response teams with members who serve multiple roles in communities with limited demand for crisis care to advance round the clock support when called-upon.
5. Establishing rural reimbursement rates for services that support the development of adequate crisis care in the area.
6. Creating crisis service response time expectations that consider the geography of the region while still supporting timely access to care.

Residents of rural and frontier communities are at risk of experiencing mental health and substance use crisis. When this occurs, these individuals must have access to care that meets their needs in a timely manner much like their counterparts in urban communities. Limited resources may make this aspiration challenging. However, approaches are available to narrow the difference between these rural communities and those with higher population densities.

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Funding Crisis Care

Approaches to fund mental health and substance use crisis services vary widely from state to state. In many cases, funding is cobbled together, inconsistently supported and inadequate when not aligned with best practices. One of the greatest factors contributing to these funding challenges is the inconsistent expectations around crisis provider service delivery; allowing providers who staff and operate in very different ways to utilize the same crisis stabilization service coding.

Consider the nature of crisis care in systems with multiple payers. If a provider commits to fully align their practices to the *National Guidelines for Crisis Care* contained in this toolkit, then that provider is poorly positioned to negotiate reimbursement with each of those multiple funders in a region simply because the funder knows the provider will accept all referrals and serve them even if they do not reimburse in a manner that covers the cost of care. In these cases, it is often local jurisdictions who are paying part of the bill for legally or contractually responsible payer health plans that fall short in reimbursement. The solution is to create rate reimbursement structures that sustain delivery of services that align with best practice guidelines and secure capacity funding for community members who otherwise do not have insurance to cover critical care. This is not a new concept given the funding streams that exist in support of 911, fire, ambulance and emergency department services but it is one that must be extended for mental health and substance use crisis care for parity to be realized.

In a November 13, 2018 letter from the Centers for Medicare & Medicaid Services to State Medicaid Directors, a path to receive a waiver on the payment exclusion for Institutions of Mental Disease (IMD) was offered:

*“CMS will consider a state’s commitment to on-going maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state’s proposed demonstration project in order to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Furthermore, CMS strongly encourages states to include in their application a thorough assessment of current availability of mental health services throughout the state, **particularly crisis stabilization services.**”*

The letter clarifies that *“states may receive federal matching funds for Medicaid-coverable services provided to individuals residing in psychiatric hospitals and residential treatment settings that are not ordinarily matchable because these facilities qualify as IMDs”* under an approved demonstration project. This represents an opportunity leverage the additional federal funding in lieu of state payment for these IMD services; freeing up state funding to support local crisis care.

The Firehouse Model: Crisis Care Funding vs. Emergency Care Funding

It is revealing to compare mental health crisis care to other first responder systems like firefighting or emergency medical services (EMS). There are striking similarities:

- The service is essential and may be needed by anyone in the community;

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- The need for it is predictable over time but the timing of individual crises events is not; *and*
- Effective crisis response is lifesaving and much less expensive than the consequences of inadequate care.

One might measure the effectiveness of emergency medical services (EMS) in lives saved because of timely intervention for individuals with acute heart disease. For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief respite stays that might cost \$300 per day versus inpatient rates of \$1,000 per day. This approach better connects the individual to his or her community while minimizing disruption in the person's community connections.

It is also useful to think about the financing of core crisis services. It would be unthinkable for any community, except frontier or very small ones, to go without their own fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are simply made available. Sometimes users may pay a fee for service calls but the station and the equipment are available to anyone in need regardless of ability to pay. In most communities, mental health crisis services take a different approach or are not offered at all due to the lack of coverage or reimbursement for this level of care. Health coverage (e.g., Medicaid) will pay for professional fees as if services were delivered as part of a routine office visit but few entities pay for the infrastructure of a crisis system with rates that reflect the "firehouse model" expenses involved in being available for the next call or referral.

For those who have ever experienced a medical emergency and contacted 911 for help, they probably know how this plays out. Fire departments and/or an ambulance respond quickly to deliver emergent care. If they assess a need for further support, they may transport to the emergency department for care. What follows in the subsequent weeks, following care, is the delivery of bills or invoices for the ambulance care and transportation followed by any services received within the emergency department. These bills or invoices total thousands of dollars in most cases; expenses that represent the higher cost of offering emergent care that is accessible to **anyone, anywhere and anytime**. Unfortunately, crisis care reimbursement is often a fraction of that of its physical health counterparts and is, therefore, delivered in a model that falls short of best practice expectations or is simply not offered because there is no mechanism to adequately reimburse the cost of the level of care.

A Potential Solution

Funding crisis care through a firehouse model may be the best approach for some of these services while other viable options are also evolving with the implementation of parity. A leading solution to the crisis care funding puzzle is to model reimbursement after the physical health service counterparts already in place. Subsequent efforts to enforce parity laws in a manner that removes much of the burden on local communities by shifting the expense to the person's health insurance plan that, by law or contract, is actually responsible for covering this care will position crisis care to have sustainable funding streams in support of best practice care; leading to care that can truly lower health care costs while dramatically improving the experience of people in crisis and the health of communities through justice system and ED diversion.

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Multiple Payer Systems

The approach proposed supports reimbursement within multiple payer systems when responsible payers (health plans) each pay for services at rates that support operations. Therefore, it is recommended that states, counties or local jurisdictions establish rates for their communities that can be applied to all payers. Otherwise, local jurisdictions will be forced to cover the shortfall in funding from the legally or contractually responsible payers who offer lower reimbursement for care that is always made available to all community members. In essence, the lead of local government to establish reasonable reimbursement rates for best practice crisis services amongst all responsible payers offers a sustainable model that reduces the demand on communities to cover health care expenses that should be covered by an insurer; supporting the existing of the safety net service that is accessible in real-time when called-upon.

Regional 24/7 Crisis Call Center Hub

This service is really meant to serve entire regions in a manner similar to 911 call responses with SAMHSA delivering some funding to support this valuable resource currently. Although there is some ability to verify certain information identifying the caller, reimbursing for care using the Behavioral Health Hotline code, call center funding might be best served through a population-based funding stream that comes from an assessment on cell phone and/or land line utilization. This approach would more cleanly sustain nationwide funding for this safety net service and implementation of advanced air traffic control-type technology in all parts of the country.

Crisis Mobile Response Services

Crisis mobile response services are analogous to fire and ambulance responses for emergent physical health issues. As such, funding mechanisms should align so that adequate capacity can be in place to serve communities. Given that demand is not completely predictable, there will be some down time for these teams and reimbursement rates must be set so that the health plan still realizes value in the service (largely value realized by avoiding ambulance and emergency department bills) while community members get better access to care. If commercial and Medicaid plans pay at this reasonable rate for quality care, the state, county or city funding of contributions will be relatively low; particularly in states with low uninsured rates.

Crisis Receiving and Stabilization Facility Services

Crisis receiving and stabilization services are analogous to emergency department services but typically fall under a crisis stabilization coding approach that offers hourly and per diem reimbursement. Facilities are likely licensed outpatient programs that offer flexibility to deliver care to a larger number of people in smaller spaces; necessitating that service duration be limited to under 24 hours (often referred to as 23 hour programs). Professional fees are usually billed in addition to the crisis stabilization service but can be bundled if that approach is preferred. The benefit to separate billing of professional services is that practically all payers currently reimburse for these services while few outside of Medicaid recognize crisis stabilization for reimbursement at this time. Getting some of the expense covered by these payers (pending a better enforcement of the parity law) is better than none when it comes to minimizing the financial cost to the community served.

Crisis Service Coding

Establishing a common definition for “crisis services” is essential to this coding process given the ever-expanding use of the term “crisis” by entities describing offerings that do not truly function as no-wrong-door safety net services accepting all referrals. Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime**. This crisis service coding discussion focuses solely and exclusively on the three essential crisis services. Any other service may offer value within the continuum of care but should not use “crisis service” coding.

Crisis services are designed to connect individuals to care as quickly as possible through a systemic approach that is comparable to that of the physical healthcare system. The table below provides a look at similarities between crisis services and their physical health counterparts; offering a framework that can be used to model reimbursement for these similar services in a manner consistent with public expectations of parity.

Table 2 – Emergency and Crisis Service Analogies

Services for Responding to a Health Crisis		
	Physical Health	Mental Health & Substance Use
Emergency Call Center	911	Crisis Line
Community-Based Response	Ambulance / Fire	Mobile Crisis Line
Emergent Facility Care	Emergency Dept.	Crisis Receiving & Stabilization Facility

[Healthcare Coding of Crisis Services](#)

Coding of crisis services must be standardized to support reimbursement for these important services. Additionally, coding for mobile and facility-based crisis services has a clear to path to reimbursement much like what currently exists for ambulance and emergency department service providers. Although a bit different than the analogous 911 service that largely focuses on dispatching support, crisis line services represent an essential element of improving access to care that includes the delivery of telehealth services. Here’s a brief description of these services and a straightforward strategy for healthcare coding in each case:

- 1. Crisis Call Center:** This service represents the incorporation of a readily accessible crisis call center that is equipped to efficiently connect individuals in a mental health crisis to needed care; including telehealth support services delivered by the crisis line itself. Recognizing the provider’s limited ability to verify insurance and identification over the phone, these services may be best funded as a safety net resource but reimbursement for services delivered is an

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option. The most straight-forward option is to bill for services delivered to eligible individuals using the Healthcare Common Procedure Coding System (HCPCS) code of H0030 - Behavioral Health Hotline Service.

The limitation of the direct billing approach is that it can be very difficult to acquire the information adequate to verify healthcare coverage and the identity of the service recipient during the phone interaction. However, some level of direct billing for care could be used to augment the funding received by regional and state government entities to support operations. Crisis line providers do indeed deliver telehealth support to insured callers every day. Data elements such as member phone numbers of Medicaid-enrolled or privately insured individuals can be combined with Caller ID technology to support billing efforts.

2. **Mobile Crisis:** Mobile crisis services represent community-based support where people in crisis are; either at home or a location in the community. Services should be billed using the nationally recognized HCPCS code of H2011 Crisis Intervention Service per 15 Minutes. Limiting the use of this code to only community-based mobile crisis team services positions a funder to set a reimbursement rate that represents the actual cost of delivering this safety net service much as it does for a fire department or ambulance service reimbursement rate. When applicable, transportation services should be billed separately.
3. **Crisis Receiving and Stabilization Facility:** Crisis receiving and stabilization facility services that meet minimum expectations described in this paper are delivered by a 24/7 staffed multidisciplinary team that includes prescribers (psychiatrists and/or psychiatric nurse practitioners), nurses, clinicians and peers. Nationally recognized HCPCS codes of S9484 Crisis Intervention Mental Health Services per Hour and S9485 Crisis Intervention Mental Health Services per Diem can be used to reimburse for services delivered. Medications, radiology, laboratory, CPT codes and professional evaluation and treatment services may be billed separately or bundled into reimbursement rates.

Table 3 – Crisis Service Coding

Service	Recommended Coding Option Approach
Crisis Line	H0030 – Behavioral Health Hotline Service and contract as a safety net resource to augment funding
Mobile Crisis Response	H2011 - Crisis Intervention Service per 15 minutes <i>Note: The HT modifier can be utilized in combination with this code to denote a multi-disciplinary team if codes are used for multiple crisis delivery modalities.</i>
Crisis Stabilization Facility (non-hospital)	S9484 - Crisis Intervention Mental Health Services per Hour S9485 - Crisis Intervention Mental Health Services per Diem <i>Note: The TG modifier can be utilized to denote a complex level of care if these codes are utilized for multiple crisis delivery modalities</i>

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A Call for Parity

Establishing universally recognized and accepting coding for crisis services is an essential step towards delivering on our nation’s promise of parity; moving mental healthcare out of the shadows and into mainstream care of the whole person. Parity should be the expectation. Individuals experiencing a mental health or substance use crisis must have access to timely and effective care, based on the person’s needs, that aligns with access to care for a person with a physical health emergency.

Anyone!

Anywhere!

Any Time!

Unfortunately, access to effective care during a mental health crisis is widely known to be deficient in healthcare settings across the country. “8 in 10 ED Doctors Say Mental Health System Is Not Working for Patients” according to a survey by the American College of Emergency Physicians (ACEP). Thousands of Americans are dying from suicide every month and many family members of those coping with serious mental illness or loss of loved ones to suicide are experiencing unspeakable pain. Individuals with limited options are getting the wrong care in the wrong place with jails, EDs and inpatient care substituting for mental health crisis services and law enforcement is functioning as defacto mobile crisis units.

According to the 2019 Treatment Advocacy Center published *Road Runner* study, more than \$17.7 million was spent in 2017 by reporting law enforcement agencies which transported people with severe mental illness. If extrapolated to law enforcement agencies nationwide, this number is approximately \$918 million or 10% of law enforcement’s annual operating budget. Additionally, mental illness is the most prevalent disability in the United States. The time is ripe to solidify better access to crisis care and change these unacceptable outcomes that are adversely impacting communities, filling jails and crowding emergency departments. A nationally recognized framework for delivering a full continuum of crisis care has been established by the National Action Alliance for Suicide Prevention Crisis Services Task Force with resources found on the National Association of State Mental Health Program Director’s (NASMHPD’s) www.crisisnow.com website and healthcare coding, as defined in this document, is available to support reimbursement for that care

Assessing Adequacy of System Capacity

Care for All Populations Throughout Lifespan

Crisis services are meant to address the acute mental health, substance use and suicide prevention needs of a community. This can only be achieved by designing services that meet the unique needs of all members of that community. Therefore, crisis services must offer the capacity to address the needs of rural and urban communities that may be experiencing mental health, substance use, intellectual, developmental disability and co-occurring medical problems by accepting all at the front door. This also means offering crisis services for children, adolescents, adults and an aging population that each have their own unique set of needs in each community.

Crisis Resource Need Calculator

To lower the cost of care, enhance community health and improve the experience of residents needing emergent mental health and substance use services, a full continuum of care must be developed that includes adequate psychiatric bed capacity and community-based alternatives to care. The innovative *Crisis Resource Need Calculator* offers an estimate of optimal crisis system resource allocations to meet the needs of a community as well as the impact on healthcare costs associated with incorporation of those resources. The calculator analyzes a multitude of factors that includes population size, average lengths of stay in various system beds or chairs, escalation rates into higher levels of care, readmission rates, bed occupancy rates and local costs for those resources. In communities in which these resources do not currently exist, figures from like communities can be used to support planning purposes.

The calculations are based on data gathered from several states. The *Crisis Now* Business Case video that explains the rationale behind the model can be seen on the National Association of State Mental Health Program Directors (NASMHPD's) www.crisisnow.com website. Quality and availability of outpatient services also influences demand on a crisis system so the *Crisis Resource Need Calculator* should be viewed as a guide in the design process. True assessment of system adequacy must include a look at overall functioning of the existing system. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in emergency departments and incarceration for misdemeanor offenses when connection to care is the preferred intervention.

The table on page 44 shows the very real cost savings that can be realized by implementing mobile crisis and facility-based crisis services in your community. In this table, the population of the community is set at 1,000,000 and if this community was working to address the acute mental health needs of individuals experiencing a crisis solely through inpatient care, the data indicates that those with LOCUS levels 5 and 6 (68%) would be referred to inpatient care. This would require 500 beds if the average length of stay was 10.06 days; which aligns with the Treatment Advocacy Center's published consensus estimate of needing 50 beds for every 100,000 members of the population. The table that follows (*next page*) includes a per diem inpatient rate of \$900 which would result in an inpatient cost of \$164,179,200. After applying an ED cost of \$1,233 per person to those referred to an inpatient bed (medical clearance and assessment), total estimated costs rise to \$184,301,760.

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For the 32% of individuals with LOCUS levels 1-4, no cost or service is included in the calculations although it seems unlikely no actual cost would be incurred. When mobile team and facility-based crisis services are included in optimal ratios (*last column of table that follows*), total cost drops by 52% in these projections despite engaging all of these individuals. This means that 32% more individuals are served with programs that align better to the unique level of clinical need while costs are reduced by 52%. Additionally, alignment of clinical level need to the service delivered improves from 14% to as high as 100% (*please see LOCUS analysis from Georgia earlier in this toolkit*) in a *Crisis Now* system that aligns with this *National Guidelines for Crisis Care*.

Indicators of Insufficient Capacity

The *Crisis Resource Need Calculator* offers an estimate of community resource need to help guide development of crisis capacity for communities. However, this is only meant to estimate need while true evaluation of capacity must be based on the availability of services to meet the actual demand of the specific community or region. Signs of insufficient resources will include, but are not limited to, psychiatric boarding in emergency departments, incarceration for misdemeanor offenses when connection to urgent care is the preferred intervention and misalignment of service intensity to the actual need of the individual served. Misalignment and the absence of a continuum of care often results in a defaulting to placement in more restrictive environments or minimal connection to outpatient care.

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Figure 1 – Crisis Resource Need Calculator

Crisis Now Crisis System Calculator Projections - Pop. 1,000,000		
	No Crisis Care	Crisis Now
# of Crisis Episodes Annually (200/100,000 Monthly)	24,000	24,000
# Initially Served by Acute Inpatient	16,320	3,360
# Referred to Acute Inpatient From Crisis Facility	-	1,336
Total # of Episodes in Acute Inpatient	16,320	4,696
# of Acute Inpatient Beds Needed	500	144
Total Cost of Acute Inpatient Beds	\$ 164,179,200	\$ 47,237,736
# Referred to Short-Term Bed From Stabilization Chair	-	5,342
# of Crisis Beds Needed	-	41
Total Cost of Short-Term Sub-Acute Beds	\$ -	\$ 13,356,000
# Initially Served by Crisis Stabilization Facility	-	12,960
# Referred to Crisis Facility by Mobile Team	-	2,304
Total # of Episodes in Crisis Facility	-	15,264
# of Crisis Stabilization Chairs Needed	-	48
Total Cost of Crisis Stabilization Chairs	\$ -	\$ 18,840,137
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	-	7
Total # of Episodes with Mobile Team	-	7,680
Total Cost of Mobile Teams	\$ -	\$ 2,761,644
# of Unique Individuals Served	16,320	24,000
TOTAL Inpatient and Crisis Cost	\$ 164,179,200	\$ 82,195,517
ED Costs (\$1,233 Per Acute Admit)	\$ 20,122,560	\$ 5,789,675
TOTAL Cost	\$ 184,301,760	\$ 87,985,192
TOTAL Change in Cost		-52%

Tips for System Implementation

Workforce Development

Communities across the nation are challenged by a limited workforce to meet the needs of individuals with mental health and substance use needs. On the surface, the creation of no-wrong-door crisis care services would seem to create greater demand for this already strained workforce. However, implementation of crisis care that aligns with these best practice guidelines actually reduces that demand by more efficiently deploying resources, connecting to care in real time in a manner that minimizes the time for symptoms to escalate and the broader inclusion of peers as a vital workforce resource with the potential to grow more quickly than others employed in behavioral health care delivery.

Crisis call center operations that incorporate air traffic control-type functioning dramatically increase the efficiency of the overall system. Offerings such as GPS-enabled mobile team dispatch, real-time bed registry with coordination into care and outpatient appointment scheduling all decrease the volume of mobile teams and beds needed to meet the needs of the community. Crisis receiving and stabilization centers that efficiently assess the needs of the individual and stabilize crisis episodes in less than half the time of traditional inpatient settings further decrease the demand on beds that must be staffed.

In the *Crisis Resource Need Calculator* example, implementation of a comprehensive crisis system with the addition of seven mobile teams decreases the projected bed need from 500 to 233 (beds and chairs) for the hypothetical community of 1,000,000 residents. This translates into a reduction in workforce demand and it should be noted that staffing patterns that align with these best practice guidelines will employ peer workers into approximately 1/3rd of the projected positions.

Mobile Team Staffing

Community-based mobile crisis 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 community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's or Bachelor's-level clinician may be paired with a peer support specialist with backup by psychiatrists or other master's-level clinicians who are typically accessed for on-call support as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis.

In this model, almost half of the mobile team system workforce would be filled by peers who are more broadly available to fill roles that their licensed and/or credentialed clinician team partners may not be available to fill.

Crisis Receiving and Stabilization Facility Staffing

Crisis receiving and stabilization facilities must be staffed every hour of every day without exception so they will be equipped to accept any referral that comes to the program. To fulfill

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this commitment, programs must be staffed by a multidisciplinary team with expertise in mental health and substance use care that includes the following:

1. Psychiatrists or psychiatric nurse practitioners (telehealth may be used);
2. Nurses;
3. Licensed and/or credentialed clinicians capable of completing assessments; *and*
4. Peers with lived experience similar to those of the population served.

The innovative *Crisis Receiving and Stabilization Facility Staffing Calculator* (example below) can be used to project optimum staffing for one of these programs based on a number of variables that include:

1. Percentage served under involuntary commitment;
2. Percentage served via law enforcement drop-off;
3. Number of admissions per day;
4. Average length of stay;
5. Average number of seclusion and restraints per day;
6. Average program census; *and*
7. Number of one-on-one assignments in the program.

Figure 2 – Crisis Receiving and Stabilization Facility Staffing Calculator



Training Crisis Team Members

Many members of the crisis services delivery team are licensed mental health and substance use professionals operating within the scope of their license and training with supervision delivered in a manner consistent with professional expectations of the licensing board. Licensed

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professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program; including the incorporation of ongoing supervision with licensed professionals available on site at all times. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives and role-specific tasks.

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

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; *and*
4. Essential crisis care principles and practices that include:
 - Addressing recovery needs,
 - Significant role for peers,
 - Trauma-informed care,
 - Suicide safer care,
 - Safety/security for staff and consumers *and*
 - Crisis response partnerships with law enforcement.

All of these must be presented and learned within the context of embracing the crisis system's responsibility to serve as a no-wrong-door path to accessing care for all community members in need of immediate access to mental health and substance use care. Let the message of "Thank you, can I have another?" remain at the forefront of every team members' minds as they engage in activities that support true emergency department and justice system diversion by offering care that aligns with the needs of the individual engaged by the team. Providers must ensure that non-licensed individuals deliver services within the scope of their allowed practice with supervision that supports best practice care.

Technology in Crisis Care

Technology such as GPS-enabled mobile team dispatch, real-time bed registry and coordination, centralized outpatient appointment scheduling and performance dashboards that support air-traffic control-type functioning in the crisis system play an important role in solidifying crisis care. Additionally, telehealth is becoming increasingly important within the context of increasing access to limited mental health and substance use resources; particularly licensed and/or credentialed clinicians as well as psychiatrists and psychiatric nurse practitioners. Although this mode of service delivery is more prominently applied in rural and frontier communities, there is

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also an opportunity to use this approach to establish greater efficiencies when offering 24/7 access that may not have a consistent or high-volume flow during specific times throughout any given day. Application of telehealth services must align with local regulations and should continue to involve other members of the multi-disciplinary crisis team in face-to-face support as these advanced technologies are incorporated in crisis care practices.

System Evaluation Tools

As communities work to implement true crisis systems of care that meet the needs of their residents, SAMHSA wants to ensure resources to support advancement of best practice care be made accessible to all. Innovative community and staffing analytic calculators and videos around program structure have been made available on the National Association of State Mental Health Program Director's (NASMHPD's) www.crisisnow.com website and are also published as part of this evidence-based practice resource page. Additionally, we have created a *Crisis Service Best Practice Review Tool* with a listing of evaluated elements included in this section of the toolkit. You will see that the tool is designed to evaluate the degree of implementation of essential element implementation tips that have been defined throughout this *Toolkit*. The elements are summarized here:

1. Regional or statewide crisis call centers coordinating in real time:
 - a. Operate every moment of every day (24/7/365);
 - b. Staff with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
 - c. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
 - d. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
 - e. Coordinate connections to crisis mobile team services in the region;
 - f. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed;
 - g. Incorporate Caller ID functioning;
 - h. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
 - i. Implement real-time regional bed registry technology to support efficient connection to needed resources; *and*
 - j. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.
2. Centrally deployed, 24/7 mobile crisis systems:
 - a. Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
 - b. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or to particular days/times;
 - c. Connect individuals to facility-based care through warm hand-offs and coordinating transportation as needed;
 - d. Incorporate peers within the mobile crisis team;
 - e. Respond without law enforcement accompaniment unless special circumstances warrant inclusion; supporting true justice system diversion;
 - f. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*

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- g. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.
- 3. 23-hour crisis receiving and stabilization programs:
 - a. Accept all referrals;
 - b. Do not require medical clearance prior to admission but will assess for and support medical stability while in the program;
 - c. Design their services to address mental health and substance use crisis issues;
 - d. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges;
 - e. Staff at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
 - i. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
 - ii. Nurses
 - iii. Licensed and/or credential clinicians capable of completing assessments in the region; and
 - iv. Peers with lived experience similar to those of the population served.
 - f. Offer walk-in and first responder drop-off options;
 - g. Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no-rejection policy for first responders;
 - h. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated;
 - i. Function as a 24 hour or less crisis receiving and stabilization facility;
 - j. Offer a dedicated first responder drop-off area;
 - k. Incorporate some form of intensive support beds into a partner program (could be own program or another provider) to support timely transitions to secure placement for individuals who need additional support;
 - l. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
 - m. Coordinate connection to ongoing care.
- 4. Essential crisis care principles and practices:
 - a. Addressing recovery needs,
 - b. Significant role for peers,
 - c. Trauma-informed care,
 - d. *Zero Suicide*/suicide safer care,
 - e. Safety/security for staff and consumers *and*
 - f. Crisis response partnerships with law enforcement.

Monitoring System and Provider Performance

In addition to monitoring fidelity to the *National Guidelines of Crisis Care*, funders, system administrators and crisis service providers should continuously evaluate performance through the use of shared data systems. System transparency and regularly monitoring of key performance indicators supports continuous quality improvement efforts. It is highly

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recommended that systems connect data in a manner that offer real-time views of agreed-upon system and provider-level dashboards that can also be used to support alternative payment reimbursement approaches focused on value. Performance metrics should include the following:

- Crisis Call Center Services:
 - Call volume,
 - Average speed of answer,
 - Average delay,
 - Average length of call,
 - Call abandonment rate,
 - Percentage of calls resolved by phone,
 - Number of mobile teams dispatched,
 - Number of individuals connected to a crisis or hospital bed, *and*
 - Number of first responder-initiated calls connected to care.
- Crisis Mobile Services:
 - Number served per 8-hour shift,
 - Average response time,
 - Percentage of calls responded to within 1 hour... 2 hours,
 - Longest response time, *and*
 - Percentage of mobile crisis responses resolved in the community.
- Crisis Receiving and Stabilization Services:
 - Number served (could be a measure of individuals served per chair daily),
 - Percentage of referrals accepted,
 - Percentage of referrals from law enforcement (hospital and jail diversion),
 - Law enforcement drop-off time,
 - Percentage of referrals from all first responders,
 - Average length of stay,
 - Percentage discharge to the community,
 - Percentage of involuntary commitment referrals converted to voluntary,
 - Percentage not referred to emergency department for medical care,
 - Readmission rate,
 - Percentage completing an outpatient follow-up visit after discharge,
 - Total cost of care for crisis episode,
 - Guest service satisfaction, *and*
 - Percentage of individuals reporting improvement in ability to manage future crisis.

Marketing and Communication Efforts

The evolution of true crisis care services is essential to improving the health of our communities. Comprehensive crisis systems that align with these best practice guidelines offer universal real-time access to the most appropriate services, supports and resources to decrease the utilization of 911, emergency departments and jail for individuals experiencing mental health and substance use emergencies. Critical to the success of these services is an effective marketing strategy and campaign to inform communities of their existence and educate how to access the services when needed.

To evolve marketing and communication plans that effectively meet the community education objectives, communities are encourage to engage broad stakeholder groups that should minimally include law enforcement, hospitals with emergency departments, fire departments, ambulance providers, mental health advocacy agencies, community health providers, faith-based communities, schools, health plans, local Medicaid team members, those engaged in the service delivery system and their families.

The goal of these dialogs is to create public information materials and educational marketing campaign strategies that translate into regional and statewide crisis system resource access educational efforts with specific details on how the three core elements of the crisis system (crisis line, crisis mobile and crisis receiving and stabilization facilities) offer immediate access to care for anyone in the community through a no-wrong-door safety net system.

Minimum elements of a successful plan marketing and communication plan include:

1. Evaluation of educational and marketing services for various age groups and other targeted populations;
2. Key metrics that can be used to assess the impact of marketing strategies along with an evaluation plan to determine the effectiveness of the statewide and regional marketing strategies;
3. Distribution of materials based on the collaboratively developed marketing and communication plan;
4. Assessment of effectiveness of the plan and adjustment of the approach as needed; *and*
5. Ongoing meetings with key stakeholders, including first responders, local hospitals and health plans, to support appropriate diversion from emergency departments and justice systems.

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Conclusion

Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care – A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

For crisis services to work effectively, the handoff from law enforcement must be quick, with assessment occurring after—and not before—the handoff takes place. There must be a full partnership with the community and an understanding by community partners, particularly law enforcement, of how crisis services can most effectively work to divert individuals from hospitalization and longer-term engagement with the criminal justice system.

Once the individual is engaged, treatment must be trauma and recovery-informed and engage peers with lived experience who can serve as mentors and models. Zero Suicide and safer-suicide must be a central focus.

But an effective crisis services program must be sustainable and sustainability requires a sustainable funding mechanism, supported by formal funding codes, that is not wholly dependent on the innovative braiding of small streams of revenue. Commitment by the community and state and local governments is essential for crisis services to remain an important element of the continuum of care for individuals in behavioral health crisis. And of course, any continuous funding stream requires continuous quality improvement of the system to ensure that it is effective and cost-effective, using current best evidence to produce positive outcomes that ensure clients will find their way to recovery.

Continuous Quality Improvement & Innovation

Case Study #1

In 2014, Connections Health Solutions began operating the crisis stabilization programs inside the Crisis Response Center in Tucson, Arizona. It seems self-evident that crisis services should offer timely, high quality care to people experiencing a psychiatric emergency. The response must match the need. Remember the opening theme to the long running NBC hit ER: everyone is running because lives depend on it.

Dr. Margie Balfour found the reality of crisis services was often the exact opposite. It can take hours or even days in an emergency department to be “medically cleared” before entrance is granted to many of the nation’s “crisis stabilization” programs. Law enforcement and first responders are expected to take the person in crisis to the hospital first, not the crisis unit. It should be noted that these programs do not represent crisis receiving and stabilization facilities as defined in this *Crisis Service Best Practice Toolkit*.

The experience of the more than 13,000 individuals that utilized the services of the Crisis Response Center each year had been uneven. There were often long delays in the clinical triage area while the patient awaited a decision on whether he or she would be admitted or discharged. Frustration abounded. The result was a decrease in safety that manifested as increases in injuries and assaults. Individuals in crisis were sometimes left unattended for long periods of time and staff were spread areas amongst multiple program areas. Security was frequently involved.

Lean Six Sigma in Action

There was a significant need to improve and speed the triage process but there was a lack of agreement on the mission of the facility. Dr. Balfour and the Connections Health Solutions team met with the leadership and front-line staff in a series of town-hall meetings, conducted rounds in the facility to interview patients and staff, and worked shifts to view the experience up close and personal. The result of this process was a singular mission: **Meet the immediate needs of those in behavioral health crisis in a safe and supportive environment.**

In order to re-engineer the Crisis Response Center for this new mission, Dr. Balfour and the team incorporated a Lean Six Sigma approach to quality improvement. Motorola and Toyota both revolutionized process improvement by eliminating waste and improving the flow of manufacturing and by building upon the pioneering work of Edwards Deming in the 1950s (think Plan-Do-Study-Act). Healthcare has been slow to catch the vision and crisis care for behavioral health has been characterized by “crisis programs” that do not actually operate as emergency or crisis service options that serve all in need. These programs that do not align with best practice guidelines are characterized by waiting for care and clearance or screening to initiate an often-lengthy process.

The team began by establishing some assumptions. They would achieve gains with the existing resources and staff by standardizing the process and eliminating the waste of inefficient practices. They also introduced a number of interventions that include improved dashboard

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tracking tools. Next, they analyzed wasted time and function. What were the tasks that added value? What were the tasks that added little value but were nevertheless required (by licensure, contract, etc.)? And finally, what were the tasks that were unnecessary and simply represented waste?

The value analysis found that the old process required almost 11 hours to connect to needed care and that nearly 40% of this process was simply unnecessary and non-value added. Wasted time for individuals and family members dealing with a behavioral health crisis. Idly sitting in the waiting room comprised a significant portion of this time but there were also inefficiencies in some of the tasks of the crisis provider.

The Results

The Connections Health Solutions team reduced the “door to door dwell times.” The average time spent in the triage clinic decreased from seven hours to two hours and the time in the 23-hour unit decreased by 30%; improving not only the patient experience but also the capacity of the facility to serve the community by more efficiently serving those in need.

Even if you haven’t been in a psychiatric crisis, most everyone has been to the emergency room and the key metric we all remember from the experience remains with us... how long did it take us to see the doctor? Dr. Balfour’s team reduced the waiting time by nearly 80%. These significant gains had other cascading benefits. For example, the facility dramatically reduced the time it spent on diversion from referrals due to operating at full capacity so that it could better serve the needs of those in crisis in the greater Tucson area. Assaults to staff and calls to security were also dramatically reduced and the changes in process yielded additional space availability. The building was remodeled to take advantage of these improvements and the capacity of the temporary observation unit was increased by 36% to further increase capacity in a manner that supports their commitment to accept all referrals.

Dr. Balfour believes there were several key ingredients in their Tucson Arizona success. They engaged everyone from top leadership to the line staff. They kept compliance and quality functions separate and obtained Lean Six Sigma green belt certification for quality staff while building the IT and data system necessary to track and report accurately.

The metric that brings all this into focus is the law enforcement drop-off turnaround time. First responders do not take people in crisis to the emergency room first. They drive straight to crisis facilities in Phoenix or Tucson where they spend less than 10 minutes before returning to their patrol. Connections Health Services measures performance and progress through the levels below.

Levels of Accomplishment

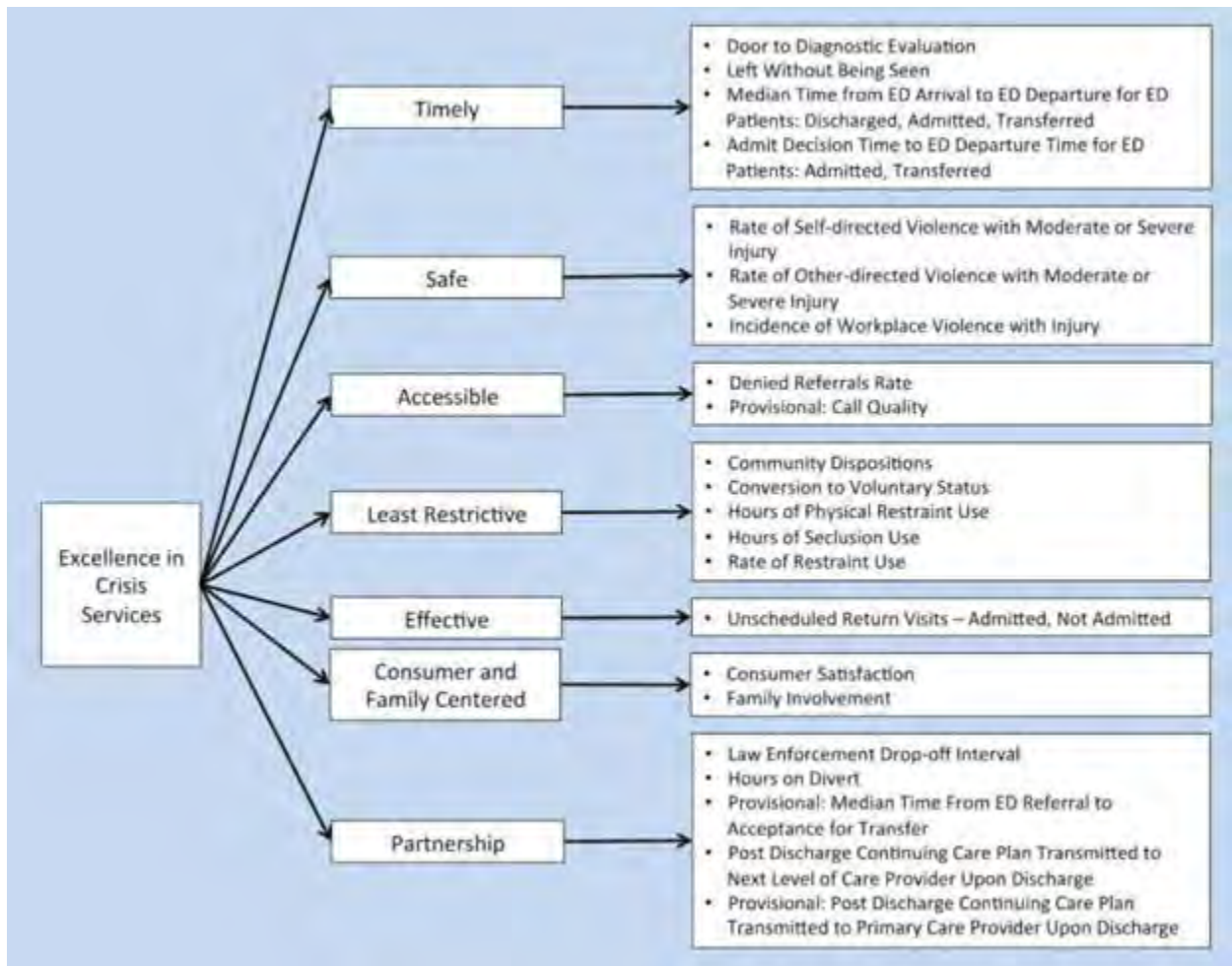
Level 1	Everyone in the organization/department knows what the unit’s core processes are.
Level 2	Each core process is fundamentally documented.
Level 3	The primary customer requirements of each process are documented and conformance to spec is tracked.
Level 4	The primary control factors that drive desired performance for each process are documented and tracked.

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Level 5	Each process can be documented to be behaving as intended (e.g., is “in control”).
Level 6	Each process is completely standardized, in control, and has an on-going continuous improvement plan.

Dr. Margie Balfour’s article *“Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs,”* *Community Mental Health Journal*, 2015 ([download here](#)), includes the outcomes model below.

Figure 3 – Crisis Reliability Indicators Supporting Emergency Services Framework



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Case Study #2

In 1996, Recovery Innovations, Inc. (dba RI International) created its first Crisis Recovery Center just outside Phoenix, Arizona in the west valley city of Peoria. Like many similar Crisis Stabilization Programs across the country, it offered an alternative to acute inpatient, jail and emergency departments (EDs), a place where a mental health crisis could be handled by professionals as immediately as possible.

This program was an improvement, but it still had some of the issues that plague crisis care in EDs. It focused too much on procedures and diagnoses and too little on engagement and collaboration, which are vitally important for the individual in a mental health crisis. The hospital model was designed to treat disease and injury and RI set out to develop a new and unique approach that would handle the needs of those in debilitating emotional pain.

In 2002, RI began its evolution of the Crisis Recovery Center with the development of the Living Room model. It featured a strong focus on good contact with the person in distress and introduced new staff types as well. Certified Peer Specialists brought their own experience in mental health crisis and recovery and empathic and trauma-informed care into the interdisciplinary team.

The facility transformed from a colder, more sterile, traditional medical setting to have a warm inviting feel. Individuals were referred to as guests and not consumers. The teams began quality improvement efforts to reduce the prevalence of seclusion and restraint. And, overall, the Living Room felt more like home than an institution.

Still, there was the potential to make real community impact, since most acute cases were being diverted to traditional crisis facilities, i.e., hospitals and jails. In 2014, the leadership at Mercy Care, the health plan tasked by the Arizona Healthcare Cost Containment System (AHCCCS, the Arizona Medicaid authority), challenged RI to adopt the never-reject approach to law enforcement drop-offs.

At that time, RI was receiving 100 to 150 law enforcement drop-offs per month, but they were also diverting individuals that were deemed inappropriate. If there was concern about a medical challenge, primary substance use problem, history of aggressive behaviors, etc., law enforcement was instructed to take the person to a different facility. This approach required law enforcement to wait around while decisions were made (an approach leaders in LAPD have coined “wall time”) and then transport them after evaluation.

RI determined to fully adopt the new approach. The facility already had a special law enforcement drop-off admission room that was attached directly to the 23-hour temporary observation and treatment unit. A lighted sign directed the officer to park directly adjacent to the unit where they could easily walk the individual in crisis a few short steps to immediate access.

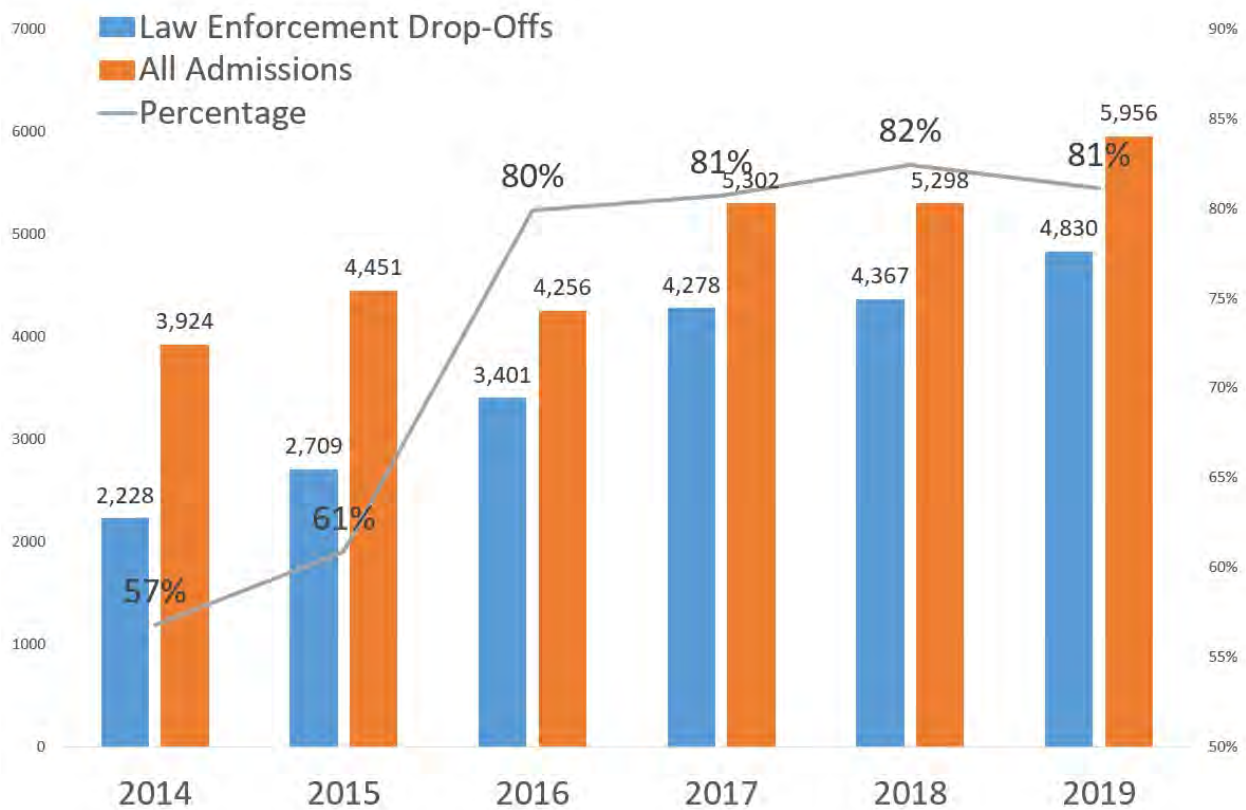
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The new approach meant that the officer would never be asked to wait for an evaluation. A peer leader would greet the individual and introductions would be made. The law enforcement officer would share any paperwork, if available, and exit to return to the work of public safety within three to five minutes.

RI leadership was concerned about the potential loss of the Living Room culture and experience but also fully grasped the stronger community impact of a true no-wrong-door approach. And, the Fusion Model was born, combining the direct and safe access of a hospital ED with the recovery-oriented approach of the Living Room.

Figure 4 – Peoria, Arizona Crisis Recovery Center Law Enforcement Drop-Offs



In late 2019, RI will admit the 20,000th consecutive guest who is dropped off by law enforcement, without a single rejection for any reason. While there have occasionally been guests who had a medical complication that was not obvious to the law enforcement officer, and that required more intensive hospital attention, additional treatment was organized by the Crisis Recovery Center, including transportation where appropriate. None of this was delegated to law enforcement, which has been immediately released to return to duty following a referral.

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The graphic on the previous page demonstrates the increase in the total number of individuals in a crisis served by the program and law enforcement referral activity over the time period that this model was adopted. With 32 licensed chairs in the 23-hour observation and treatment program and 16 beds in the sub-acute crisis program, the law enforcement drop-off number doubled over the time-frame. Always accepting law enforcement referrals increases officer trust that making a drive to the facility is preferable to other traditional options, i.e., jail, hospital, relocation, etc.

Today, 80% of all guests received by the program are referred by law enforcement, and none of them first visited a hospital ED for medical clearance. The program has literally not refused a single police referral in the past five years, despite over half being involuntary. But unlike entering a hospital or jail, these individuals in crisis are immediately greeted by a peer staff who orients them to the care they will receive. There is active engagement and collaboration throughout their stay, and they become active participants.

In the Fusion Model, crisis becomes an event to be resolved and stabilized, versus a diagnosis to be treated. And, since law enforcement engages in zero wall time by by-passing the ER completely and is back on the street in less than five minutes, the burden on police is eased and the experience for the person in crisis is improved.



Figure 5 - Crisis Recovery Centers implementing the Fusion Model Across Several States

Addendum

Interview 1 – Wesley Sowers, MD

Ahead of the Curve: LOCUS Is as Relevant Today as It Was in the Nineties

In the mid-1990s, Wesley Sowers, MD, was the medical director for St. Francis Medical Center in Pittsburgh, the largest addiction treatment center in Pennsylvania at the time. A tug-of-war was brewing between clinicians and managed care plans over who got to determine what was best for clients. Dr. Sowers, who is now the director for the Center for Public Service Psychiatry at the University of Pittsburgh, says clinicians showed considerable variability in decision-making, which didn't always include judicious use of resources and often resulted in more extensive hospital stays than people needed.

“There wasn't much thought about how we could use resources most effectively.” This began to manifest in burgeoning costs of care and was one of the reasons state and local governments, as well as private insurers, started to examine ways to control costs. The behavioral health community understandably feared that these limitations would harm treatment quality, and clinicians worried that managed care would eliminate their autonomy. “Both had a rationale behind what they were doing and why they were doing it. While managed care reforms were needed, many went too far.” Dr. Sowers, who had long been interested in systems, believed there was a sweet spot where balance could be achieved, and so he began to develop a mechanism that would determine best outcomes for people and systems of care: a win-win in facilitating person-centered care and cost-effective resource use.

Examining how to optimize treatment quality and manage costs, Dr. Sowers attempted to develop an integrated medical necessity tool to help match patient need with the appropriate service intensity. He also wanted to create a structure that was as effective for people with addictive disorders as those with mental health issues, closing a divide perpetuated in behavioral health. “I was interested in co-occurring disorders and wanted to consider the interaction of mental illness, addiction, and physical issues that might affect people's treatment response.” Dr. Sowers' answer was to design a comprehensive system that focused on seven assessment dimensions: risk of harm; functional status; medical, addictive and psychiatric comorbidity; recovery environment (this dimension has two subscales: level of stress and level of support); treatment and recovery history; and engagement and recovery status. These became the core of the Level of Care Utilization System known as LOCUS. With input and support from the American Association of Community Psychiatrists (AACCP), Dr. Sowers developed an algorithm in 1996 that makes it simple for clinicians to provide best-fit recommendations for care intensity. A rating in each dimension ranges from lowest to highest need: from 1 to 5, respectively. The clinician then adds the numbers for each dimension together, resulting in a composite score that indicates a person's degree of need and the corresponding level of care required. Scores range from 7 as the lowest possible level of need and 35 as the highest.

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Once LOCUS identifies the correct level of care in the continuum, providers can select from a menu of services tailored to a person's particular needs. Menu items include clinical services, supportive services or crisis resolution and prevention services and describe the conditions of the care environment. Dr. Sowers says that, on average, a person with a lower composite score wouldn't have the same need-intensity as a person with a higher one, but that isn't always the case. He says the first three dimensions—risk of harm, functional status, and comorbidity—include overriding concerns. If a person scores high in these critical areas, the algorithm will alter recommendations accordingly, pairing the person with an increased level of service. "There is a composite score and treatment grid that gives clinicians the correct placement. It's easy to use."

Dr. Sowers never anticipated it would work so well and has been pleasantly surprised at how widespread adoption has been; not just when it was developed in the 1990s but in the decades since. Unlike most innovations, LOCUS is a tool that is as applicable today as when it began. Since their inception, LOCUS and CALOCUS (the Child and Adolescent counterpart) have gone through revisions to improve accessibility and clarity. "Along the way, we have asked people to tell us what doesn't work and what could be improved." Interestingly, he says that over the years, there hasn't been much need to change the rating system, but there have been minor adjustments to service intensity and level of care descriptions. "It has been a 20-plus-year process, and LOCUS is continually picking up momentum." Part of the reason, he says, is that while many clinicians still use paper and pencil, the automated version is increasingly used and preferred, particularly as hospitals and treatment centers move toward electronic medical records.

Though the use of LOCUS is widespread, Dr. Sowers isn't sure how comprehensively clinicians are using it. He built the system to span the service array and care continuum. The clinical structure translates from one level of care to the next and easily lends itself to a person-centered care and recovery paradigm. Dr. Sowers says there should be ongoing, continuous assessment throughout a person's treatment experience. "Using surveys, we have tried to determine whether there is full LOCUS use, but it hasn't yielded much information. Anecdotally, we can tell that many organizations only use it in a crisis setting, in some residential facilities, or in inpatient settings instead of along the entire continuum of care."

Using LOCUS in limited settings doesn't maximize its potential. Unlike alternative tools, the assessment takes into consideration prior responses to treatment and social and interpersonal determinants of functional impairment. Dr. Sowers says he and the AACP designed the system to guide continuous treatment planning, giving clinicians an indication of what needs to be improved upon to move a person down to a lower, less restrictive level of care. The objective is to follow the person as he or she moves through different care levels, tracking not only individual progress but also the entire system of clinical management. "It clarifies and unifies what we do in clinical settings, allowing us to identify the correct level of care for a person and the most cost-effective measures that ensure the best outcomes."

Interview 2 – Sandra Schneider, MD, FACEP

Emergency Mental Health is a Throwback of the 1950s Emergency Department

Sandra Schneider, MD, FACEP, a past President of the American College of Emergency Physicians (ACEP), says current day emergency mental health is reminiscent of the 1950s Emergency Department. It is a throwback, she says, in dire need of an upgrade.

What we know of today as the Emergency Department, shortened to ED by those in the field, began to take shape immediately after World War II. The climate in the United States at the time held lingering remnants of recent conflict and economic depression. At the same time, the innovation of the interstate highway made opportunity boundless, offering Americans a fresh start and quickly changing the face of medicine. Specialists who used large equipment they couldn't transport replaced family doctors and their small, black bags. These doctors had office hours and didn't make house calls. If an emergency arose, people went to the hospital. The ED started as a room in a hospital basement called 'The Pit.' It was overcrowded and run by some of the least experienced physicians who were treating the most dangerous situations, often resulting in grave consequences. ^[1] Dr. Schneider says that since then emergency medicine has made remarkable strides in every specialty area except mental health. The reasons for stagnancy, she says, are vague diagnostic criteria, challenges in case follow-up, lack of warm handoffs, and unlike all other specialties, emergency medicine physicians and psychiatrists have not had decades of collaboration.

Partnerships and the Golden Period of Intervention

While the direst situations were brought to the ED in the 1950s, specialists often failed to give patients timely care because they were on call for their practices. In 1961, Dr. James D. Mills realized that emergency medicine needed to be a specialization in and of itself. He convinced three of his coworkers to leave private practice to develop an ED alongside him in Alexandria, Virginia, becoming full-time emergency physicians working 12-hour shifts 5-day a week. Simultaneously, a group of 23 doctors in Pontiac, Michigan, did the same, working part-time to staff the ED at Pontiac General Hospital 24-hours a day.

Dr. Mills and his colleagues were the first to do this full time and say, "Hey, this works for patients and us." Dr. Mills would call in a surgeon to do surgery or a pediatrician if the patient was young, fostering a partnership between ED physicians and specialists. Patients spent about the first 30 minutes with the ED physician and the next half-hour with a specialist, allowing emergency medicine physicians to learn: first through observation, then by consulting with specialists on the phone until finally, they could generally handle the cases themselves. Today, Emergency Department (ED) physicians often do procedures and no longer need specialists to come in and perform them. For example, says Dr. Schneider, ED physicians do far more intubations than many physicians in internal medicine or even anesthesiologists who predominantly do outpatient work. No such leaps have happened in psychiatric emergency medicine. She says the result is that ED staff often don't identify and fail to treat mental health crises during critical intervention periods. Emergency medicine physicians believe the first 30 minutes to an hour to be the most critical for outcomes, calling it the golden hour of intervention. For example, if a person has a stroke, ED

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staff have about three hours to get the clot-busting drug tPA (tissue Plasminogen Activator) into the patient. “If that doesn’t happen, the person is out-of-luck.” In the case of a heart attack, doctors have a 90-minute window to intervene. Partnerships with specialists have allowed ED physicians to fully utilize the golden hour of intervention, improving outcomes and mortality and allowing patients a far better chance of leading normal lives.

Dr. Schneider says that in mental health, she and her colleagues understand that the longer a person is in psychosis, the more challenging it is to reverse. “It may not be a golden hour but more like golden days or even a week, but there is a critical window for intervention, especially in high acuity suicidality and psychosis.”

Pattern Recognition and Follow-up

Emergency medicine physicians have learned through patterns, and, with the help of specialists, what is best to do during the golden hour of intervention. The field has developed through partnership, follow-up, and pattern recognition. That is not the case for psychiatry, which Dr. Schneider says is the least rote specialty. She can look at an EKG and see that the patient is experiencing a heart attack, or, if a patient comes in and cannot lift his arm and is not using his leg, he might have a seven on the Stroke Scale. Or if the person’s blood count is low, he may need a blood transfusion. Through pattern recognition, training, and established intervention, Dr. Schneider can determine a person’s critical needs.

Psychiatry is not as transparent. “I may have a patient who isn’t making sense or is depressed, but there is no serum delirium or depression score for me to determine the level of acuity. We’ve not been trained and, as a result, never figured out the pattern recognition like we have in all other specialties. For many of us, our background is the month we spent on psychiatry in residency, so we feel out of our comfort zone.” She says this is compounded by vague psychiatric diagnostic criteria, the components of which most emergency medicine physicians do not understand and minimal, if any, feedback after a handoff. Pattern recognition, says Dr. Schneider, is not just developed by working alongside specialists but also through follow-up. Dr. Schneider says that doesn’t happen with psychiatric patients. If a patient has a rash that the ED physician suspects is a melanoma, she can follow-up and find out if she was correct, which helps to improve pattern recognition. On the other hand, if she wants to know whether she was right about the acuity of a patient’s suicidality, that information is not accessible. “The result is we don’t gain critical follow-up knowledge on psychiatric crisis.”

No Warm Handoff

One challenge, says Dr. Schneider, is that while it is impossible to see the level of acuity in mental health, ED physicians realize that lack of bleeding does not mean it is not a high acuity case. The result is ED physicians often default to an assumption of high acuity, triggering numerous challenges for patients, including hospitalization and the corresponding trauma of institutionalization, stigma, and the detrimental impact on the patient’s employment, finances, and personal life.

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Part of the reason for defaulting to high acuity is the result of an ‘it’s-better-to-be-safe-than-sorry’ mentality, but it is also because ED physicians are not always confident that the patient will get the care she needs if discharged. Dr. Schneider says that more than any other specialty, there is a disconnect on what comes next for the patient. For example, if a patient comes in with appendicitis, the ED physician can call a surgeon. In the case of a rash, the ED has a roster of dermatologists and clinics, and in many cases, the physician can even make an appointment for the patient. These partnerships create confidence in the system and an appeals process if the ED doctor doesn’t agree with the specialist: the emergency medicine physician and specialist can get on the phone and discuss the case.

Dr. Schneider says this communication does not exist between most EDs and the mental health system, making navigating it incredibly difficult for ED staff. She says if she has a patient with depression who is feeling suicidal and needs mental health care in the next couple of days, she has no idea how to get them what they need.

The same is true for substance abuse. “Let’s say a person with an opioid use disorder comes in and has managed to withdraw but needs help for his addiction. All most ED physicians can do is hand him a list of addiction centers to start calling in the morning. Can you imagine if we did that with any other medical issue? If someone comes in with chest pain, I can get them set up with a stress test the next day, regardless if she has insurance. Why is it with mental health it’s okay to give patients a list and say, ‘Good luck?’” Emergency medicine physicians need to be able to do a handoff and have confidence in that handoff. “If there is someone to evaluate the patient, but I don’t know the person and whether he or she has made the right decision for the patient, that’s not a warm handoff.”

Dr. Schneider says now is the time to improve the relationship between the ED and psychiatry because she believes emergency medicine physicians will soon be playing an increasingly critical role. The approved use of intervention medications, such as Ketamine and Brexanolone, for depression and postpartum depression, means that ED physicians will be able to decrease acuity with medication so that patients can go home and seek care within a week or so. She says it is similar to how the ED addresses patients with atrial fibrillation (A Fib) or a blood clot. Physicians diagnose, stop, and often reverse the emergency, before sending the patient to primary care. “We would acutely treat them and do a warm handoff.”

Replicating the Poison Center Model in Emergency Mental Health

Dr. Schneider recommends that mental health mirror the poison control center. Each center has a medical director and pharmacists, physicians, nurses, and toxicologists that answers the phone 24/7. If a physician is unfamiliar with the drug a patient took, the center will triage the call to a Specialist in Poison Information (the specialists are called SPIs, pronounced spies). For example, if a person took Banamine, a horse anti-inflammatory, the ED physician can call a poison control center and speak with an SPI who has access to a vast database that lists all chemicals and outcomes in previous exposures. The SPI would tell the ED physician what’s happened in previous cases such as: “Above this amount we’ve seen these problems so you should watch the person for kidney function.” If the situation is more complicated because the person took more than one

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drug, then the ED physician's call would be forwarded to the toxicologist. (Typically, only 1 out of 100 calls escalate to the toxicologist.)

The SPI also does follow-up and tracks outcomes. For example, if the person who took Banamine had a seizure, the SPI would add that to the database. They would also call the patient and ask how the person is doing and see if he or she needs an appointment. If a child drank bleach, the SPI would speak with the parents, telling them that they are not bad parents, and talking them through how to prevent the incident from happening again. They can even address more obscure poisonings. If a person eats a rare mushroom, the center will get the caller in touch with a mycologist (mushroom expert), local resources for dialysis, and the best hospital to care for the patient. The idea is that no matter where the person is at that moment, experts will be reached and local resources provided.

Psychiatric Triage with a Mental Health Center

Dr. Schneider says a similar structure for mental health would allow ED physicians to speak to experts and have strong confidence in their abilities. The call could be from an ED doctor who is uncomfortable giving Suboxone, a blockbuster medication that reduces symptoms of opiate addiction and withdrawal, for the first time. The mental health center would go through a checklist and then provide a dosage recommendation. If it does not work, the ED doctor would call back, and the center would walk her through the next dose. They would also give guidance on more complex cases.

Suppose a patient has depression but no suicidal plan, a supportive family, and no lethal weapons. The mental health center expert might recommend the patient be discharged and meet with a mental health worker the next day. If the ED physician is not comfortable sending the patient home, a psychiatrist for the center could get on a video call. Dr. Schneider believes the escalation rate would be similar to that at poison centers: roughly 1 out of 100 calls would triage to the psychiatrist. After the video chat with the patient, the psychiatrist might recommend he be admitted, and help with the process, or say the patient can go home, but the center would call him in the morning to arrange an appointment. "ED physicians spend 15 minutes with a patient. We aren't going to be able to add a 30-minute psychiatric evaluation, but the center would give us access to experts and a database of resources. It closes the loop of care and is the warm handoff that gives us confidence that patients will get the care they need."

Sources:

[1] 24 | 7 | 365: The Evolution of Emergency Medicine. Retrieved March 11, 2019, from <https://www.emra.org/about-emra/publications/legacy-documentary>

Interview 3 – Shelby Rowe

The Elephant in the Room: Mental Health Professionals Experience Crisis Too

When Shelby Rowe realized she needed help in September 2010, she called a close friend, asking the friend to drive her to a hospital out-of-state. As the executive director of the Arkansas Crisis Center, Rowe didn't want to run into anyone she worked with or had trained. Her distress had been slowly escalating, culminating in months filled with ruminating flashbacks and anxiety. Her marriage was quickly unraveling, triggering trauma from when she'd been in a similar position. Years prior, during her first marriage, Rowe and her husband had a terrible argument, and he left. Thirty-minutes later she received a call that tragedy had occurred: while at a friend's house, someone accidentally shot and killed her husband. "The last time I'd been in this situation, someone I loved died. During our fight, I'd told my husband, 'I hate you and wish you were dead.' A half an hour later he was. Years later, at the end of my marriage, I feared if I walked away, one of us was going to die. It didn't make sense, and I knew that, but it didn't lessen my fear."

As Rowe spent her days overseeing the implementation of the Arkansas plan for suicide prevention and running the center that operated the state's only 24/7 crisis hotline, she was simultaneously experiencing increased distress. To mitigate it, she applied the coping skills she taught others, but it wasn't enough. Her expertise in suicide prevention made her achingly aware that she was experiencing hopelessness, but Rowe questioned her symptoms: how could she, a mental health expert aware of critical interventions, be at risk? She wasn't the only one applying scrutiny as her therapist told Rowe, "You don't need hospitalization because you're aware of what you're experiencing." The therapist, and other mental health experts Rowe came across during her crisis, assumed, because of her expertise, that she was a lower suicide risk than she was and knew what to look out for and do for herself during a crisis. "A mental health professional may know the signs and what to share with others, but it's challenging to apply those skills to one's own crisis. That's why people don't treat themselves."

As Rowe's symptoms increased, she performed the assessment she did with callers, asking herself, "When is the last time you ate or slept? How long do you think you can keep yourself safe?" The answers weren't comforting. She knew it was time to seek help. In the hospital, she received what would generally pass as good care—she met with the therapist daily and the psychiatrist every other day—but they failed to address what was at the core of her crisis, Post-Traumatic Stress Disorder from her first husband's death and childhood traumas. In the high-risk months following the hospital stay, Rowe continued to experience ruminating thoughts and felt frustrated that she couldn't just shake them off. She felt despair settle in her bones with no end in sight. "Hospitalization isn't a magic wand, and I came back feeling more hopeless because the experience hadn't changed how I felt, and now there was an additional hospital bill burden to figure out." Rowe wondered if this was how life would be from this point forward, getting angry at herself for not being able to control her PTSD. "It was the night before Thanksgiving, and I went into the bathroom, looked at myself in the mirror, and said, 'I hope I never see you again.' I then made an attempt on my life." Rowe woke up two days later in bed, not knowing what happened. Her 19-year-old son was home and said, "Oh, you're up. You missed Thanksgiving." She asked why he didn't take her to the hospital, and he said, "I didn't want you to get fired."

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It took four years before Rowe publicly shared her story, doing so because she felt there was a great need for more people in the mental health profession to speak about their experiences. What people often don't understand, she says, is that just because a person survives a suicide attempt doesn't mean she's committed to living. It took years, separate from public scrutiny, to set the groundwork for healing and learn to acknowledge her feelings and not be angry at herself, which reaped a highly favorable outcome: a release from fearing failure. Before that, Rowe felt embarrassed and thought her suicide attempt was an indication she should no longer work in mental health. Fortunately, Rowe's therapist when hospitalized reassured her that the field needed her perspective and expertise. He told her, "I would hire you." This shifted Rowe's perception because he could have easily suggested she pick a different career path. "I'm not certain I'd be working in this field today if it weren't for the fact that, in my moment of crisis, this person believed in my ability to do my job and to play a meaningful role in mental health." Even so, Rowe did initially have concerns about coming out as an attempt survivor because well-intentioned colleagues, some of whom heard of or directly had negative experiences when coming forward, warned her not to go public with her story.

The final push for Rowe to speak about her suicide attempt was the release of The Way Forward Report in 2014 by the National Action Alliance for Suicide Prevention's Suicide Attempt Survivors Task Force. They were putting together 60-second YouTube videos featuring attempt survivors and others directly impacted by suicide such as siblings, parents, children, and spouses. Rowe says it was remarkable to witness the field start to recognize the value of experts with direct experience. Among those coming forward were Dr. Quincy Lezine and Dr. Sally Spencer-Thomas, who asked Rowe if she'd be willing to record a video as an ally, not realizing that she was an attempt survivor. After Rowe shared her story with Dr. Spencer-Thomas, the psychologist asked her to record a video about her experience. She did. "As mental health professionals, we work against stigma, calling suicide prevention a public health issue, but then we often hide that part of ourselves for fear of rejection within that same community." Still, Rowe says sharing isn't right for everyone, and those thinking of doing so should carefully examine what they are seeking. "I never tell my story hoping to get validation from the audience. This is who I am, and my perspective is one of the tools I bring to the table." Rowe has continued to work in mental health as the suicide prevention program manager for Oklahoma's Department of Mental Health and Substance Abuse Services. She says sharing her story with those working in mental health is destigmatizing, making it easier for others to do the same. "They see me sharing my story in front of 100 to 500 of their colleagues and think, 'No one is judging her. Maybe I can do it too.'"

Rowe says the mental health community needs to work together to alter the perception of mental illness not only in the general population but also within the very community designed to treat it. "For many of us, we are facing similar struggles to the people we work with every day but hiding in the shadows regarding our own experiences for fear of stigma. That needs to change."

Interview 4 – Ron Bruno

CIT International 2nd Vice-President Ron Bruno Says Mental Health Care Shouldn't Come in a Law Enforcement Car

There are police departments throughout the United States that no longer answer calls they believe could result in “suicide by cop.” Around 100 shootings like this happen each year, making up roughly 10% of fatal police shootings. Ron Bruno, executive director of CIT Utah and 2nd vice president at CIT International, says this is a philosophy taking hold in law enforcement agencies all over the country, but he quickly points out, people can't just be left in distress. “Something has to be done, and that's why we need to examine our crisis response system as a whole, carving out clear roles for law enforcement and mental health services.” Bruno says that law enforcement has a critical part to play in the mental health crisis response system, but it needs to be in a position of support to the mental healthcare system and only when necessary. “We have to challenge the belief that mental health crisis services must come in a police car.”

While there are law enforcement agencies selectively unresponsive to some mental health calls, others are doubling down on their involvement. The impetus, says Bruno, is that, historically, mental health services haven't been appropriately funded and so law enforcement became the de facto mental health crisis response system. “It fell to us, but we aren't the best solution or help to a person in an escalated state.” Bruno travels around the world, speaking to audiences on de-escalation and advocating for clearly defined roles for criminal justice and behavioral health services to create a more effective crisis response system. At some point during a presentation, he often asks the audience to raise their hand if they've ever been pulled over by a police officer. Most of the hands raise. Then, he'll instruct them to keep their hands up if the experience increased their anxiety level. Hands remain raised. “Every time a police officer goes out to a crisis situation, it's going to escalate the person's emotional state. Yes, we can and will train officers to de-escalate situations, but often, their mere presence is stressful, and the person in crisis can become fearful and enter flight or fight. That's when we see major problems.”

Estimates suggest that 25-50% of fatal encounters with law enforcement involve a person experiencing mental illness. Bruno says that in most cases, the interaction between law enforcement and the person in crisis is unnecessary. Just like audiences raised their hands to indicate the distress they felt when pulled over by a police officer, in de-escalation training, officers share that, in the majority of cases where they were called out, the situation didn't warrant it. Bruno says having law enforcement be the go-to for mental health crisis care appears and feels criminalizing to the person in need. “Most departments have a policy that the person in crisis will be handcuffed, placed in the back of a caged police vehicle, and taken to an ER. This is traumatizing for the person and will make it so that they are reluctant to call for help the next time they are in crisis.” The result is that people in distress, and their families, allow further decompensation than they should before reaching out for help because they don't want to interact with law enforcement. “With officers declining calls and people not wanting to interface

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with law enforcement when they or a family member is in crisis, it highlights that something is wrong with the current system.”

The solution, says Bruno, isn’t complicated. When a call goes into the Emergency Communication Center—911 dispatch—operators can be trained to triage those calls and identify whether the person in crisis is a danger to her or himself or an immediate threat to someone else. If not, then the person can be passed along to appropriate care in the mental health crisis system through a warm handoff to the crisis line. At that point, says Bruno, the crisis line can also do a secondary triage and determine whether it’s still a safe situation. If they decide that it’s unsafe, Bruno says they can do a warm handoff back to law enforcement, and law enforcement can send out Crisis Intervention Team (CIT) trained officers to go out and respond to those situations. “Most calls that go through 911 don’t require a law enforcement response and can be transferred to a crisis line where we know the majority of calls, 80% and upward, are resolved at that level, and there’s no need for police involvement.”

If an officer on the street comes across a person in crisis and assesses that the person is safe, she or he should reach out to mobile crisis. The challenge is that each community is unique, and many don’t have a robust continuum of crisis care. Bruno says that’s why each community needs to take a hard (and holistic) look at what’s happening in their public mental health system, addressing potential funding and geographical challenges. Ironically, says Bruno, many communities are defaulting to the least economical solution, using law enforcement as the primary form of mental health crisis services or embedded co-responder models, where law enforcement agencies dedicate personnel and team them with clinicians to respond. “It’s expensive because now you have dedicated law enforcement officers waiting around for mental health crisis calls or, like some agencies, a clinician rides around with a police officer who is handling unrelated calls.”

Bruno says it’s time for public mental health to return to the community and allow people in crisis to be treated within it, instead of removing them from their support systems by taking them out of their day-to-day lives and roles. “It’s easier for people to transition back into their lives if they’re never fully yanked out of them in the first place and can be treated in the community.” He says by retraining people to call a crisis line instead of 911, it allows people to be treated in the least intrusive manner as opposed to the highest. “We’ve trained people to think that if a loved one is in crisis; they need to contact law enforcement who will come out and take the person into protective custody. He or she will be handcuffed, put in the back of the police car, and taken to the ER. That’s what we’ve told people is the cost of stabilization.” He says it’s a grueling, stress-inducing process, that more often than not, was unnecessary. A crisis line can help decrease a person’s distress, and if they are unable to, they can send out a clinician and certified peer specialist to talk to the person, and, when necessary, the support of a CIT trained police officer. The idea, says Bruno, is to maximize the use of a person’s natural supports into their stabilization plan. “By doing this, we are going to retrain community members to think, ‘If I become symptomatic, I contact the crisis line. If the specialist deems it appropriate, they will hand me off to a warmline. However, if necessary, they can also send out a professional who can talk to me.’”

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Figure 6 – Law Enforcement/Crisis Triage Tree

Dedicated Mental Health Crisis Response Model



As contrasted with co-responder models or communities where the crisis response defaults to law enforcement and hospitals, the dedicated approach ensures law enforcement and hospitals are only involved as required by their core mission, public safety and/or medical stabilization. The vast majority of psychiatric crises require neither.

Bruno says it's time for a change, "Let's treat crisis in the most compassionate and least intrusive manner."

Want to see a flowchart that gives a clear example of risk assessment? Take a look at the recently released Broome County 911 call diversion emotionally distressed caller risk assessment in the [CIT best practices guide](#).

Interview 5 – John Draper, PhD

Dr. Draper of the Lifeline Believes a Three-digit-number for Mental Health and Suicide Crisis will One Day be as Ubiquitous as 911

The murder of Kitty Genovese in Queens, New York, in 1964 sparked outrage and was one of the driving forces behind the 911 emergency call system people know and depend on today. It wasn't the murder itself that left people incensed but that 38 people witnessed Winston Moseley kill Genovese and did nothing about it. The behavioral reaction was later called The Bystander Effect or Kitty Genovese Syndrome. It turns out that at least one man did call the police to report that Genovese was seriously injured. His call went unanswered.

Most people can't remember a time before a centralized number for people to call in an emergency; when people dialed 0 for an operator or directly called the nearest police or fire station. John Draper, Ph.D., project director of the SAMHSA-funded National Suicide Prevention Lifeline (800-237-TALK or chat), hopes that a three-digit-number for mental health and suicide crisis will one day be equally ubiquitous. "Right now people have to remember an 800-number, and even though calls go up 15-percent per year and 2.2 million calls were answered in 2018, we know that 13-million people seriously think about suicide each year, which means we are far from the universe of people who could be reached."

In December, former Senator Orrin Hatch (R-Utah) wrote a letter to Marlene H. Dortch, Secretary of the Federal Communications Commission (FCC), urging the agency to use the three-digit-number 611 for Lifeline. The senator wrote that the designation would connect Americans experiencing mental health crises with life-saving counsel and resources. Currently, 611 links callers to telephone repair and telecom customer service. In 1997, the FCC noted it would continue to do so until needed for another national purpose. Sen. Hatch wrote that making the Lifeline more accessible and user-friendly to Americans is "a pressing, national purpose," and recommended that 611 be used solely for mental health and suicide crises to eliminate confusion and delay. He further stated that it would be more difficult to market 611 as Lifeline if the number has a dual purpose, which would limit its efficacy.

Dr. Draper says studies show it's easier to remember three-digits than an entire phone number, making a three-digit-number for mental health and suicide crisis more accessible. The designation would build off the national network infrastructure provided by the Lifeline, and trained mental health and suicide prevention counselors would answer calls. Much like 911 and Poison Control centers, the number would triage to local services and resources, including mobile crisis and respite services. It also, says Dr. Draper, has the potential to decrease stigma. While pondering the long-lasting effects of a three-digit-number for mental health and suicide crisis, Dr. Draper asked his daughter, who has a history of anxiety and depression, what she thought the impact could be. "She responded that people would finally understand mental health crises are real and require a different response than triaging to police or EMS. She said that by creating a cultural shift, 'It would likely do more than anything else to erase stigma against mental illness, and that's cool.'"

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A three-digit-number, says Dr. Draper, will likely increase the number of callers to the Lifeline and, as a result, has the power to change how people think about mental illness. More callers equate to more data the national hotline can collect and analyze. He says this is precisely what's happening in the United Kingdom with 111, a three-digit designation for all urgent health needs, including behavioral, that provides advice and triages callers to the appropriate level of care. The number of calls to 111 grew from 12 million to 16 million, with an increase in demand over time. Today, roughly 20,000 people call 111 every day to get advice over the phone from doctors, nurses, and paramedics. Dr. Draper says a similar three-digit-number for mental health and suicide crisis would trigger real parity. "People phoning would give us the data we need in terms of caller expectations from the mental health system, which will increase voice representation and help tailor demands on policymakers to respond to these needs with adequate behavioral health resources in the communities callers live."

What Dr. Draper and his partners want is to create a culture that fosters autonomy where people's ability to get help during a mental health or suicide crisis is at their fingertips, quite literally. It's up to the caller, not his or her provider. "This gives people a sense of agency at a time when they are feeling incredibly helpless, which is powerful." He also believes that when society places mental health and suicide crisis on the same level as medical crisis, there will be a repositioning, making call centers a visible service similar to EMS. Graduating students will find it a real pathway for learning how to help others. "A cultural shift through a three-digit-number is good for callers and the mental health profession."

Interview 6 – Nick Margiotta, Retired Detective

Law Enforcement Are Critical Stakeholders in Behavioral Health Crisis Services

It was September 24th, 1987, and Memphis police answered a 911 call made by a mother desperate to help her 27-year-old son experiencing an episode of Paranoid Schizophrenia. Joseph DeWayne Robinson had cut himself 120 times with a butcher’s knife, and his mother was fearful that he was going to kill himself. When police arrived at the scene at LeMoyne Gardens public housing project, it was a tight perimeter, and the officers asked Robinson to drop the knife. He didn’t. What happened next is disputed: the officers said Robinson lunged toward them; witnesses said he did not. The officers shot and killed Robinson, prompting community outrage and charges of racial bias against the Memphis administration. Robinson was Black, and the two officers who shot him were White. Sabrina Taylor, Crisis Intervention Team Training Coordinator at the Phoenix Police Department, says this tragedy was the tipping point that led to the creation of the Memphis Crisis Intervention Team (CIT).

Robinson was what law enforcement calls a frequent flier: he had a history of psychiatric hospitalizations and was a high use 911 caller, but the police officers who answered the emergency call were not trained in behavioral health crisis or how to deescalate the situation. Taylor says that people in crisis may not be easy to engage and appear out-of-control. Law enforcement can interpret the behavior as an imminent threat. Officers trained in crisis intervention have additional tools to respond to behavioral health emergencies such as knowledge, understanding, empathy, and listening techniques that may calm people down and negate the need for force. The approach decreases conflict and diverts people from jail. Instead, says Taylor, police officers often take people experiencing behavioral health crises to psychiatric emergency centers.

Nick Margiotta, president of Crisis System Solutions and retired Phoenix police officer, says CIT sounds simple, and in many ways, it is, but it takes leaders in behavioral health who understand that police officers are critical stakeholders in crisis services. “Historically, the expectation has been that law enforcement officers fall in line with whatever policy leaders in behavioral health make. That doesn’t factor in our culture and, as a result, officers won’t do it.” Margiotta was first introduced to CIT in 2001 in a training program. He says that trainings are essential, but without an infrastructure to support actual implementation, it’s a disservice. In training, Margiotta learned about mobile crisis teams and psychiatric centers, where he and his colleagues could do a warm handoff. “The training shifted my perception and made me realize we can’t arrest our way out of this problem, and I was excited to start applying CIT to my job.” Margiotta answered a call from a frequent caller with Serious Mental Illness (SMI). She was depressed, had been drinking, and threatened to take 100 Advils. Margiotta thought this was an ideal opportunity to do his first psychiatric center drop-off. When he went to the facility, the staff rejected the drop-off because the woman had been drinking. Then he took her to the detox facility, and they rejected her because she was suicidal. “I was proud to apply my CIT training only for the person to be denied in both locations, so I didn’t do again for years. All I could do was take her to the parking lot of the county hospital and say, ‘Good luck.’”

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Even though Margiotta didn't use the CIT training as initially designed, it made him rethink how law enforcement was engaging with the community. Over the next few years, he built a diversion program and housing first initiatives during the day while patrolling downtown Phoenix at night. Three years later, Margiotta worked to restart CIT, and this time it was successful. The reason, says Margiotta, is he spent 90% of his time working with the behavioral health system, educating leaders on police culture. "Law enforcement will default to the more convenient solution, which means drop-offs need to be easier than what it takes to book someone."

Police Drop-offs

The more limitations and challenges behavioral health facilities present, the less likely they will get police to drop off people in behavioral health crises. What law enforcement needs, says Margiotta, is a no-refusal policy, allowing officers to do drop-offs and return to their patrol duties. He says that initially, when he restarted CIT at his station, law enforcement faced numerous roadblocks. It took patience, collaboration, and walking crisis services staff and leadership through why service design must include a law enforcement voice to facilitate change. Margiotta says psychiatric centers were requiring police officers to take off their guns, refusing patients who had been drinking, requiring officers to obtain medical clearance, and the only door for drop-offs sometimes was the front door, with the seclusion and restraint room far away from the drop-off door. These were all barriers that, if they continued, would have made drop-offs unlikely. He says facilities also feared police officers were going to bring people experiencing delirium. If a person was clearly in need of a hospital, that's where Margiotta would take him, but in cases of delirium, which is harder for a law enforcement official to determine, the center could call for an ambulance. "If I'm going to get medically screened out and have to put the person back in my car and drive him somewhere else, why should I even bother going there in the first place? Psychiatric centers need to function like Emergency Medical Treatment and Labor Act (EMTALA) applies to them, accepting anyone police officers bring in and integrating cop culture into the development of their policies. Meaning, 100 percent of crisis workers must be trained to work with law enforcement effectively. Otherwise, officers will default to the hospital or jail."

Margiotta says successful collaboration also required law enforcement buy-in, which any refused drop-off could derail. "Years later, we've had a tremendous cultural shift here in Phoenix. Police officers automatically believe drop-offs allow them to do their job better and help people." He says increasing buy-in from law enforcement and crisis services required holding each other accountable. Side-by-side, they looked over data each month. The goal, says Margiotta, was for police drop-offs to take less than seven-to-eight minutes. "When that didn't happen, we all took a closer look at what went wrong and how to improve performance."

A threat to collaboration is inviting law enforcement officers to be part of the design and processes, but then not integrating any of their recommendations. Margiotta says this is what happened with one facility. "They brought me in, and we worked alongside one another for months, but during the grand opening, it was clear they didn't follow any of our recommendations. They were pretending to collaborate. I was there as window dressing to show that leadership had worked with us, and to keep me quiet during the implementation phase." He says the facility was unsafe for police: staff would need to buzz officers in and couldn't let anyone

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in or out. “It was a lockbox with nearby instruments that were dangerous. I made it clear there was no way officers would be coming there until they made the necessary changes.” In the end, the facility did an entire redesign. It took three years before police regularly started bringing drop-offs there.

Mobile Crisis

Margiotta says mobile crisis teams are a vital partnership for law enforcement, but working with them required similar collaborations. It took at least three years to create a robust, productive relationship. At first, they struggled with inconsistent mobile unit dispatch and crisis service provider fear of escalation. A good crisis mobile response team has rapid response and goes out 24/7, but, initially, that wasn't happening. “We were getting a 25% denial rate from mobile units. That's a no-no in our culture; officers will stop calling. We worked together and eventually, every time we called, a mobile unit was dispatched immediately. That's the compliance we needed.” Police also need to be able to do a warm handoff of 5-15 minutes to the mobile unit and quickly get back to their jobs, but crisis services personnel often wanted officers to stick around for fear that the person might escalate. “This makes sense only if the person is violent, and suicidal ideation alone doesn't mean police need to be present.” In one instance, says Margiotta, a caseworker was answering a call where the person hadn't taken her medication for a few weeks. The caseworker sent the mobile crisis team and simultaneously called police to go to the location. “There was no danger, she wasn't violent, and when I said that to the two-person mobile unit, they responded, ‘She has Schizophrenia. She could be hearing voices.’ They are the ones trained in behavioral health. I didn't need to be there.”

Today, a person in a leadership role has to authorize if a mobile unit can call law enforcement, but if a situation escalates, the unit can immediately call the police. As a result, calls for police to respond have gone down between 70% and 80%. If the crisis line gets 18,000 calls a month, Margiotta says less than 10% will triage to mobile crisis units, and less than 1% need police response. Part of the struggle, says Margiotta is viewpoint, “Behavioral health workers believe these issues to be in the community, and that they are helping us. We view it quite differently; we are bringing them their customers for who they receive state and federal dollars. We see ourselves as critical stakeholders.” He has spent most of his career developing and maintaining partnerships between law enforcement and crisis services. “You can't keep people out of the Emergency Department and jail without these relationships. It's a public safety and public health issue: we are in this together.”

Interview 7 – Anonymous Peer Recovery Coach

Peer Recovery Coach Says “Stigma of MAT Persists in the Recovery Community”

Veronica* slid into addiction slowly, increasingly drinking as a teen, and by the time college came around, she needed alcohol first thing in the morning to stop her hands from shaking. She says it escalated from there. For Veronica, addiction wasn't a straight line, more like there were times she stopped entirely and others when there was a litany of drugs she used each day, including heroin and oxycodone. She quit multiple times, promising her family she was done, but it wasn't until a close friend died in front of her, his arm hanging limply off the EMS gurney, that Veronica made a promise to herself for herself that she was going to get help. She turned a corner that day, driving to a nearby clinic where she started Medication-assisted treatment (MAT) and that, she says, “was all she wrote.” It's not though, because six years later, Veronica is now an award-winning peer recovery coach, helping people navigate the challenges she faced. When asked what or who she credits for her recovery, Veronica doesn't hesitate to say ongoing MAT and caring recovery coaches, but, she lowers her voice, her colleagues don't know. She fears they wouldn't accept her and she has good reason to think so. “There's a lot of stigma within the recovery world and a belief that MAT is simply substituting one drug for another.” Veronica says in a recent discussion, a colleague said just that. “It's startling because no one would say that about a person with a physical illness. Can you imagine if those in the medical field said to people with diabetes, ‘You shouldn't use insulin as treatment.’ Well, that's what's happening in the field of recovery: people are often judged for using evidence-based medicine.”

The belief that MAT is exchanging one drug for another is not uncommon among the general population and even among physicians in the medical field. In May 2017, Dr. Tom Price, former Secretary of Health and Human Services, said, “If we're just substituting one opioid for another, we're not moving the dial much.” He faced immediate backlash from the medical and scientific community. Dr. Vivek Murthy, former Surgeon General of the United States, responded on Twitter that an abstinence-only approach isn't backed by science, unlike MAT, which leads to better outcomes compared to behavioral treatment alone. Months later, in September, there appeared to be a shift in the federal government, with Dr. Scott Gottlieb, the FDA Commissioner at the time, saying that MAT “...is one of the major pillars of the federal response to the opioid epidemic in this country. He went on to say that MAT is an essential tool that has the potential to allow millions of Americans to regain control of their lives.

What's surprising to Veronica isn't that people in the general population don't understand that MAT is an evidence-based practice but that those working in recovery are perpetuating misinformation. Medication-assisted treatment is a holistic approach for substance use disorders that combines counseling, behavioral therapy, and FDA-approved medication. She says that without MAT, she would likely be dead. “I would have continued using, or relapsed, unsure of what I was taking and the dosage. Heroin is no longer pure. It's increasingly packed with other ingredients, many of them potentially lethal, like Fentanyl.” Veronica says that without treatment, she wouldn't have been able to enter recovery because the pain associated with withdrawal is horrendous. It's not just acute pain that's problematic, but also precipitated withdrawal that happens months later, making each day unbearable. “People in recovery who

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haven't had an opiate addiction often don't understand what this type of withdrawal feels like in the short- and long-term. I think that's why they aren't sympathetic."

Last year, Veronica's 29-year-old half-sister died of endocarditis from intravenous drug use. Having shared similar struggles, Veronica believes she and her sister ended up on divergent paths because of money and stigma. "My sister went to the nearest clinic for two years, and she did well, but then she could no longer pay the \$80 a week it costs to go to the clinic." Her sister's family refused to help with the fees because they thought taking Methadone would limit her job opportunities. "Because of stigma and fear of stigma, my sister is now in a mausoleum."

Not sharing her treatment with colleagues has been taxing, and Veronica has struggled with whether she's contributing to stigma by not telling her story. "I wonder about it every day. Am I living a lie? I don't think they would accept me. From what I've heard them say, my guess is it would diminish their respect for me. If I make a human error, will they blame the fact that I'm on treatment, even if that doesn't make sense?" Every week, Veronica goes into the clinic with her take-home bottles. The clinic fills them with medication for the next six days; on the seventh day, she goes back in to get her final dosage. She says it didn't start off that way. At first, she had to go to the clinic daily, then, over time, the recovery team would give her medication to take home. After six years, she still goes to the clinic once a week. It makes Veronica nervous because there are weeks where it has been challenging to get to the clinic. For instance, last year, a massive storm was headed to her area. She lives out in the country, and snow would have made it impossible to get to the clinic. Veronica arranged to stay with family in town so that she wouldn't risk missing the final dosage or filling her bottles for the next week. It's these small changes that colleagues can notice, she says, and it makes her worried that they will figure it out; for example, wondering why she stayed with family instead of at home. The fact that she has to worry about it at all makes her angry. "I work in a recovery environment, but, ironically, I'm forced to hide my recovery and treatment from my colleagues. Stigma inside of an industry designed to help people recover and fight stigma is problematic."

Veronica worries about how stigma affects others in recovery and how judgment toward those in recovery impacts people not quite there yet. At a recent team meeting, a colleague vented that Narcan—a medication that entirely or partially reverses an opioid overdose, including respiratory depression—enables people addicted to opioids, saying, "We'll bring them back, and they will just use again." "It made me so upset to hear someone in this role make a statement like that. We hope to keep people alive. We have many repeat clients, which is why the person was frustrated, but we want to be there for them when they take that long-lasting step into recovery. It took me multiple times to get there. What if people at the clinic had just given up on me? Where would I be? We want to do our best to create an environment for people to get the help they need when they need it."

**Veronica is not the peer recovery coach's real name. She has asked to remain anonymous.*

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Section II: Crisis Service Papers Building on SAMHSA's National Guidelines

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The background of the entire page is a painting of a blue sea. The water is depicted with various shades of blue and teal, with visible brushstrokes and ripples. In the lower half of the image, a bright red lifebuoy with two grey straps and a white rope is floating. The lifebuoy is the central focus, and its reflection is visible in the water below it. The overall mood is one of hope and rescue.

CRISIS SERVICES

Meeting Needs,
Saving Lives

Accessible • Interconnected • Effective • Just

Crisis Services: Meeting Needs, Saving Lives

Debra A Pinals, MD

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CRISIS SERVICES:



Meeting Needs, Saving Lives

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2020 Series of Eleven Technical Assistance Briefs focused on Beyond Beds: Crisis Services



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ABSTRACT:

With COVID-19 as a constant stressor and new spotlights on the need to address structural racism in society, it is more important than ever to examine how mental wellbeing in the United States can be supported. Even prior to recent events related to these issues, national attention on alarming increases in suicide rates and opioid-related overdose deaths, homelessness, the over-representation of individuals with mental illness, intellectual and developmental disabilities and substance use disorders in the criminal legal system, all called attention to an urgent need for expanded prevention and intervention strategies for people in dire need of help. In 2017, the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered in advocating for policy makers to consider what it would take to look “Beyond Beds” in state hospitals as a single solution to all the challenges and instead develop a path toward a robust continuum of accessible, effective psychiatric care. Now, three years later, NASMHPD and SAMHSA highlight the first point of entry into that continuum of care- to prevent and manage crises in a way that offers an immediately accessible, interconnected, effective and just continuum of crisis behavioral health services. By enhancing crisis response, community needs can be met, and lives can be saved with services that reduce suicides and opioid-related deaths, divert individuals from incarceration and unnecessary hospitalization and accurately assess and stabilize and refer individuals with mental health, substance use and other behavioral health challenges. This paper, *Crisis Services: Meeting Needs, Saving Lives*, furthers the *Beyond Beds* strategy by describing this vision. By knitting together several bodies of work on crisis services, it sets the stage for the next iteration of a national dialogue for developing and expanding that much needed continuum of quality mental health and substance use care for all who need it, when they need it.

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Background

Mental health and substance use services are increasingly recognized as critical infrastructure to help address a variety of societal concerns in the United States. In the throes of the COVID-19 pandemic and its emotionally tolling consequences, there is an even greater call to examine behavioral health practices, pivoting and adapting services to the needs of the population. Every aspect of the COVID-19 pandemic has shined a spotlight on the need to attend to mental wellness and make an accessible continuum of psychiatric care.¹ Demand has ranged from building access to disaster distress counseling to identifying where inpatient psychiatric services can best be delivered while minding infectious disease control. At the same time, tragic events showing violence, especially toward black men, and the disproportionate impact of COVID-19 on racial and ethnic populations have highlighted structural racism, healthcare disparities and unequal and unjust outcomes. Together, the need for comprehensive mental health supports for the population is a national imperative.

Even before the global pandemic, for persons with serious mental illness, prolonged waits in emergency departments² have been alarmingly long, and risks of arrest and incarceration, alarmingly high.³ Forensic services such as waits for competence to stand trial services have been increasingly in demand⁴, and they too are subject to the same disparities in care noted in other criminal justice landscapes.⁵ Through several initiatives spanning across decades, mental health advocates, government agencies, legislators, and providers have worked to push forward reform. The goal is to have a community system that is interconnected, effective, just and accessible, through well-coordinated services. With this as a reality, many lives could be saved, suicides averted, and even persons with serious mental illness could access quality care and avoid negative outcomes seen too often. In 2017, the National Association of State Mental Health Programs (NASMHPD) together with the Substance Abuse and Mental Health Services

SAMHSA Crisis Toolkit: A Roadmap for Crisis System Design

Earlier this year, the Substance Abuse and Mental Health Services Administration released its *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, calling on crisis services that “are for anyone, anywhere and anytime.” This toolkit provides a roadmap for crisis system design.

Administration (SAMHSA) laid a foundational clarion call with the paper, *Beyond beds: The vital role of the full continuum of psychiatric care*⁶ in which the cry for “more beds” was questioned as the single system solution. Instead, that paper pointed to building an infrastructure of a continuum of mental health services and policies to ensure timely access to appropriate care to address serious emotional disturbances and serious mental illness. In subsequent years, NASMHPD put forth bold goals to achieve improved outcomes for mental illness,⁷ and in 2019, called for an exploration of nine areas as examples of lessons that could be drawn from the international community to enhance practices and services in the United States to achieve better outcomes for mental health overall.⁸

This paper offers a next step in looking *Beyond Beds*, providing an overarching view of crisis services for persons with urgent mental health and substance use needs and policy considerations for building that effective crisis service continuum. To give readers a more complete understanding of crisis services, this paper encompasses the following topic areas:

- The Crisis Continuum
- Examples of Effective Crisis Services
- Pathways in Crisis Services



- The Evolving Role of Law Enforcement and Mobile Crisis Response
- Person-Centered Crisis Care
- Supporting the Crisis Infrastructure, From Laws to Technology
- Crisis Services During COVID-19 and Beyond

As noted in SAMHSA's 2020 *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*,⁹ a robust crisis system provides a gateway to mental health and substance use disorder treatment, and as a safety net more broadly for anyone and all who access it. In this way, crisis services support one end of the desperately needed continuum of psychiatric care.

The Crisis Continuum

The crisis continuum includes various crisis services for individuals with urgent behavioral health needs, the response to such crises and subsequent pathways toward more complete assessment and treatment when needed. According to the SAMHSA Crisis Care Best Practice Toolkit (henceforth the SAMHSA Crisis Toolkit),¹⁰ the role of crisis services includes addressing the acute suffering of persons when they are in an emotional crisis, as well as addressing mental illness itself, given it is one of the leading causes of disability.

To understand the potential for an effective crisis care continuum, it is important to break down elements into understandable component parts. Although substance use services and mental health services have historically been set up on distinct parallel tracks, a robust crisis system must examine all aspects of needs for an individual. Integrated care opportunities should be incorporated, regardless of what issue is the "primary" one that presents itself. Individuals who present will represent diverse populations, diverse age groups and they may also have other medical issues. A crisis service array must appropriately address and triage real needs in real time.

SAMHSA Crisis Toolkit: Benefits of Good Crisis Care

1. An effective strategy for suicide prevention
2. An approach that better aligns care to the unique needs of the individual
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis
4. A key element to reduce psychiatric hospital bed overuse
5. An essential resource to eliminate psychiatric boarding in emergency departments
6. A viable solution to the drains on law enforcement resources in the community
7. Crucial to reducing the fragmentation of mental health care.

SAMHSA Crisis Toolkit: Core Elements of a Crisis System

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; and
4. Essential crisis care principles and practices.



The definitions within the crisis services line-up can be important, especially as communities work to enhance the available of these services. To this day, there can be an alphabet soup of terms for levels of care. In the substance use services arena, the American Society of Addiction Medicine (ASAM) has advanced the delineation of levels of care, known as the ASAM Criteria. These help distinguish concepts of ambulatory services with and without extended onsite monitoring, non-medical but clinically managed services, medically monitored inpatient, and medically managed intensive inpatient levels.¹¹ Definitions like these, and needed definitions as pertained to crisis services for both mental illness and substance use disorders can help secure funding by establishing a clear goal and purpose of the particular program, whether it needs bricks and mortar buildings, or a billable service delivery design through Medicaid 1115 waivers, Certified Community Behavioral Health Center (CCBHC) activities, or straight Medicaid services to name a few. Also, policies, procedures and staff training needs will vary depending on the type of services provided. Without clear definitions across programs there can be ongoing confusion when comparing services.¹²

Beyond Beds

Recommendation #2: Terminology
Direct relevant agencies to conduct a national initiative to standardize terminology for all levels of clinical care for mental illness, including inpatient and outpatient treatment in acute, transitional, rehabilitative, and long-term settings operated by both the public and private sectors.

To date, there is no single federal definition for specific crisis services. For example, the Centers for Medicare and Medicaid Services, in its 115 Serious Mental Illness Availability of Services template offers some broad language in its definition of terms for “crisis stabilization units” and “coordinated community crisis response”, but leaves details up to states to define. It also leaves the term “crisis call centers” up to states to define.¹³ State by state definitions and programmatic nuances therefore can make comparisons challenging. Table 1 proposes working definitions of component parts of a crisis service continuum that are aligned with SAMHSA’s core service network features.¹⁴ Figure 1 depicts the flow through problematic crisis systems that are still too often seen and Figure 2 through a model interconnected crisis continuum.

Table 1: Types of Crisis Services across Systems

Crisis Continuum Component	Model Definitions	Additional Model Functional Components
Warm Lines/Peer Warm Lines	A call line that provides opportunities for talking, receiving support and referrals.	<ul style="list-style-type: none"> - Link individuals to crisis lines for calls that escalate - May be staffed and managed by peer-run organizations
24-hour Crisis Lines (telephone, text, or chat)	A communication system that provides screening, assessment, preliminary counseling, and resources for referrals for mental health or substance use services and suicide prevention pathways.	<ul style="list-style-type: none"> - Provide direct referrals for accessing emergency responses - Utilizes technology “air traffic control” routing, GPS locator and other data systems
Mobile Crisis Teams	A response system that utilizes behavioral health professionals to navigate within a region and at the scene of a crisis to complete mental health and substance use	<ul style="list-style-type: none"> - Work with law enforcement when needed and with appropriate protocols - Intervene as the crisis is occurring in any community setting - May provide follow up check-ins, wellness checks and other community-based interventions



	assessments or connect a person in crisis with services.	<ul style="list-style-type: none"> - Often designed for youth and adults through separate funding streams but may be linked
Crisis Intervention Teams (CIT)	Specially trained law enforcement officers who have undergone designated CIT training, adhere to policies for CIT officers and are linked to behavioral health designated crisis drop off points of access to care.	<ul style="list-style-type: none"> - More than just training, CIT programs are designed to improve police response and improve safety in dealing with individuals experiencing mental health crises - Can be successful in diversion of individuals with mental illness from the criminal justice system - Training emphasizes strategies for de-escalation and linkage to treatment - In addition to law enforcement training, the model includes partnering with drop off sites, robust community crisis care, behavioral health staff training, family, consumer and advocate involvement
Co-Response Teams	Coordinated behavioral health professionals and law enforcement teams who respond to emergency calls for emotional disturbances in the community together.	<ul style="list-style-type: none"> - May be embedded in police department staffing or may be worked out through protocol and funding with local behavioral health mobile crisis team - Practices involve simultaneous response and delineation of on the scene roles and responsibilities - Emphasizes diversion through on scene support, assessment and referrals rather than arrest
Crisis Hubs/Crisis Centers/Coordinated community crisis response center	Locations and systems that provide immediate in-person attention to any level of urgent to emergent need for mental health and substance use disorders and may include call centers, drop-in, and drop off sites.	<ul style="list-style-type: none"> - Includes virtual interconnected activities where the hub is through technology and routing - Allows walk-in clients in need of assistance and may provide urgent care assistance - Ideally offers combined management of substance use and mental health crises including withdrawal management and harm reduction strategies - Serves as drop-off center for law enforcement with the goal of diverting patients in a mental health crisis or with a substance use need away from the criminal or juvenile justice system - Manages crisis response across various community of crisis services - May manage calling centers to answer crisis calls
Psychiatric Urgent Care	Clinics with screening, assessment, brief intervention and prescribing capabilities that operate for walk-in visits with no appointment needed for immediate mental health and substance use support during day hours and limited weekends.	<ul style="list-style-type: none"> - Multidisciplinary staff including peers - Outpatient services and supports - Provide brief prescriptions - Withdrawal management and referrals - Provide linkages to longer term services
Transition or Bridge Clinics	Clinical therapeutic and medication management services made available for individuals moving from one level of care to the next (e.g., emergency department to long-term supports, or inpatient to community).	<ul style="list-style-type: none"> - Provide psychiatry access for medication prescriptions to avoid gaps in care while waiting for openings at regular outpatient services - Can be built to address medications and brief counseling to support opioid use disorder and other substance use needs
Crisis Stabilization Units (CSU) and	Brief, time limited (usually Up to 23 to 72 hours), medically monitored or supervised, observation units that	<ul style="list-style-type: none"> - Small facilities (less than 16 beds) for patients whose needs cannot be met in the community alone following a behavioral health crisis, sometimes licensed similarly



Extended Observation Units	provide care to assist with de-escalating the severity of a crisis and/or need for urgent care.	<p>to inpatient units, sometimes licensed with separate regulatory schemes short of inpatient level of care</p> <ul style="list-style-type: none"> - Provide prompt assessment, medical monitoring, stabilization and determination of next level of care needed - Considered less restrictive and an alternative to traditional inpatient psychiatric hospitalization - May allow for either voluntary and or involuntarily holds under mental health statutes similar to civil commitment provisions depending on state statutes and regulations - Involuntary medications usually only administered in an emergency context
Crisis Residential Services	Services where individuals in crisis can voluntarily reside for brief periods (usually up to 14 days) and receive behavioral health supports in a less intensive setting than inpatient level of care.	<ul style="list-style-type: none"> - Can be used as a step-down or diversion from an inpatient hospitalization - Can be used to assist in de-escalating a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder by providing continuous observation and clinical support - Can include access to multidisciplinary treatment including treatment with medications and therapeutic supports
Living Room/Peer Run Crisis Centers	Comfortable non-clinical space that provides an alternative to emergency rooms for adults for short-term stays where individuals have available recovery support staff such as peers to help resolve crises.	<ul style="list-style-type: none"> - Provides a calming and safe environment - Short term stays (days to weeks)
In-Home Supports/Family-Based Crisis Home-Based Support/Respite Services	Short-term intensively supported services where individual may stay with their own family or other qualified local family or provider-based locations with add-on supports.	<ul style="list-style-type: none"> - Includes regular contact and home visits with mental health professionals and other support staff, parent peers or mentors
Emergency Rooms with or Without Dedicated Behavioral Health Sections	Embedded hospital-based service for medical emergencies, including psychiatric emergencies, especially where safety related to psychiatric illness, medical management of substance use or medical co-occurrence may be an immediate concern.	<ul style="list-style-type: none"> - More appropriate when medical issues or uncertain diagnostic complexity need careful monitoring - More appropriate for severe drug use or alcohol use where medical monitoring is indicated - Increasingly able to induce medication assisted treatment for opioid use disorder - May be more appropriate for extreme behavioral dysregulation challenges
Partial or Day Hospitals	Community-based day mental health services with full multidisciplinary team with groups, therapies, medically monitored, and access to prescribers who can adjust medications while the individual resides at home.	<ul style="list-style-type: none"> - Appropriate for individuals with ongoing symptoms of mental illness but low safety concerns - Individuals typically sleep at home and come to hospital during daytime hours - May be used as a transitional treatment site when moving from inpatient to outpatient care



<p>Acute Psychiatric Hospital Units</p>	<p>Hospital level of 24-hour care for psychiatric illnesses for a person who needs intensive, multi-disciplinary treatment with medically managed intensive and round-the-clock nursing, usually addressing safety and complex care-management needs.</p>	<ul style="list-style-type: none"> - Typically, a locked setting - Typically, a length of stay days to weeks - May allow voluntary and involuntary patients - Treatments provide maximum diagnostic assessment, observation, medication adjustments, and address risk of harm to self and/or others - May allow ECT administration - Considered the highest medically necessary level of care - May be found in critical access hospitals as small facility that have 24-hour emergency care, outpatient and inpatient services - May be found in general hospitals, freestanding private, or, in some places, within state psychiatric hospitals still accepting acute patients
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*Adapted from: [Crisis services](#). National Alliance on Mental Illness; [Crisis services: Effectiveness, cost effectiveness, and funding strategies](#), 2014, SAMHSA; Saxon V, et al. [Behavioral health crisis stabilization centers: A new normal](#), 2018, *J Mental Health & Clin Psychology*; [National guidelines for behavioral health crisis care best practice toolkit](#), 2020, SAMHSA; [Getting to the ideal behavioral health crisis system: Essential elements, measurable standards and best practices](#), 2020 (draft under review), Group for the Advancement of Psychiatry. Centers for Medicaid and Medicare Services 1115 Waiver Definitions of Terms used in the Availability Assessment, 2020.

Figure 1: Flow of the Current Problematic Crisis System

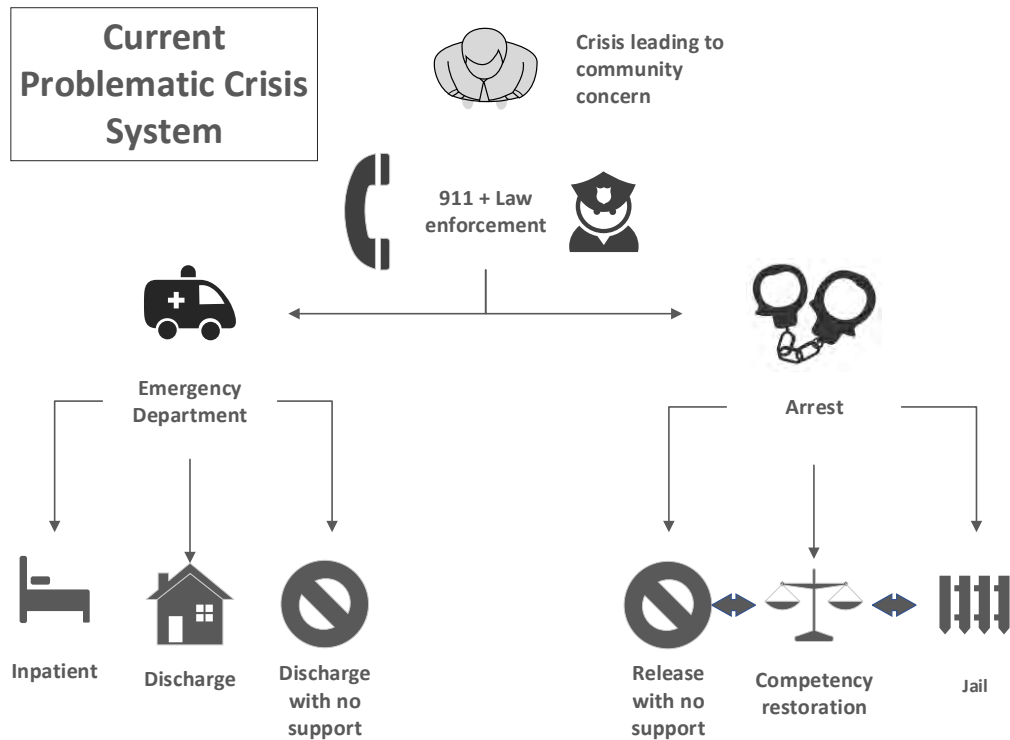
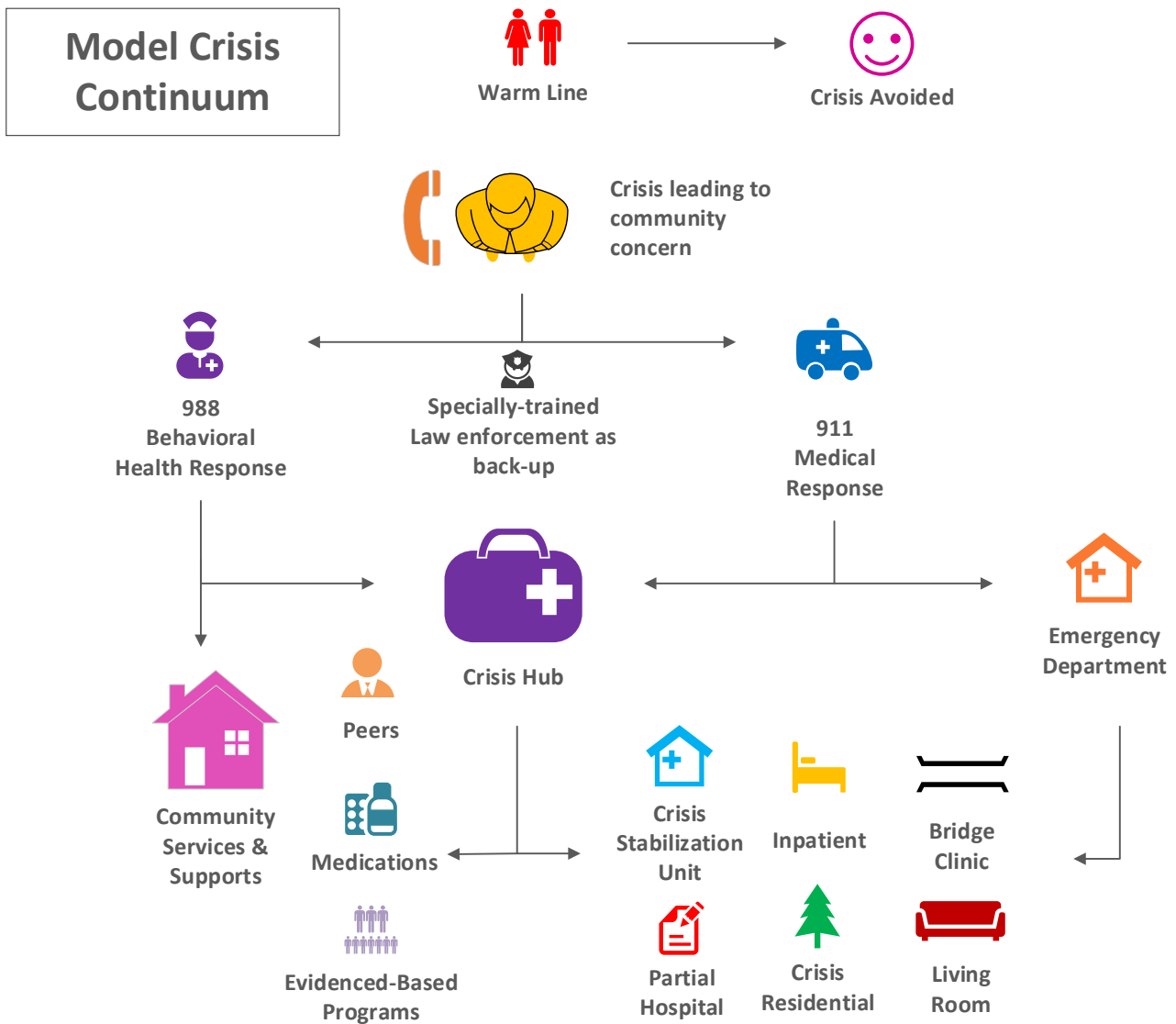


Figure 2: Flow of an Interconnected Model Crisis Continuum



Examples of Effective Crisis Services

In some parts of the country, the work of building out crisis systems has been long standing or recently begun in earnest. One example of such effort has been realized through the Crisis Now model, which was started in Phoenix, Arizona. The model incorporates technology, crisis centers, case processes, suicide prevention, and more improved management of persons in distress than had been available through traditional medical emergency department response, and a methodology that de-emphasizes routing individuals to psychiatric inpatient beds as a single option.¹⁵ The Crisis Now model has gained tremendous traction and was described in a well-circulated 2016 report spearheaded by two behavioral health thought leaders.¹⁶



In 2014, National Public Radio aired a story of the “Restoration Center” in San Antonio, Texas, that helped it gain national attention.¹⁷ This center was designed as a community crisis resource and as a “police friendly” drop off site to help improve jail diversion initiatives for persons with mental illness and substance use.¹⁸ People from around the country traveled to visit the site to learn about its vision and mission and to see how it could be adapted to their local communities. More recently other centers and models have gained national attention, such as the Pima County, Arizona Crisis Response Center, which was developed through local partnerships and funded in part through a ballot initiative.¹⁹

Other types of supports are being built to help individuals access outpatient services outside of traditional models where there may be waits for appointments. For example, psychiatric urgent care clinics have opened, some inspired by demand and complexity related to COVID-19.²⁰ There are several on-demand mental health clinics available in Massachusetts,²¹ and envisioning the continuum of tomorrow, advocates have called for same-day access while considering the challenges to funding services of this nature.²² Even in addiction care there has been much done around the country to get immediate access to medication assisted treatments (MAT). The Certified Community Behavioral Health Clinics model also is setting forth a path given that the model requires easy access to care and 24/7/365 crisis services and is being examined as a model in various states.²³

Pathways in Crisis Services

One of the critical elements of crisis service continuums is the importance of understanding the flow, or pathways that individuals may follow as they move from the initial crisis response through the rest of the array of services.²⁴ The pathways an individual will follow can look very different depending on that person’s needs, with continuous treatment and supports that can last hours to days to months. For example, for someone with a serious mental illness, an individual in crisis may ultimately only need time to be re-stabilized on medication. Others might need significant medication changes or supports that address housing needs. Ultimately, an individual’s treatment should be geared specifically to their needs.²⁵ Moreover youth, older adults, or persons of diverse backgrounds should have equal access to crisis supports that are capable of meeting their needs, and the crisis service continuum will need to be able to equally and adeptly serve everyone.²⁶

Beyond Beds

Recommendation #7: Linkages Recognize that the mental health, community, justice, and public service systems are interconnected, and adopt and refine policies to identify and close gaps between them. Practices should include providing “warm hand-offs” and other necessary supports to help individuals navigate between the systems in which they are engaged.

Crisis call lines and “warm” lines function as an important entry point into the crisis service continuum. These types of systems connect individuals calling in to specialized counselors or peers on the other end of a phone line. Some individuals prefer outreach in a moment of distress through text or online chat. At times, an individual may call or text just to connect or to seek information, but during the contact, the individual may reveal information that raises more urgent concern. Some individuals are calling in a suicide crisis or looking for urgent support to help with substance use, or they may have any number of other distressing concerns. With the expansion of these types of call services, there is an increasing need for them to be streamlined and readily accessible with the responders knowledgeable about the rest of the



continuum of mental health and substance use care. Regardless of the modality or context, access to them as part of an interconnected range of responses across modalities is critical.

Crisis call lines have in fact proven to be a critical part of the crisis system infrastructure during the COVID-19 pandemic. The National Disaster Distress Line quickly saw a rapid rise in utilization as societal distress over this disaster spread throughout the country. States have responded by attempting to coordinate crisis services more broadly. Take for example the Michigan “Stay Well” initiative,²⁷ which was launched after the statewide stay home order in response to COVID-19 went into effect, and has been sustained even after the lifting of the restrictions.²⁸ The state’s efforts put forth several options to persons in need of emotional supports, including a peer warm line that has received thousands of calls,²⁹ crisis counseling with “Stay Well” counselors, video resources, and written guides for the public managing stress and anxiety pertaining to COVID-19. With the support of SAMHSA and Federal Emergency Management Agency (FEMA), additional staff have been deployed to a call center in Michigan.

Throughout the United States, these types of call centers are connected to the National Suicide Prevention Lifeline and the National Disaster Distress Helpline. At the federal level, there has been growing advocacy to make the pathways to crisis supports even easier with a simpler national suicide prevention lifeline number. The Federal Communications Commission voted in July 2020 for “988” to serve as the nation’s forthcoming new number to connect people to the National Suicide Prevention Lifeline or other types of crisis counselors.³⁰ This new number has far-reaching implications. Though further development and implementation details would need to be worked out, it could presumably differentiate a mental health crisis in need of mental health support from those requiring a law enforcement response.

Psychiatric bed registries are another example of a means to build better linkages to psychiatric services in a crisis context. These have been developed in an effort to curb emergency department boarding times. The idea behind them is that individuals coming for acute assessments who need a psychiatric hospital bed could be sent to one without delay. With the passage of the 2016 21st Century Cures Act came grants to help foster psychiatric bed registries around the country. A 2017 report by NASMHPD Research Institute of existing bed registries showed 16 states had some type of bed registry and eight states were in some phase of planning for one.³¹

For individuals in crisis due to substance use, there may be a need for a crisis response that includes robust withdrawal management practices, even including the induction of medications to assist with treatment during the initial response, and then a linkage to a community prescriber as part of the crisis response pathway. There may be individuals who are not yet ready to embark on their recovery journey after the crisis, so regardless of their readiness, crisis services staff should be adept at motivational interviewing, as well as techniques such as Screening, Brief Intervention, and Referral to Treatment to help point individuals to treatment appropriate to their need beyond the crisis period.³²

The Evolving Role of Law Enforcement and Mobile Crisis Responses

The Sequential Intercept Model, a framework for helping systems develop strategies to identify and intercept an individual with mental illness and/or substance use away from criminal justice involvement and toward treatment, expanded its focus to include examination of the crisis care continuum with the addition of “Intercept 0” in 2017.³³ The Department of Health and Human Services Assistant Secretary for



Planning and Evaluation (ASPE) in 2019 also examined early diversion activities around the Country at “Intercept 0 and 1” of the Sequential Intercept Model.³⁴ These reports pointed out service gaps that needed to be filled at the law enforcement interface and even before law enforcement are called in response to a behavioral health crisis. Several recent tragic violent incidents between police and persons of color have brought these issues under the spotlight even more. They inspired community support for the Black Lives Matter movement and a cry to re-examine police practices. This has included calls from some advocates to defund law enforcement and examine shifting the allocation of resources between law enforcement and other systems. With these conversations, the role of law enforcement in behavioral health crisis response has also emerged as part of the conversation.

The interface of law enforcement and mental health response has a long history, and over the last several decades has been increasingly developed. The Council of State Governments Justice Center, for example, has put together several resources, for example, to help communities enhance collaborations between police and mental health systems.³⁵ The International Association of Chiefs of Police also launched the One Mind campaign.³⁶

In the literature, the collaborations have generally been described by three main designs.^{37,38,39} “Police-based specialized police response” includes law enforcement officers who are specifically trained to manage behavioral health crises and have knowledge of and access to the system to help support their response. In a second model of police response, behavioral health clinicians are hired by police departments for a “police-based specialized mental health response.” Their job is to accompany officers on calls where an individual might be in a behavioral health crisis or for calls where a behavioral health specialist might be helpful (e.g., death notifications, follow up visits). A third model of coordinated law enforcement and behavioral health specialized crisis response is a “mental health-based specialized mental health response,” which includes services also known as mobile crisis services, where a mental health unit, staff person or team of staff respond directly at the scene of the crisis, and link to law enforcement on site to jointly respond to an incident when needed. A fourth, design of crisis response includes mobile crisis teams, a non-law enforcement-based response that allows mental health clinicians to respond to crises directly. These mobile crisis response teams may have protocols where law enforcement serve as back-up but are designed to be a distinct non-law enforcement-based response.

The Crisis Intervention Team (CIT) is an example of a police-based specialized police response strategy. A core component of the model is a 40-hour curriculum of specialized training on mental health and systems issues to law enforcement officers. The curriculum generally includes topics such as an overview of mental illness and de-escalation strategies, and typically incorporates individuals in recovery as lecturers as well as tours to their living facilities to help law enforcement understand these issues firsthand.⁴⁰

Studies have shown positive impact with CIT interventions with regard to diversion to treatment, reduced use of force and officer injury.^{41,42,43} The model has gained international support. Yet, a review of the literature found the strongest evidence on the effectiveness of CIT showed its ability to enhance officer cognitive and attitudinal outcomes, but the same review indicated

Beyond Beds

Recommendation #3: Criminal and Juvenile Justice Diversion

Fund and foster evidence-based programs to divert adults with serious mental illness and youth with serious mental illness or emotional disorders from justice settings to the treatment system. These programs should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with correctional and other systems.



more research is needed to determine if the change in officer beliefs results in changes in behavior.⁴⁴ Rigorous studies of racial breakdown of outcomes is also not yet available for CIT. Data on the effectiveness of CIT also shows that volunteers who sign up to become CIT officers seem to show greater benefits and positive outcomes than those who are assigned.⁴⁵ Although the CIT model is very well-respected, this should be a cautionary note for departments that have taken on wholesale adoption of one-time CIT training to all officers as a single policy solution to address the intricacies of crisis response in the behavioral health context. Here, the crisis service behavioral health system, which is called for as an integral part of a robust CIT model, becomes increasingly relevant.

Models where behavioral health and law enforcement are designed to co-respond in some fashion also show promise and several have highlighted that consumer experience is positive.^{46,47} An example of an effective police-based specialized mental health response is the Crisis Response Team in Seattle, WA.⁴⁸ Starting in 2010, the police department contracted with the local mental health agency to have mental health clinicians work directly with CIT officers. A qualitative study of the program found that the model improved encounters between law enforcement officers and people experiencing mental health crises as well as better utilizing police department resources.⁴⁹ In Massachusetts, the provider organization Advocates launched a co-responder model in 2003, partnering with the state Department of Mental Health and other stakeholders and has continued to grow across the state, showing successful outcomes for jail diversion, cost savings and shifts in police culture and attitudes about managing mental health crises by embedding a clinician in local police departments to ride with police and respond to crises⁵⁰ In addition to having specialized behavioral health staff assigned to work within local police departments to jointly respond to crises, they were able to leverage the entire mobile crisis service to help the communities they serve.

A third design is a “mental health based mental health co-response” designed specifically to have a behavioral health mobile crisis provider co-respond with police to a scene without necessarily being stationed in the police department or riding in the police car. However, separate from law enforcement, mobile crisis services have expanded in many states based on a variety of policy shifts and intentional program design. These mental health crisis response models serve as a growing fourth, non-law enforcement, model of crisis response. One program gaining national attention recently is the CAHOOTS (Crisis Assistance Helping Out on the Streets) program run out of a Federally Qualified Health Center. CAHOOTS was established in 1989 as a community policing initiative in Eugene and Springfield, Oregon to help with managing mental health crisis, addiction and homelessness in the community.⁵¹ It involves the deployment of two-person teams consisting of a medic (such as a nurse, paramedic or EMT professional) and a mental health crisis worker who can provide a trauma-informed response to help diffuse crises. A recent report showed that in 2019, out of approximately 24,000 CAHOOTS calls, police backup was requested only 150 times.⁵²

In some jurisdictions, mobile crisis response was enhanced in response to class action litigation and other system developments. For example, in Massachusetts, the landmark Rosie D litigation centered on Medicaid eligible youth with serious emotional disturbances whose needs were historically addressed with an over-reliance on out of home settings. The remedy catapulted an entire systemic response to youth in need, including the establishment of an array of services that included

Beyond Beds

Recommendation #10: Partnerships

Recognize the vital role families and non-traditional partners outside the mental health system can play in improving mental health outcomes and encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.



more robust mobile crisis intervention (MCI), defined as “on-site, face-to-face crisis response” 24/7/365 for youth in a behavioral health crisis, and includes the ability for a comprehensive behavioral health assessment, intervention, stabilization and coordination.⁵³ This has allowed crises to be addressed where they occur—be it at home, in schools, or elsewhere in the community. The services even include in-home follow up after the crisis. As another example, Connecticut’s youth mobile crisis service has demonstrated significant reduction in emergency department visits and positive outcomes.⁵⁴ Typically, the mobile crisis clinicians also have specific safety protocols that help determine when back up law enforcement response is needed and how it should be coordinated. Models such as these offer guidance to other jurisdictions considering expanding strategies of non-law enforcement-based crisis response.

Person-Centered Crisis Care

Crisis services require the ability to serve all populations that access them.⁵⁵ To adhere to the principles outlined in the SAMHSA Crisis Toolkit, this will include addressing individual recovery needs, utilizing peers and being trauma informed.⁵⁶ Related to these goals, there is increasing attention to the importance of engagement as a way to help drive person-centered care.⁵⁷ One review of several studies demonstrated that interventions to improve mental health knowledge, attitudes and reduce barriers helped improve retention in psychiatric services.⁵⁸

SAMHSA Crisis Toolkit: Principles of a Crisis Service Continuum

1. Addressing recovery needs
2. Significant role for peers
3. Trauma-informed care
4. Zero suicide/suicide safer care
5. Safety/security for staff and people in crisis
6. Crisis response partnerships with law enforcement, dispatch and emergency medical services

One strategy to maximize individual voice in their care is through Psychiatric Advance Directives (PADs) (sometimes also referred to as Behavioral Health Advance Directives).⁵⁹ For crisis service providers, it is important to know if the individual has a psychiatric advance directive and then to understand what it means and how to honor it. The 1990 Patient Self-Determination Act codified the need to have certain healthcare facilities make patients aware of opportunities for advance directives. In the mental health area, these are legal documents that an individual executes typically during a period of

wellness that codify their specific behavioral health treatment decisions that then could be enacted when their mental health deteriorates to the point where their decision-making is compromised.⁶⁰ Decisions might include determining a surrogate decision-maker who can help interpret the individual’s preferences during a crisis. In addition, decisions that are spelled out might include authorizing or declining particular medications or somatic treatments (including electroconvulsive therapy) and preference for particular psychiatric hospitals, to name a few. Several resources are available to crisis service providers that provide further details about PADs (see for example, the Psychiatric Advance Directive Resource Center at <https://www.nrc-pad.org/>).⁶¹ SAMHSA has also funded further information about PADs through its technical resource site for providers, individuals and family members dealing with serious mental illness at www.SMIAdviser.org. This resource site offers an app available for furtherance of individual psychiatric advance directives. Although some individuals who encounter psychiatric services may be under an assisted outpatient treatment court order or brought in by police,⁶² PADs may be one strategy that can ultimately



reduce coercive interventions.⁶³ It is important to consider all forms of engagement through voluntary service provision and individual voice to help improve retention over time.

Person-centered crisis care requires a service array to address the whole person, and this means helping them with needs regardless of whether their primary issues are situational, related to severe mental illness, substance use challenges, or a combination of these. The call for nimble service provision to address this vast array of considerations is a tall but necessary order. For example, it is well established that incorporating medication assisted treatments for withdrawal management for opioid use disorder can be lifesaving,⁶⁴ yet access to prescribers and high overdose mortality remains a critical issue that requires analyses of geographic differences and other factors to improve outcomes.⁶⁵ To leave a gap in time risks an individual returning to substance use and overdosing. The crisis service continuum must be prepared to adroitly address all needs, including those that are not traditionally in the wheelhouse of “mental health” services.

Creating a culture of welcome-ness is another way to enhance person-centered care. One study identified numerous challenges faced by individuals with mental illness as they described their experiences in emergency departments, including a lack of privacy, long waits, professionals who are less adept at relating to the individual’s distress on a person-level, lack of prioritization during triage, minimal family support available, and shame and stigma associated with mental health conditions as felt during the emergency department experience.⁶⁶ Numerous reports have begun to elucidate the important role of peers in the crisis continuum. This can include their participation in low intensity supports, such as through warm lines where individuals provide a listening ear, all the way to the deepest parts of the crisis continuum, such as through peer-run or peer-led respite centers.⁶⁷

The Living Room models are perfect examples of fostering the core principles highlighted in the SAMHSA Crisis Toolkit of including peers, being recovery oriented and trauma informed. One Living Room model found in Skokie Illinois addresses some of the barriers that individuals might face in going to a traditional emergency department when in psychiatric care by providing immediate, client-centered, and recovery-oriented services, as well as being embedded into a home-like setting in the community, promoting autonomy, respect, hope and social inclusion.⁶⁸ In this way, models such as these foster what it truly means to create crisis services that can be person-centered. Individuals seeking crisis services, by their very nature, will be at risk of being further traumatized if these principles are not incorporated.

The importance of having all staff trained appropriately on safety and security, as well as Zero Suicide principles is critical given that the crisis service itself can result in a critical lifesaving opportunity. Accessibility to medical services when needed should be part of proper linkage supports. The 2020 NASMHPD Series of technical

assistance papers focused on *Beyond beds: Crisis Services* includes examination of crisis services for diverse populations including individuals with substance use disorders,⁶⁹ children and adolescents,⁷⁰ homeless

2020 NASMHPD *Beyond Beds: Crisis Services* Technical Assistance Briefs

1. Crisis services: meeting needs, saving lives
2. Crisis services and homelessness
3. Technology to address suicide
4. Substance use disorders
5. Legal issues
6. Best practices
7. Funding
8. Diverse Populations with unique needs
9. Child/Adolescent
10. Rural crisis services
11. Police partners in crisis response



persons,⁷¹ among others.⁷² Each of these areas of focus helps enhance the ability to respond to individual needs across the crisis continuum.

Supporting the Crisis Infrastructure, From Laws to Technology

At the core of the crisis continuum are a host of details that must support the infrastructure. Funding will likely be generated from various federal, state and even local resources.⁷³ Billable time may be based on volume or time, with bundled rates or per service rates for different elements of the crisis service. In addition, enabling legislation may be needed in states that do not allow for specific aspects of crisis care, such as crisis stabilization units. Licensing rules in each state will need to be considered to determine which parts of the crisis care continuum will need specific certifications. As these are developed communities will need to consider the applicability of the Emergency Medical Treatment and Labor Act (EMTALA) for these types of services, some of which might hold themselves out as emergency providers sufficient enough to risk Medicare funding if individuals are not stabilized prior to transfer.

Beyond Beds

Recommendation #4: Emergency Treatment Practices

Monitor hospitals for adherence to EMTALA in their emergency departments and levy sanctions for its violation, including the withholding of public funding. Hospitals with licensed psychiatric beds that refuse referred patients should similarly be sanctioned if monitoring shows they have a record of refusing referred patients without legitimate cause.

Legal and regulatory considerations in crisis centers where evaluations are conducted are complex.⁷⁴ Strategies for engagement in voluntary services should be maximized, but depending on the jurisdiction, crisis stabilization and evaluation sites may be regulated to allow for both voluntary and involuntary holds. Even when there are these options, individuals should be served in the least restrictive settings possible. In states that have assisted outpatient treatment laws, there may be arrangements with the courts regarding the ability to bring people to a crisis center to determine if a higher level of care is needed. In addition, individuals may only be legally held in a crisis center for a finite number of days or hours based on the statutory provisions in the state, after which the individual may need a further assessment, admission to a psychiatric unit, or discharge. Due process and other rights of individuals served- especially in involuntary contexts- are critical and most state laws provide for mechanisms to support this aspect of the legal regulation of behavioral health practices.

Partnerships will be another key element in the crisis care continuum. Schools, local hospitals, senior housing centers, law enforcement, sheriffs and with other state agencies that work with veterans, older adults, persons with developmental disabilities, native populations, immigrants, and those with serious mental illness, are just some examples of the types of partnerships that are beneficial to establish as a crisis system. Organizations through provider networks, peer organizations, and advocates will all benefit from participating in the enhanced crisis continuum. Non-traditional partners who will be a resource in building out these services include those in faith-based communities, local tribal leadership, small businesses and others.

Many crisis services already rely on technology, but reliance on technology will only expand overtime, especially with the emergence of COVID-19. Beyond bed registries described above, use of other



technologies is also going to be necessary. For example, as the Crisis Now technology demonstrates, the concept of an interconnected dispatch system “air traffic control” will allow persons in crisis to be efficiently, empathically, and effectively routed to the most appropriate response. GPS technology that can identify the location of an individual caller through geo-mapping who may need a rescue response, or who simply may need a referral for services nearby, attached to databases that will show where services exist and are available hold promise that in many ways is as yet unimagined. In addition, a single call to a call center that has exceeded its capacity will be able to be routed to the next available call center, though ideally, calls will be responded to locally with knowledge of local resources. The importance of hearing a voice on the other end also means that when needed, overflow capacity can be handled anywhere. With the right connectivity, individuals will still be able to be immediately directed to the resource and level of support needed following the initial crisis contact.

Workforce development to effectively manage the crisis continuum is a key component to its success.⁷⁵ Clinical staff responding to distress calls all should be well-versed in healthcare disparities, areas of vulnerability to negative bias in response to persons of color or other minorities. Ideally staff diversity will also reflect diversity in the community. Training will be required on the critical importance of engagement into voluntary substance use disorder and mental health treatment, as well as the legal regulations of practices in crisis services that might require intervention even when the individual declines it. Such training would need to help clarify statutory requirements for the criteria that usually include risk of harm to self or others that could permit involuntary holds and referrals when needed to inpatient services, and issues of confidentiality. Staff working in crisis services therefore need to be adept at understanding and operationalizing the legal and regulatory provisions of the crisis continuum. Since crisis services are for anyone, anytime, staff should be equally trained across shifts for this 24/7/365 operation. In addition, these staff will require intentional trainings and support on what it truly means to serve anyone and everyone with a welcoming and engaging attitude.

Crisis Services During COVID-19 and Beyond

Perhaps one of the most recent catalysts for the need of a robust crisis care continuum has been the responses needed to manage the COVID-19 pandemic. As the pandemic swept through the states, societal stress and distress over this newly emerging type of disaster has created the need for nimble and evolving policy and planning in crisis services. Early on as the COVID-19 pandemic was spreading through the United States, there was an astounding increase by over 890% of calls to the National Disaster Distress Helpline.⁷⁶ This level of need occurred amidst an already alarming rise in suicide rates with 2018 showing the highest age- adjusted suicide rates since 1941.^{77,78} Although some states were seeing promising evidence of improvement prior to the COVID-19 pandemic, the opioid crisis had already been reaching new levels and claiming more lives than motor vehicle accidents.⁷⁹

Disaster behavioral health is increasingly recognized as mission-critical to overall disaster response. For the National Incident Management System (NIMS)⁸⁰, which operates out of FEMA, specific regional responses are important to allow operations to continue without disruption.⁸¹ Continuity of Operations Plans (COOP) are designed to further delineate smooth transitions without interruption in core functions. Many states sought to plan for surge capacity initially, as medical beds were being deployed to take care of patients needing ventilator support from the novel coronavirus. In the behavioral health crisis context, dramatic shifts in demand of psychiatric crisis services and volume made planning challenging.



There are continuing ongoing demands for needed supplies such as personalized protective equipment (PPE) and testing for the behavioral health population and the staff that care for them. States have worked hard to satisfy the shifting demand to best help the needs of vulnerable persons in the behavioral health system including those with mental illness, intellectual and developmental disability and substance use disorders. Crisis counseling and crisis prevention through outreach activities have been supported through SAMHSA and FEMA funded grants. The pandemic has only highlighted the needs for a coordinated and adept crisis continuum that will likely be utilized even more as the pandemic evolves along with the strain on the economy and social networks.

Especially with COVID-19, much has also shifted with new reliance on video and telephonic technology for clinical services.⁸² Even in mobile crisis response, the use of tele-health practices has expanded. Jurisdictions have begun to use telephonic or video connections with emergency medical workers or law enforcement to help navigate complex situations in the community. In order to protect hospitals from excessive traffic during times of high community penetrance of COVID-19, much of these technologies were born out of necessity. Additionally, crisis hubs also developed video and telephonic access to help screen individuals to focus in-person visits only on those that could not be triaged through technology connections. With the COVID-19 pandemic and the ongoing community behavioral health challenges likely to be seen in its aftermath, services developed through these changing practices will continue. They will likely evolve further as providers learn more about best practices in the long run. This includes how to balance in-person contacts with telepractices while mitigating risk of viral illness in crisis support contexts.

Conclusions

Crisis services sit at the “crossroads” and must be adept at serving the needs of all individuals immediately at the time they need support. Some of these individuals may be in their darkest hour, in suicidal crisis, psychotic, intoxicated, recently in contact with law enforcement, or recently victimized. The crisis continuum offers an opportunity for life-saving intervention. It is impossible to quantify how many more lives could be saved and how many better outcomes could be achieved with access to a robust and well-developed crisis continuum.

The current fragmented system has too many gaps to appropriately address the needs of all individuals, regardless of age or the severity of the individual’s needs. As well, all individuals in a community, regardless of background, race, ethnicity, or prior mental health history may experience an emotional or suicide crisis.

As noted in the SAMHSA Crisis Toolkit, services must be available to anyone at any time, and this means that bias and racial inequities must be eradicated. This means that although they must incorporate technology at its highest capability to interconnect the crisis continuum with a host of other services, they must also provide human responses in real time. Building out a complete crisis services array represents one step in fully realizing an integrated and complete psychiatric care continuum that has been the vision of behavioral health for well over 50 years. Although there is much work ahead, the global pandemic and recent strains related to racial issues in society serve as reminders of the critical importance of supporting each other through difficult times. The possibilities of providing effective, interconnected, just and accessible crisis services that can save lives and improve mental health outcomes should provide the inspiration to take on the challenges ahead.



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Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness

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Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness

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EXECUTIVE SUMMARY

The *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* issued by SAMHSA in February 2020 provides guidelines for a comprehensive and integrated behavioral health crisis network that should exist in communities throughout the country.¹ Using the *National Guidelines* as a framework, this paper explores issues that should be considered in the design and implementation of core crisis system components, with specific consideration of the needs of individuals who experience homelessness.

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.^{2,3} There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*, ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.⁴

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. Just as the symptoms of untreated mental illness and substance use disorders (SUDs) often make homelessness more difficult to overcome, lack of stable housing creates extra challenges for engagement in treatment and recovery from behavioral health conditions. Many people who experience homelessness are disconnected from behavioral health systems and providers, and may distrust them. Such individuals often “fall through the cracks,” having costly and frequent contacts with shelters, hospital emergency departments, inpatient units, and law enforcement. Once engaged and housed, people with the most significant behavioral health conditions are often better able to access treatment, services, and supports and to remain stably housed.

Local homeless response systems are charged with outreaching and engaging homeless individuals and “meeting them where they’re at” by providing for basic needs, including helping to locate emergency shelter, resolving immediate housing crises, and connecting individuals to longer-term housing and supports. Behavioral health crisis programs provide short-term interventions that can play an important role in helping persons with behavioral health conditions who are experiencing homelessness to establish access to long-term treatment and services. Such programs can also proactively collaborate with homeless systems and providers and with law enforcement to ensure cross-system coordination, the use of effective engagement strategies, and meaningful connections — all key steps in breaking the costly cycle and reducing the human toll of homelessness.

¹ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

² Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health, 103* Suppl 2(Suppl 2), S180. <https://doi.org/10.2105/AJPH.2013.301727>

³ Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

⁴ Pinals, D. A., & Fuller, D. A. (2018). *Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes*. Alexandria, VA: National Association of State Mental Health Program Directors.

BACKGROUND

Homelessness, now recognized as a national public health crisis, is highly correlated with behavioral health conditions.^{5,6} There is significant attention to homelessness through a housing lens, yet solutions to homelessness are complicated by a range of issues, including poverty, housing unaffordability, structural racism, and behavioral health conditions. As discussed in the National Association of State Mental Health Program Directors report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*, ending homelessness is key to achieving the maximum possible success in strengthening behavioral health systems and improving mental health outcomes.⁷

Mental illness and SUDs have been consistently associated with housing instability.^{8,9} Numerous studies have demonstrated that behavioral health conditions are a significant risk factor for becoming homeless, as well as a barrier to exiting homelessness.¹⁰ The most recent U.S. Department of Housing and Urban Development (HUD) Annual Homeless Assessment Report (AHAR) to Congress, a point-in-time estimate of the number of sheltered and unsheltered¹¹ homeless people in the United States, found that 567,715 individuals were experiencing homelessness.¹² Data from the report shows that African Americans, Native Americans, and Hispanics/Latinos remain overrepresented among people experiencing homelessness. Twenty percent of those in the point-in-time count reported they were “severely mentally ill,” while nearly sixteen percent reported “chronic substance abuse,” though these percentages more than double (55 percent and 42 percent respectively) for those who were unsheltered (211,293). Because 18 percent of the total individuals counted in the AHAR were under age 18, the percentage of those aged 18 years and older who have serious mental illness or who have chronic substance use is likely substantially higher. A review of the literature by the Substance Abuse and Mental Health Services Administration (SAMHSA) cites several studies that estimate between 20 and 50 percent of people who are homeless have serious mental illness.¹³ In 2018, SAMHSA’s Projects for Assistance in Transition from

⁵ Donovan, S., & Shinseki, E. K. (2013). Homelessness is a public health issue. *American Journal of Public Health, 103* Suppl 2(Suppl 2), S180. <https://doi.org/10.2105/AJPH.2013.301727>

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⁷ Pinals, D. A., & Fuller, D. A. (2018). *Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes*. Alexandria, VA: National Association of State Mental Health Program Directors.

⁸ Kerman, N., Aubry, T., Adair, C. E., Distasio, J., Latimer, E., Somers, J., & Stergiopoulos, V. (2020). Effectiveness of Housing First for homeless adults with mental illness who frequently use emergency departments in a multisite randomized controlled trial. *Administration and Policy in Mental Health, 47*(4), 515–525. <https://doi.org/10.1007/s10488-020-01008-3>

⁹ Glasheen, C., Forman-Hoffman, V. L., Hedden, S., Ridenour, T. A., Wang, J., & Porter, J. D. (2019). Residential transience among adults: Prevalence, characteristics, and association with mental illness and mental health service use. *Community Mental Health Journal, 55*, 784–797. <https://doi.org/10.1007/s10597-019-00385-w>

¹⁰ Nilsson, S. F., Nordentoft, M., & Hjorthøj, C. (2019) Individual-level predictors for becoming homeless and exiting homelessness: A systematic review and meta-analysis. *Journal of Urban Health, 96*, 741–750. <https://doi.org/10.1007/s11524-019-00377-x>

¹¹ For HUD’s definition of sheltered and unsheltered homelessness, see p. 4 of “A Guide to Counting Unsheltered People,” by HUD’s Office of Community Planning and Development: <https://www.hudexchange.info/sites/onecpd/assets/File/Guide-for-Counting-Unsheltered-Homeless-Persons.pdf>

¹² U.S. Department of Housing and Urban Development (2019). HUD 2019 Continuum of Care homeless assistance programs homeless populations and subpopulations. Retrieved June 22, 2020 from https://files.hudexchange.info/reports/published/CoC_PopSub_NatTerrDC_2019.pdf

¹³ Substance Abuse and Mental Health Services Administration (2013). TIP 55: Behavioral health services for people who are homeless. Retrieved July 15, 2020 from https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4734_literature.pdf

Homelessness (PATH) program documented the prevalence of co-occurring mental illness and SUDs among persons experiencing or at risk of homelessness at nearly 41 percent (28,945).¹⁴

Individuals with mental illness or SUDs who experience homelessness are among those most likely to be inadequately connected with and distrustful of behavioral health providers,¹⁵ to have complex needs that cannot be met by any one system, and to cycle continually among shelters, emergency departments, psychiatric and medical inpatient units, and the criminal justice system.¹⁶ Some behavioral health systems fund homeless outreach to engage this specific population. Local homeless systems also provide outreach in order to bring homeless individuals, including those with behavioral health conditions, into engagement with housing and services. However, while some behavioral health providers may be part of a homeless system's provider network, homeless and behavioral health systems operate quite distinctly in most communities. Thus, many homeless systems and providers are not naturally connected with behavioral health crisis systems, nor are they often equipped to manage behavioral health crises among the individuals they serve.

Barriers and Risk Factors Faced by Individuals who Experience Homelessness

In addition to being without a place to live, most persons experiencing homelessness face significant barriers to other positive social determinants of health, a lack of which can precipitate or exacerbate a psychiatric or substance use condition.¹⁷ At a basic level, primary safety and security needs largely go unmet. Lack of food, money, employment, health insurance, clothing, transportation, and access to safe and clean spaces to manage hygiene are all conditions that compromise people's ability to manage their behavioral health.

People who experience homelessness also face a set of common risk factors that are likely to further complicate behavioral health crises. The prevalence of abuse and trauma among both sheltered and unsheltered homeless individuals is significant, particularly among those with co-occurring mental illness and SUDs; research has shown that trauma can be the cause of homelessness just as homelessness can lead to further traumatization.¹⁸¹⁹ Many studies have also documented a remarkably higher prevalence of suicidal ideation and attempts among people experiencing homelessness as compared to the general population.²⁰

Mental illness and SUDs co-exist in a significant portion of those experiencing homelessness, a condition which can be further complicated by untreated physical health conditions. One study found that 78 percent of unsheltered homeless individuals experienced mental health conditions, 75 percent experienced substance use

¹⁴ Substance Abuse and Mental Health Services Administration (2019). PATH annual report for FY18. Retrieved June 22, 2020 from https://pathpdx.samhsa.gov/Content/preGen/national/23/PATH_Annual_Report_For_FY18.pdf

¹⁵ Hwang, S. & Henderson, M. (2010). Health care utilization in homeless people: Translating research into policy and practice. Agency for Healthcare Research and Quality Working Paper No. 10002. <http://gold.ahrq.gov>.

¹⁶ Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. *Housing Policy Debate*, 13(1), 107-163.

¹⁷ World Health Organization and Calouste Gulbenkian Foundation. (2014). Social determinants of mental health. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=696605E826D2A544DA6E56CA24F93304?sequence=1

¹⁸ Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-Informed care in homelessness services settings. *The Open Health Services and Policy Journal*, 3: 80-100. <https://www.homelesshub.ca/sites/default/files/cenfdthy.pdf>

¹⁹ Christensen, R. C., Hodgkins, C. C., Garces, L. K., Estlund, K. L., Miller, M. D., & Touchton, R. (2005) Homeless, mentally ill and addicted: The need for abuse and trauma services. *Journal of Health Care for the Poor and Underserved*, 16(4):615-622. <https://doi.org/10.1353/hpu.2005.0091>

²⁰ Ayano, G., Tsegay, L., Abraha, M., and Yohannes, K. (2019). Suicidal Ideation and attempt among homeless people: A systematic review and meta-analysis. *Psychiatric Quarterly*, 90(4), 829–842. <https://doi.org/10.1007/s1126-019-09667-8>

conditions, 84 percent experienced physical health conditions, and 50 percent experienced all three.²¹ The coexistence of these challenges, or “multiple morbidities,” place such individuals at greater risk of premature death and overutilization of emergency departments and acute care, in addition to behavioral health crises.

People experiencing homelessness have a higher risk for exposure to infectious diseases due to poor sanitary conditions in unsheltered environments. The current COVID-19 pandemic appears to be affecting people experiencing homelessness at a disproportionate rate, and if exposed, they may be more susceptible to illness or death due to the prevalence of underlying physical health conditions and a lack of reliable and affordable health care.²² The impact of COVID-19 on crisis response for individuals with behavioral health conditions who are experiencing homelessness is addressed later in this paper.

Individuals with behavioral health conditions who are experiencing homelessness are also more likely to be arrested and incarcerated for low-level crimes than the general population, including public nuisance laws related to loitering, theft, or disturbing the peace.²³ These individuals, in turn, are more likely to return to homelessness and become disconnected from providers.²⁴

The Intersection of Homeless Individuals with Behavioral Health Crisis Response Systems

SAMHSA’s *National Guidelines for Behavioral Health Crisis Care* provide a framework for a no-wrong-door approach to crisis services that are available to anyone, anywhere, anytime. This core network of services includes 24/7 regional crisis call centers, mobile crisis team services, and crisis receiving and stabilization facilities. According to these SAMHSA guidelines, the absence of an organized crisis services network containing these core elements contributes to the revolving door of repeated hospital admissions, the overuse of law enforcement, and homelessness among individuals with behavioral health conditions.

Crisis programs are frequently engaged to respond to homeless individuals who are experiencing a behavioral health crisis. For some, crisis episodes are a result of uncontrolled symptoms of a mental illness or SUD because the individual cannot access treatment, or their symptoms are such that they are unwilling or unable to engage in treatment. For others, the stress of living on the street or in crowded shelters, exposure to the elements, lack of family connections, poverty, and social supports can precipitate a behavioral health crisis. Whereas a safe apartment can be a therapeutic setting that allows someone to manage a behavioral health crisis in the comfort of home, individuals who are homeless lack many of the basic necessities that are important to coping with a specific episode as well as to long-term recovery.

Behavioral health crisis call centers receive calls directly from homeless individuals, but more often from third parties such as homeless shelter and transitional housing providers, first responders, private businesses, or the general public. Frequently, the contact between homeless individuals and behavioral health crisis programs

²¹ Roundtree, J., Hess, N., & Lyke, A. (2019). Health conditions among unsheltered adults. Los Angeles, CA: California Policy Lab. <https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf>

²² Lima, N. N. R., de Souza, R. I., Feitosa, P. W. G., Moreira, J. L. de S., da Silva, C. G. L., & Meto, M. L. R. (2020). People experiencing homelessness: Their potential exposure to COVID-19. *Psychiatry Research*, 288. <https://dx.doi.org/10.1016%2Fj.psychres.2020.112945>

²³ The Sentencing Project (2002). Mentally ill offenders in the criminal justice system: An analysis and prescription. Washington, DC: The Sentencing Project. Retrieved on July 15, 2020 from <https://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf>

²⁴ Greenberg, G. & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, 59(2)

occurs when mobile crisis response is called to assist a homeless individual in crisis, or through referrals or “drop-offs” by first responders to crisis receiving and stabilization facilities.

Effective crisis programs recognize that providing for basic needs creates an opportunity; they employ the same types of person-centered engagement strategies that are the cornerstone of effective homeless outreach. This includes “meeting people where they’re at,” providing relief for the most immediate needs, and offering to make connections with resources that the individual both wants and needs in order to access housing, benefits and entitlements, and other services and supports that can address their underlying condition of homelessness. Nevertheless, it is important for crisis programs to retain a focus on resolving behavioral health crises and not assume responsibility for fully resolving homelessness and other social service challenges.

RESPONDING TO HOMELESS INDIVIDUALS IN CRISIS: ESSENTIAL PRINCIPLES AND PRACTICES

Ensure that Crisis System Components are Responsive to the Needs of Homeless Individuals

Effective crisis care for individuals experiencing homelessness requires consideration of the basic needs and unique circumstances they face, along with attention to their clinical and social service needs that extend beyond the brief period during which crisis programs seek to resolve a behavioral health crisis. Here, we present considerations for each of the core components of a crisis response system identified in the SAMHSA guidelines.

24/7 Regional Call Center Strategies

As noted, crisis call centers may be more likely to receive calls *about* individuals who are homeless and experiencing a behavioral health crisis than to hear from homeless individuals themselves. This may be due to the fact that individuals experiencing homelessness are less likely to have access to phones. They may also be distrustful of behavioral health providers due to paranoia, past experiences with civil commitment or law enforcement, or racial discrimination.^{25,26,27}

When a crisis call center receives a call either from or on behalf of a homeless individual, screening, assessment, and intervention strategies must be sensitive to a number of situational factors that may be influencing the behavioral health crisis. In addition to clinical considerations, crisis hotline screening and assessment should consider the following when receiving calls either directly from or on behalf of homeless individuals:

- What is the person’s housing status — are they currently homeless?
- Is the person with anyone such as a friend or other support?
- What is the person’s current location — are they on the street, staying in a shelter, or in an encampment²⁸?
- How long has the person been homeless?
- Is the area safe? Are there any public health or safety threats in the area?

²⁵ Sweeney, A., Gillard, S., Wykes, T., & Rose, D. (2015). The role of fear in mental health service users' experiences: a qualitative exploration. *Social psychiatry and psychiatric epidemiology*, 50(7), 1079–1087. <https://doi.org/10.1007/s00127-015-1028-z>

²⁶ Institute of Medicine (US) Committee on Health Care for Homeless People (1988). *Homelessness, health, and human needs*. Washington (DC): [National Academies Press \(US\)](#)

²⁷ National Alliance on Mental Illness. Webpage: Identity and Cultural Dimensions. Retrieved on July 15, 2020 from <https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American>

²⁸ To learn more about homeless encampments, see “Understanding Encampments of People Experiencing Homelessness and Community Responses” by HUD’s Office of Policy Development and Research: <https://www.huduser.gov/portal/sites/default/files/pdf/Understanding-Encampments.pdf>

- Does the person have a behavioral health provider, case manager, or housing supports?

Designing and implementing crisis call center strategies that are sensitive to these issues and that collect as much information as possible about a homeless person's individual circumstances, location, and other situational factors can help staff actively engage callers and appropriately triage a response. Good knowledge of specific community programs and resources available to address the needs of homeless individuals may enable call center staff to resolve the immediate issue and divert the individual from further crisis system involvement. In other cases, an individual may be encouraged to come to a facility for further assessment, require connection with mobile crisis response, or be linked to a warm line for ongoing support.

Close collaboration between crisis call centers and programs that are well-equipped or even specifically designed to respond to homeless individuals in crisis can be helpful in beginning to break the cycle of crisis and homelessness for an individual. White Bird Clinic is a Federally Qualified Health Center (FQHC) in Eugene, Oregon that is also a federally funded Health Care for the Homeless Program grantee. White Bird provides a range of health and behavioral health services including a 24/7 crisis hotline, a crisis walk-in clinic, and a 24/7 CAHOOTS (Crisis Assistance Helping Out On The Streets) mobile crisis team. The CAHOOTS team is well-versed in responding to behavioral health crises among homeless individuals; nearly 60 percent of its calls involve unhoused or inadequately sheltered individuals. CAHOOTS is dispatched by White Bird's crisis hotline and the Eugene police-fire-ambulance communications center, and by the Springfield police non-emergency line when calls come in to first responders.²⁹

Netcare Access in Columbus, Ohio operates a range of behavioral health crisis services for Franklin County. Individuals, businesses, and other providers can call Netcare's 24/7 crisis hotline to request assistance from a specialized mobile outreach service called ROW ONE that transports approximately 1,500 publicly intoxicated persons per month off the streets to safe locations that include homeless shelters, substance use and mental health treatment centers, crisis centers, and hospitals.³⁰ The organization also recently began staffing the county's homeless services hotline, so staff have good working knowledge of community resources to prevent and address homelessness.

Mobile Crisis Response Strategies

When mobile crisis response is required for an individual in crisis who is also homeless, teams may be deployed to a variety of locations. Mobile crisis teams must always consider staff safety in responding to crises. Understanding both the various locations and environments involved, as well as any public health concerns such as the current the COVID-19 pandemic or a hepatitis outbreak, for example, is important when responding to a homeless individual.

A community's formal homeless provider network may include programs that offer street outreach, shelter, homeless health care or other safety net clinics, and transitional and permanent supportive housing, along with government-sanctioned homeless encampments, food banks and soup kitchens, and domestic violence programs. Informal settings can include unsanctioned encampments in remote areas and shelters at churches. In many jurisdictions, formal or informal shelters may be seasonal. During the day, many shelters require

²⁹ White Bird Clinic (n.d.). Crisis Assistance Helping Out On The Streets. Retrieved June 22, 2020 from https://whitebirdclinic.org/wp-content/uploads/2020/06/11x8.5_trifold_brochure_CAHOOTS.pdf

³⁰ Netcare Access (n.d.). ROW ONE program. Retrieved June 22, 2020 from <https://www.netcareaccess.org/services/help-in-a-crisis-adult-youth/reach-out-program/>

individuals to vacate the premises, leaving them to spend the day in locations like parks, downtown business areas, libraries, bus or train stations, public transportation, and in remote locations (e.g., under bridges, along trails, and in wooded areas).

Responses to a staffed shelter, an encampment, a train station, a vehicle, or out on the street each have their own circumstances that mobile crisis teams must consider. A homeless individual's location may determine whether the mobile crisis team has communication with a provider who can ascertain specific types of information that will help determine their assessment and response. Crisis programs should work in concert with existing street outreach teams that may have preexisting relationships with individuals. Typically run by homeless service providers, street outreach teams work to engage and stabilize the most vulnerable homeless individuals by placing them into shelter and housing. They provide outreach and care management to homeless people living on the streets who have severe illnesses, and team members may include doctors and nurses.³¹ Crisis programs should also understand local shelter requirements, available low-barrier shelter or safe haven options, specific cultural norms at large encampments (i.e. how to enter and exit appropriately and safely), and common safety concerns in shelters or other settings that can exacerbate a behavioral health crisis. They should be familiar with the areas where homeless individuals may congregate, and whether there are site-based or outreach staff present.

In Eugene, CAHOOTS' mobile crisis response team staff are well-known to homeless individuals in the community because White Bird Clinic is also a Health Care for the Homeless provider. The team takes situational and environmental factors into account when responding to homeless individuals in crisis to ensure staff safety, engaging individuals in a non-threatening, trauma-informed manner. Staff wear plain clothes and work to verbally engage individuals while kneeling or using what they call the 'empathy squat', particularly when responding on the streets or in encampments. The team addresses immediate needs such as dehydration and hunger before fully assessing an individual's behavioral health crisis in order to build rapport and engage a person's optimal problem-solving skills.³² CAHOOTS can directly refer and transport those needing crisis stabilization to another provider who operates those services in the community. CAHOOTS shares a dispatch radio with police and emergency services, allowing it to intervene if the police are called in response to a homeless individual, thereby diverting police contact. Should a homeless individual be considered, based on assessment, to need acute care in an inpatient setting, CAHOOTS can facilitate transport and transition of care at the hospital emergency department (ED) and ensure that the person is triaged as though an ambulance had transported them. Should an individual choose police transport, CAHOOTS stays with the person and similarly facilitates transition of care at the ED. The team is able to resolve most crises by focusing on immediate needs, thereby diverting homeless individuals from further crisis or acute care. The team continues to engage homeless individuals who request their assistance by calling back in to the dispatch line. Peer support workers and case managers are available for warm handoffs from the team when an individual is ready and willing to access housing and other needed treatment and supports.

Baltimore Crisis Response, Inc. (BCRI) operates a range of behavioral health crisis services in Baltimore City, MD; approximately 70 percent of the individuals served are homeless or unstably housed. BCRI's mobile crisis team, composed of a clinician and a nurse who respond in pairs, is accessed through its mobile crisis hotline.³³ The

³¹ Boston Health Care for the Homeless Program. Retrieved July 16, 2020 from <https://www.bhchp.org/specialized-services/street-outreach>

³² Phone interview with Tim Black, CAHOOTS Operational Coordinator, May 29, 2020

³³ Baltimore Crisis Response, Inc. (n.d.) Mobile crisis team. <https://bcresponse.org/our-work/mobile-crisis-team.html>

team is often called by shelter or transitional housing providers when a homeless individual is experiencing a crisis that is beyond the staff's ability to effectively manage. The team responds in those settings and is well-trained to be aware of the environment, using trauma-informed and gentle engagement techniques to encourage individuals to come into care. Should an individual be assessed as needing a bed in BCRI's Crisis Residential Unit, this is facilitated and the individual is returned to the homeless provider's setting once stabilized. While BCRI does not utilize a co-responder model, the team is sometimes called to accompany police to homeless encampments to help defuse a crisis or encourage individuals in crisis to come into care.

Crisis Receiving and Stabilization Facility Strategies

Crisis receiving and stabilization facilities offer an alternative to hospital ED assessment and inpatient care for those with more acute needs. They also may have an added benefit for individuals experiencing a behavioral health crisis who are homeless by providing basic necessities, such as food and shelter, which can help mitigate a crisis.

Homeless individuals may walk in on their own or may arrive via mobile crisis team if a crisis cannot be resolved in the setting where the team responded, or after being diverted from the ED. When law enforcement is the first responder to a homeless person in crisis, the person may be dropped off at a crisis facility; programs should have procedures in place that allow officers to quickly return to their duties.³⁴ RI International's (RI) crisis recovery response center (RRC) model is a crisis receiving and stabilization facility that provides an example of an alternative option to ED drop-offs by law enforcement and others.³⁵ Its RRC in Peoria, AZ, located 13 miles outside of Phoenix, receives more than 80 percent of its clients, including homeless individuals, via law enforcement drop-offs; whereas another crisis center located in downtown Phoenix receives more walk-ins than police drop-offs due in part to the facility's proximity to the city's homeless population.³⁶ Staff at crisis facilities should use the same types of trauma-informed and gentle engagement techniques used by mobile crisis teams in engaging homeless individuals, and should also consider how to manage any personal belongings or pets that may accompany an individual.

Effective crisis receiving and stabilization programs accept everyone who comes in the door, and given that they have only hours to resolve a behavioral health crisis and connect individuals with additional care, many operate short-term crisis residential or subacute stabilization beds or can refer people to a program where they can stay longer to stabilize.³⁷ These and other step-down resources from core crisis system components create much-needed flow in crisis systems, and provide added time for engagement and to link people experiencing homelessness with possible temporary, transitional, or permanent housing and other longer-term resources.

Short stays in these settings allow homeless individuals to continue to be engaged as they begin the process to access housing and other needed treatment, services, and supports, which can take several weeks. Having good contacts for referrals into the local homeless response system, as well as in-house staffing for warm handoffs

³⁴ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration

³⁵ RI International (n.d.). RI Crisis Recovery Response Center. Retrieved June 22, 2020 from <https://riinternational.com/wp-content/uploads/2015/10/RI-Crisis-RRC-General.pdf>

³⁶ Vestal, C. (2020). As suicide rates climb, crisis centers expand. *Stateline*, an initiative of the Pew Charitable Trust. Retrieved on July 21, 2020 from: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/02/24/as-suicide-rates-climb-crisis-centers-expand>

³⁷ The length of stay in these programs varies from a few days to a couple of weeks to help resolve the immediate behavioral health crisis. They are not designed as a transitional or permanent housing option.

once an individual is ready to transition from crisis care, is an effective combination of strategies for ensuring continued engagement and linkages with longer-term resources.

Netcare Access in Columbus, OH provides step-down care for homeless individuals with mental illness following a stay in its Crisis Stabilization Unit (CSU) through a nine-bed crisis residential program called Miles House funded by the Franklin County Alcohol, Drug and Mental Health system. The program, which also serves individuals coming from psychiatric inpatient units, provides for a stay of up to two weeks, during which individuals can apply for and access transitional housing also funded by the county, or other available housing resources in the community. Peer Specialists work to support homeless individuals as they transition from the CSU back to the community, and provide recovery supports for those who choose a brief stay at Miles House while gaining access to housing and other community resources.

BCRI in Baltimore operates 21 psychiatric crisis beds and 18 SUD treatment beds that offer medically monitored detox; the average length of stay is seven to ten days. State and federal block grant funds support case managers who work to transition homeless individuals to ongoing treatment, housing, and other supports post-care. BCRI is able to effectively connect homeless individuals with housing once they are stabilized through direct partnerships with transitional and permanent housing providers. Case managers actively work to make referrals to these providers and to connect individuals with benefits and entitlements. The program provides individuals with 30 days' worth of medications as a bridge while they wait for prescribing appointments, or in the event their Medicaid has lapsed, a service that makes housing providers more receptive to warm handoffs following crisis care.

Incorporate Interventions that Effectively Engage Homeless Individuals

In addition to the above considerations, effective crisis response with individuals who are experiencing homelessness requires that crisis programs incorporate into crisis service design and delivery evidence-based and best practice interventions that are responsive to the population's needs, along with workforce development and training for staff on implementing these interventions.

Effective crisis service delivery with homeless individuals means moving beyond crisis response that is disposition-focused to incorporating more resolution-oriented practices. This involves being *person-centered* in terms of service delivery approach, collaborating with the individual on solutions. Such interventions recognize the individual in crisis as the expert in identifying the immediate needs to be resolved. By taking the time to establish rapport and understand the person's overwhelming situation, crisis program staff can help mitigate the behavioral health crisis and facilitate access to resources that can help address the person's homelessness, but which they may have been hitherto unable to navigate.

Motivational interviewing (MI) is a strengths-based, client-centered engagement intervention that enhances motivation to change and resolves ambivalence. It is a particularly effective approach for working with long-term homeless individuals with mental illness and/or SUDs who have not responded well or have been resistant to more traditional forms of treatment engagement. MI is frequently used by homeless outreach workers and other homeless system providers to engage individuals in a sensitive and nonaggressive manner. Tenets of MI that can inform crisis program staff response to individuals experiencing homelessness include:³⁸

³⁸ Substance Abuse and Mental Health Services Administration (2010). Spotlight on PATH practices and programs: Motivational interviewing. Retrieved on June 22, 2020 from https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/path-spotlight-motivational-interviewing.pdf

- Asking permission to talk with individuals instead of assuming they want to talk
- Finding a safe space for the individual to talk
- Learning what is important to the individual and addressing their immediate needs
- Finding out what services the individual wants and has the motivation to pursue
- Refraining from pushing individuals into services they do not want
- Exploring ambivalence using open-ended questions and reflective statements

Trauma-informed care is included in the SAMHSA guidelines as a core principle. Because so many studies have shown high prevalence rates of trauma among persons in the behavioral health and homeless system, effective crisis response programs assume that individuals presenting will have personal experiences with prior and/or more recent trauma. During a crisis, such experiences may result in an exacerbation of one's behavioral health condition and affect people's problem-solving capacity. Trauma-informed approaches are particularly crucial with individuals experiencing homelessness due to high trauma rates that may be both a risk factor and a cause of homelessness.³⁹ Poorly designed crisis response that is not trauma-informed can have negative effects and cause more trauma and distrust.

Culturally responsive services are critical to engaging populations that are disproportionately represented within a community's homeless population. To the extent possible, staff should be representative of the racial, ethnic, and gender identities of a community's population, inclusive of those experiencing or at greatest risk of homelessness, and competently trained and supervised in culturally responsive practices. Attending to these considerations will better prepare staff to address racial and other disparities that may be factors in people's behavioral health crises. Designing services to be culturally responsive promotes the ability of staff to build the trust, rapport, and continuous engagement required over long periods of time to fully engage individuals experiencing homelessness.

SAMHSA's crisis care guidelines recommend the **inclusion of peers as crisis program staff**. Similarly, the homeless system frequently includes individuals who have previously been homeless in various staff roles.⁴⁰ Because homelessness is prevalent among individuals that crisis programs encounter, programs should employ individuals who have lived experience with mental illness, SUDs, and homelessness in each of their core crisis services. Peers with these qualifications can be particularly effective in engaging those who are experiencing long-term homelessness and who may be reluctant to engage with behavioral health professionals or first responders. Peers can also be very effective at helping to transition and link individuals to follow-up care and resources in the community post-crisis. RI International's peer-operated "Living Room" programs ensure that participants are paired with a team of Peer Support Specialists in recovery.⁴¹ Each guest is encouraged to work with the team and empowered to develop their own recovery plan. RI employs more than 500 peers who have experience with addiction and/or homelessness in addition to mental illness.⁴²

³⁹ European Federation of National Organisations Working with the Homeless (2017). Recognising the link between trauma and homelessness. Retrieved on July 16, 2020 from https://www.feantsa.org/download/feantsa_traumaandhomelessness03073471219052946810738.pdf

⁴⁰ Barker, S. L., & Maguire, N. (2017). Experts by Experience: Peer support and its use with the homeless. *Community Mental Health Journal*, 53(5), 598–612. <https://doi.org/10.1007/s10597-017-0102-2>

⁴¹ RI International (n.d.). RI's crisis services improve care and reduce costs. Retrieved on July 21, 2020 from: <https://riinternational.com/crisis-services/>

⁴² Covington, D. (2016). Yes, I can! What if we all embraced recovery? RI International blog. Retrieved on July 21, 2020 from: <https://riinternational.com/2016/09/>

The ability of staff to **respond to co-morbid medical conditions** is particularly critical in crisis response with homeless individuals given high rates of tri-morbidity in this population. White Bird Clinic’s CAHOOTS mobile response team pairs behavioral health clinicians with a nurse or EMT and also has access to other health care services thanks to its status as an FQHC and Health Care for the Homeless provider. In addition to psychiatrists and an addiction medicine physician, Baltimore Crisis Response, Inc. has in-house nursing staff who can manage both physical and behavioral health conditions, including administration of medications, enabling the program to care for homeless individuals who might otherwise require a hospital setting to receive needed health care.

In addition to ensuring **workforce development and training** specific to the interventions above, crisis programs should incorporate training for staff on a range of topics, including population-specific issues and challenges related to homelessness, SUDs, chronic health conditions, and co-occurring disabilities (e.g., developmental disabilities). Staff training should facilitate clinical assessments that consider these needs. Further, while the primary role of crisis programs is to resolve an immediate behavioral health crisis, staff should receive basic training on the range of social service needs that homeless individuals have and how these resources are accessed in the community in order to refer and link individuals as necessary. This includes homeless housing programs and services offered by the local homeless Continuum of Care (CoC), Health Care for the Homeless and other safety net health clinics, mental health and substance use treatment providers, peer and recovery support programs, SOAR⁴³ or other programs that assist with accessing benefits and entitlements, and programs that provide food assistance, to name a few.

Proactively Collaborate with Homeless Housing Systems and Law Enforcement

Effective behavioral health crisis response for individuals experiencing homelessness also calls for proactive collaboration with homeless housing systems and providers and with law enforcement to ensure effective handoffs and connections to those who can help address the underlying causes of people’s homelessness. Such cooperation also serves to mitigate responses that might otherwise be harmful to a homeless individual or escalate their crisis. Collaboration strategies can include:

- Implementing training across systems to understand the resources and roles of each, and to encourage best practices
- Establishing procedures for information- and data-sharing and for warm handoffs
- Formalizing partnerships and roles through memorandums of understanding (MOUs) and other opportunities for formal cross-system involvement

Strategies for Working with Homeless Systems and Providers

Training opportunities. Crisis and homeless systems and providers each have expertise that can be leveraged to improve outcomes for people experiencing homelessness, and should engage in cross-training so each is knowledgeable about what the other has to offer. In some communities, behavioral health providers may be part of the homeless provider network, but this is often not the case. Some homeless service agencies may have very little contact or coordination with behavioral health providers, and may not be aware of how to access crisis services other than by calling 911. Crisis providers can train homeless providers on the services a crisis program can provide, when and how to call crisis services, when and how it can respond, and limitations to its scope or resources. Crisis providers can also train homeless providers with basic knowledge on recognizing the

⁴³ SSI/SSDI Outreach, Access, and Recovery (SOAR) helps states and communities increase access to Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits for people who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

signs of a behavioral health crisis, including those associated with substance use and overdose, and de-escalation strategies.

Likewise, homeless systems and providers can train crisis system providers on effective approaches for working with homeless individuals, with an emphasis on meeting basic needs and strategies to develop rapport. Crisis providers should also learn the basics of the local CoC, its scope and role, and the process by which its resources are prioritized and accessed by homeless individuals. Most planning and funding for homelessness is done at the local community level through the HUD CoC process. HUD awards funding for emergency shelter, affordable housing, and services such as outreach to assist those experiencing homelessness through competitive grants to providers who are part of local CoCs which are typically administered at the county or city level.⁴⁴ Crisis programs not familiar with their local CoC and its provider network can inquire with the contacts in their community.⁴⁵

Crisis programs should have a basic understanding of their community's approach to the prioritization of HUD-funded housing resources available through the CoC. While other sources of affordable housing administered by housing authorities, private developers, or state- and locally-funded programs may be accessed by individuals experiencing homelessness, HUD's CoC program is the largest form of targeted federal housing assistance dedicated to resolving homelessness. Demand for these limited homeless housing resources far exceeds capacity in each community, so CoCs use a process known as coordinated entry (CE) to prioritize resources for those with the greatest vulnerabilities. While it is outside of most crisis programs' role and resources to assist homeless individuals in accessing permanent housing, crisis providers should become familiar with the basics of their CoC's CE system and policies, which are often posted publicly on the CoC's website, and include:

- *Priority populations:* The populations that are prioritized most frequently for a CoC's housing resources. Often, priority populations include those who have been homeless the longest, or those with the greatest vulnerability to adverse outcomes while living unsheltered. Psychiatric crises and behavioral health conditions are often taken into account.
- *Access Points:* CE systems typically have one or more access points where people experiencing homelessness can be assessed for CoC housing resources. These access points are often published online and distributed widely to community stakeholders. In some communities, behavioral health providers, health care providers, and hospitals have volunteered to become access points in a community's CE system due to the overlap in populations served. Access points typically offer problem-solving assistance to rapidly resolve a homeless crisis, and assessment and referrals to potential housing options for which an individual may qualify.

Information sharing and warm handoff. If the crisis program is called to respond to a homeless individual, the program should engage homeless providers to share information on the best ways to contact homeless outreach teams, shelter staff, or case managers in order to garner as much information as possible to support crisis triage and response, and to facilitate a transition back into services as applicable once the individual is stabilized.

⁴⁴ States also manage larger geographic areas through Balance of State CoCs.

⁴⁵ CoC contact information is available on the HUD Exchange at:

<https://www.hudexchange.info/grantees/contacts/?params=%7B%22limit%22%3A20%2C%22sort%22%3A%22%22%2C%22order%22%3A%22%22%2C%22years%22%3A%5B%5D%2C%22searchTerm%22%3A%22%22%2C%22grantees%22%3A%5B%5D%2C%22state%22%3A%22%22%2C%22programs%22%3A%5B%5D%2C%22coc%22%3Atrue%7D##granteeSearch>

Each CoC is required to input homeless services data into a Homeless Management Information System (HMIS). At a minimum, HMIS captures data on homeless services usage; however, many communities have customized their own HMIS to collect additional data points such as where people are residing (i.e. encampment location, exact emergency shelter), vulnerability factors an individual has experienced that may contribute to prolonged homeless episodes, collateral contacts, and even touches with medical or corrections systems. Crisis programs could benefit from entering into data-sharing arrangements (and corresponding data-sharing agreements that address HIPAA, 42 CFR Part 2, and other issues) with homeless service providers to access important information that could help facilitate crisis response. Similar collaborations have been developed between health care and homeless service providers to integrate HMIS with electronic medical health records to provide seamless intake, assessment, and referral of individuals between systems of care. Data-sharing collaborations such as these could assist crisis services to quickly locate participants, as well as tap into collateral contacts that can be leveraged to create sustainable warm handoffs from crisis services.

Recognizing opportunities for warm handoffs from crisis programs to homeless system providers who are most able to assist, and ensuring that such handoffs are accomplished, can provide meaningful and lasting connection to resources that go beyond resolving the immediate crisis, and can also mitigate the risk of future crises. Homeless systems should ensure that crisis programs have contact information for homeless provider staff who can be leveraged for warm handoffs. In each community, the staff who can assist in finding permanent housing, refer to community-based treatment and supports, maximize income options, and in some cases provide ongoing behavioral health treatment as a part of the services will be different. They may include case managers or peer support workers/navigators embedded in street outreach teams, emergency shelters, and supportive housing programs. As previously noted, crisis programs like BCRI and CAHOOTS use flexible funds to support their own staff who link people who are willing but not otherwise engaged with housing, treatment, and supports. Staff such as these in either system can be important connectors between the two.

Finally, some communities have incorporated case conferencing strategies into their efforts to end homelessness, bringing together stakeholders to create tailored pathways to permanent housing for homeless individuals who are a community's most vulnerable or who are experiencing long-term or chronic homelessness.⁴⁶ Some crisis providers join case conferencing when their caseload significantly overlaps with the community's homeless population in an effort to create care plans with service providers that mitigate the risk of continued behavioral health crises.

Formalizing partnerships and cross-system involvement. Many partnerships and referral processes begin informally through relationships built over time. Often these provider-level arrangements are formalized through MOUs that establish clear roles and responsibilities for each entity. Such partnerships can lead to broader knowledge and collaboration at the systems level where MOUs can be created as well.

In some communities behavioral crisis providers like the CAHOOTS mobile response team have MOUs with the CoC or with the entities that manage their CoC's CE system so they can refer homeless individuals to be assessed and triaged for housing resources. While these types of referrals may not be made directly by crisis program staff, they are an important step in the process of connecting individuals to housing resources that can support long-term recovery. Crisis programs should also consider building relationships and establishing MOUs with homeless outreach teams as the entities that are often most familiar and engaged with homeless individuals in a

⁴⁶ To learn more about chronic homelessness as defined by HUD, see "Here's What You Need to Know about HUD's New Chronic Homelessness Definition" by the National Alliance to End Homelessness: <https://endhomelessness.org/heres-what-you-need-to-know-about-huds-new-chronic-homelessness-definition/>

community. Crisis service providers can participate more formally in their local homeless response system by becoming a homeless system provider as well. For example, Netcare Access is the behavioral health crisis system provider in Franklin County, OH and also operates the county's homeless services hotline, an arrangement which has opened the door to further collaborations with the homeless response system.

Crisis providers can also seek to become a member in their CoC's governing body. HUD has charged its nearly 400 CoCs across the country to convene a diverse set of community stakeholders, including those from other systems of care that frequently have contact with homeless individuals. Membership is often open, but each CoC has its own process for becoming a member. Benefits of membership in a CoC's governing body include helping to inform the deployment of resources that are mutually beneficial to multiple systems of care. Many CoCs have strategic plans to actively guide their efforts and resources to address homelessness, and behavioral health crisis service providers can identify mutually beneficial goals to work toward through CoC involvement.

Strategies for Working with Law Enforcement

Law enforcement is often the first to receive the call in response to a homeless person who is experiencing a behavioral health crisis. Thus, good planning and coordination between behavioral health crisis systems and law enforcement is essential to properly de-escalate the situation as necessary, engaging individuals and diverting them from unnecessary justice system involvement.

Training opportunities. As noted above, training can be beneficial to encourage the adoption of best practices in responding to homeless individuals experiencing a behavioral health crisis. Many communities offer specialized Crisis Intervention Training (CIT) to a subset of their emergency responders who can be deployed when responding to 911 or crisis line calls where law enforcement is required. CIT-designated first responders are trained to be familiar with available local crisis response resources and protocols for securing additional services. The CAHOOTS mobile crisis team regularly collaborates with law enforcement, a relationship which also involves CIT and Mental Health First Aid training for officers. BCRI similarly offers CIT training for local law enforcement, in addition to offering a training module on 'trauma-informed policing.' BCRI invites officers to visit its crisis facility to talk with consumers about the experiences that have contributed to their conditions in order to encourage more collaborative problem-solving in response to the crises they encounter.

Information-sharing and warm handoffs. If law enforcement is the first to respond to a homeless individual experiencing a behavioral health crisis, they should be able to contact a crisis call center for support, rely on a mobile crisis team to respond, and have the capability to bring a person to a crisis receiving facility to divert individuals from the criminal justice system through brief warm handoffs so that officers can get back to their work. In an interview included in the SAMHSA *Guidelines*, Nick Margiotta (president of Crisis Service Solutions in Phoenix, AZ) discusses this element as being critical to law enforcement buy-in and collaboration with crisis services.⁴⁷

Some communities have developed specialized consortiums to coordinate between service providers and first responders on appropriately triaging people experiencing homelessness when a psychiatric or substance-use-related crisis occurs. These consortiums often focus on frequent utilizers of emergency services and consist of law enforcement, EMS, hospitals, managed care organizations, street outreach, and other homeless service providers. Client-level interventions are developed by these groups with the aim of reducing the use of emergency services, acute care, and jail by leveraging partnerships and existing community-based services.

⁴⁷ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Solutions developed include strategies for law enforcement to divert individuals from jail to available shelter or detox beds, and for EMS to identify frequent users of the service who may benefit from more stable housing.

Formalizing partnerships and cross-system involvement. The CAHOOTS mobile crisis team was designed as an alternative to police intervention in response to mental health crises in the community. Thus, its partnership with local law enforcement is formalized through an MOU and the two work together closely to divert individuals in crisis, including those experiencing homelessness, from police contact as much as possible. The CAHOOTS team responds to calls involving individuals with behavioral conditions that come in through 911 as well as the police non-emergency line. The team also works to actively find and engage those identified by patrol officers for quality of life offenses to divert them from further justice system involvement.

BCRI works formally with the Baltimore Police Department on two programs that regularly interface with individuals in behavioral health crisis who may also be experiencing homelessness. Its Crisis Response Team (CRT) pilot program pairs a CIT-trained police officer with a licensed clinical social worker to jointly respond to police calls involving individuals experiencing a behavioral health crisis. Officers receive training and support in order to safely engage these individuals, improving outcomes for all involved. The second collaboration involves diverting individuals who are homeless and have been identified by police for certain low-level offenses to the Law Enforcement Assisted Diversion (LEAD) program in lieu of arrest. LEAD case managers engage these individuals by meeting basic needs for food, clothing, and housing prior to addressing treatment needs. Nationally, the LEAD program has shown promising outcomes for individuals who are homeless and in need of housing.⁴⁸

COVID-19 Considerations for Responding to Individuals Experiencing Homelessness

Behavioral health crisis programs will need to continue to adapt to the effects of the COVID-19 pandemic and related economic crisis, with unique considerations for persons living with behavioral health disorders who are experiencing homelessness. In many communities across the country, homelessness was growing prior to the pandemic, and there could be increases in homelessness ahead, as lost incomes are likely to result in more evictions despite legislative efforts to prevent people from losing housing. Coupled with increased need for behavioral health services against strained or decreasing services, crisis response programs will likely experience more encounters with individuals who are experiencing or at risk of homelessness, particularly with racial and ethnic minority groups disproportionately affected by the pandemic⁴⁹ and the resulting economic crisis.⁵⁰

Crisis programs should be aware that many individuals who are homeless have nowhere to shelter in place, quarantine, or isolate without public health disaster response resources. Those living in encampments are subject to social distancing protocols placed upon them by public health, public safety, and homeless service providers that interfere with outreach, engagement, and service delivery, even while reducing viral spread. Providers in emergency homeless shelters have also been significantly impacted and are having to implement new and potentially stressful safety protocols that create physical distance between the individuals being served, staff, and volunteers. These new disease management measures, which may also prohibit homeless

⁴⁸ Collins SE, Lonczak HS, Clifasefi SL. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. *Eval Program Plann.* 64:49-56. doi:10.1016/j.evalprogplan.2017.05.008

⁴⁹ Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>

⁵⁰ Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire*, blog of the Urban Institute. Retrieved on July 16, 2020 from <https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity>

individuals from accessing their friends and other naturally occurring support systems, may further exacerbate behavioral health conditions and have a lasting impact for years to come.

Early in the pandemic, shortages of personal protective equipment (PPE) inhibited crisis mobile response teams from responding to many calls and often required a default to crisis hotline and telehealth triage strategies, especially with callers such as first responders and providers. Access to PPE is critical for mobile crisis teams when working with individuals who are homeless due to high rates of infection in this population. In Boston, nearly 40 percent of homeless individuals tested positive for the virus at one large shelter.⁵¹ Responding to homeless shelters may require mobile teams to engage an individual just outside of the shelter. Even in open air encampments, living conditions may result in tight spaces that impede physical distancing standards, and mobile teams must have policies and strategies in place to address these scenarios.

Several communities have established temporary housing and temporary quarantine sites in hotels or other settings for individuals who are homeless.⁵² Crisis providers should explore ways to collaborate with, respond to, support, and utilize these sites for mobile crisis response, crisis stabilization, and temporary crisis residential support.

Some crisis stabilization and residential programs have had to decrease capacity in order to implement physical distancing protocols. This can limit access to step-down options from crisis care that homeless individuals may need as they are coming out of a behavioral health crisis and being connected with longer-term resources to resolve their homelessness. Access to transitional and permanent housing programs may also be limited for similar reasons during the pandemic which may impact flow through some crisis systems for people experiencing homelessness who are interested in accessing these resources.

State and local policymakers and payers must ensure that behavioral health crisis programs retain capacity in order to respond to crises rather than default to law enforcement or other first responders. Crisis hotlines and mobile teams must be able to respond to calls in a timely manner. For mobile teams and crisis receiving facilities, this also requires an adequate supply of PPE.

CONCLUSION

Effective crisis response for people experiencing homelessness requires attention to each individual's unique clinical and social service needs, as these can further complicate a behavioral health crisis. The current pandemic and attention to structural racism have increased the visibility of the challenges in working with individuals who are homeless and experiencing behavioral health conditions. By collaborating with homeless system providers, behavioral health crisis programs can ensure that their screening, assessment, and intervention strategies are sensitive to these and other situational and environmental factors, thereby informing an appropriate crisis response for individuals who are experiencing homelessness and helping to ensure the safety of crisis program staff.

Beyond individual crises, behavioral health crisis programs have a unique opportunity to facilitate access to resources that can help resolve homelessness among persons with behavioral health conditions. Evidence-based

⁵¹ Baggett, T., Keys, H., Sporn, N., Gaeta, J. (2020). Research Letter: Prevalence of SARS-CoV-2 infection in residents of a large homeless shelter in Boston. *Journal of American Medicine*, 323(21)

⁵² University of Wisconsin, School of Medicine and Public Health, Department of Family Medicine and Community Health (2020). Responding to COVID-19: Operational guidance and considerations. Retrieved on July 16, 2020 from <https://www.fammed.wisc.edu/files/webfm-uploads/documents/covid19/operational-guidance.pdf>

and best practice interventions shown to be effective with homeless individuals who may be unable or unwilling to engage should be incorporated into crisis services design and delivery, including the use of peer specialists, and supported through workforce development and training. Interventions should meet individuals experiencing homelessness “where they’re at,” not only providing relief for immediate and basic needs during a crisis, but making connections with housing and longer-term resources that can address their underlying condition of homelessness.

To ensure continued engagement and linkages with longer-term resources, it is important to have both good contacts for referrals into the local homeless response system and in-house crisis program staffing for warm handoffs once an individual is ready to transition from crisis care. Peer specialists with lived experience of homelessness and/or mental health and addiction challenges, in addition to case managers, can work to transition individuals back to the community, making referrals as needed.

Behavioral health crisis programs should not be relied on to resolve homelessness and other social service challenges; however, step-down resources from crisis systems are a critical “back door” for homeless individuals as they come out of behavioral health crisis and seek longer-term resources. Access to short-term residential, subacute crisis stabilization beds, or to other programs where homeless individuals can stay longer to stabilize, allows them to stay engaged as they begin the process of accessing housing and other needed treatment, services, and supports.

Crisis programs should proactively collaborate with homeless systems and providers and with law enforcement — both to ensure effective handoffs and connections with those who can assist a homeless individual longer-term, and to avoid responses that might be harmful to them or escalate their crisis. Cross-system training should encourage understanding of each system’s respective resources and roles, and should encourage best practices. Protocols should be established for information-sharing and warm handoffs to inform crisis triage and response and to facilitate smooth care transitions for the individuals served. Informal partnerships and collaborative relationships should lead to more formal ones, including broader systems-level efforts that recognize people with behavioral health conditions who are experiencing homelessness as a commonly encountered population requiring a coordinated response to break the cycle of crisis and homelessness.

Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the U.S.

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Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the United States

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Introduction and Methodology

Behavioral health crisis services are critical components of the behavioral health service continuum. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently released the *National Guidelines for Behavioral Health Crisis Care* (“*National Guidelines*”); a toolkit that details the essential components and best practices of a behavioral health crisis services delivery system. According to this toolkit, an effective crisis continuum includes centralized crisis hotlines that enable a provider to assess an individual’s needs and dispatch support as needed; mobile crisis teams available to attend to individual needs in the community; and crisis receiving and stabilization facilities that are available to “anyone, anywhere, anytime”.¹ State Behavioral Health Authorities (SBHAs) are responsible for establishing and supporting crisis service systems to ensure that anyone experiencing a crisis, regardless of background or ability to pay, can receive appropriate behavioral health care in a timely manner. The array of crisis service availability varies across the states, and even across regions within states. Crisis services of the same name offer differ in their definitions from state to state due to lack of consistent definitions (see the first paper in this series, *Crisis Services: Meeting Needs, Saving Lives for model definitions*).¹ The vast majority of states (98%) offer at least one of the three of the services recommended in SAMHSA’s *National Guidelines for Behavioral Health Crisis Care*. Of those, 82% offer 24-hour crisis hotlines, 86% provide mobile crisis response services, and 90% provide crisis stabilization beds (offering either less-than-24-hour or more than 24-hour stays).² It is important to note that although these services are provided in the majority of states, they may not align with the best practices prescribed in the *National Guidelines*, and they may not be available to “anyone, anywhere, anytime”.³

Many technologies exist that can be used to facilitate and enhance the delivery of each of these three critical behavioral health crisis services, and others, including predictive technologies, are in development. The importance and promise of technology in the delivery of these services has never been more relevant than in 2020, when the world is adjusting to the effects of a global pandemic that limits face-to-face interventions, isolates individuals from their natural support systems, and heightens anxiety due to fear and uncertainty.

A review of the literature was conducted to understand the opportunities and challenges technology presents in the delivery of behavioral health crisis services. Ensuring that only relevant and timely information is included, the literature review focuses on journal and news articles, publications from government agencies, and blog posts from technology and marketing companies published between 2017 and 2020. To understand how SBHAs are leveraging technology in the delivery of crisis services, structured phone interviews were held with representatives from state, local, and non-profit organizations in Alaska, Colorado, Nebraska, New Mexico, Tennessee, and South Carolina. This report addresses how technology is being used by the states, and the opportunities and challenges it presents, in the delivery of each of the three critical services identified in the *National Guidelines*.

Marketing Crisis Services through Digital Media

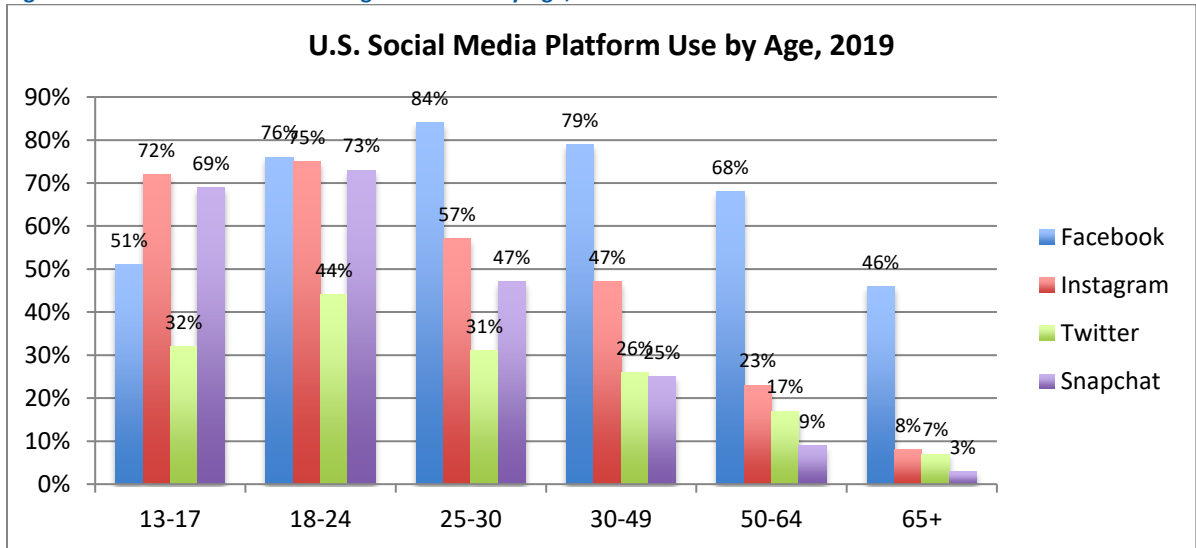
In order for people to seek out services during times of need, they must first be aware that services are available. While many traditional mediums exist to market the availability of

¹ See Pinals, D.A. (2020). *Crisis Services: Meeting Needs, Saving Lives*. Alexandria, VA: National Association of State Mental Health Program Directors.

behavioral health crisis services (e.g., television, radio, print publications, etc.), in the last decade, the use of social media has expanded rapidly and is an important tool to engage individuals of all backgrounds and ages, and can be especially effective in reaching youth and young adults. Engaging individuals at younger ages is important in providing prevention and early intervention services that may reduce the need for future crisis services, as “the onset of mental health problems peaks between adolescence and young adulthood”.⁴ States are investing in the use of social media to promote the availability of crisis services, and to help normalize the need for and use of behavioral health crisis services.

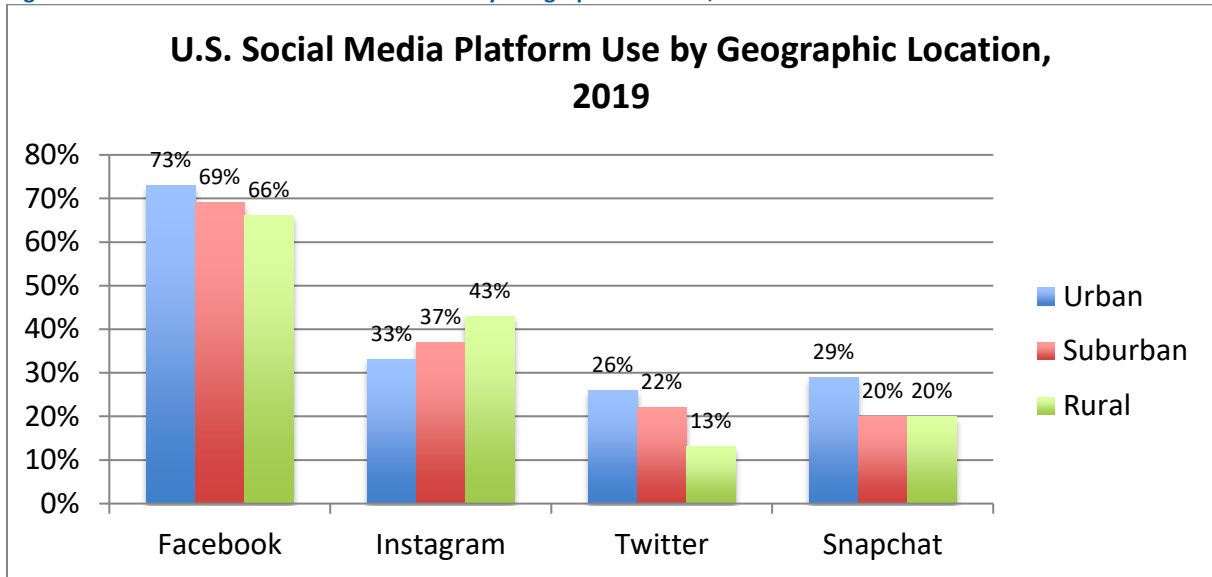
The social media platform a state uses should be determined by which age group and geographic location the SBHA is trying to reach. Facebook has the broadest reach among all age groups, with nearly 50% of all age groups using this platform. Snapchat and Instagram are more effective at engaging youth when compared to Facebook and Twitter.⁵ See Figure 1.

Figure 1: Social Media Platform Usage in the U.S. by Age, 2019



Use of social media is greatest in urban areas, regardless of platform. However, Facebook and Instagram are widely used among individuals in all geographic areas.⁶ See Figure 2 on the following page.

Figure 2: Social Media Platform Use in the U.S. by Geographic Location, 2019⁷



In addition to broader, yet more targeted reach, this strategy is also cost effective and allows SBHAs to make better use of their marketing budgets. In 2020, on average, social media influencers charge between \$2.00 and \$25.00 per post per 1,000 followers (Twitter: \$2/post; Snapchat: \$10/post; Instagram \$10/post; and Facebook \$25/post).⁸

Colorado’s Crisis Services (CCS), operated out of the state’s Office of Behavioral Health, relies on influencers as part of a larger marketing campaign to promote the state’s crisis services and suicide-prevention hotlines and text lines (Lee, personal communication, July 1, 2020). Colorado finds this strategy effective at reaching all areas of the state, including rural and urban areas, and at engaging more youth and young adults when compared to traditional marketing methods. CCS has found that youth listen to each other and respond better when the message is coming from their peers (Lee, personal communication, July 1, 2020). Utilization data from the state’s crisis text line support this theory, and show that each time the CCS promotes their services for youth and young adults, there is an increase in utilization of the state’s crisis text line (Lee, personal communication, July 1, 2020). This strategy also allows CCS to maximize its tight marketing budget, which is a critical consideration as states consider how to reduce costs without reducing access or services as states face unprecedented budget cuts due to budget shortfalls related to COVID-19.

Using Technology to Improve Crisis Hotlines & Text Lines

The majority of SBHAs (82%) offer statewide or regional hotlines that are available 24 hours per day, seven days per week, 365 days per year.⁹ However, the existence of a crisis hotline does not guarantee that people will use it, or that it is being used effectively. SAMHSA’s *National Guidelines* recommends that, at minimum, states operate either regional or statewide crisis call centers that are fully staffed and provide crisis intervention services and suicide risk assessments by trained professionals, coordinate callers with nearby mobile crisis teams, and conduct warm hand-offs to facility-based care when needed. Best practices for call centers create an “Air Traffic Control” model for hotlines, and include the incorporation of caller-ID technology, the use of GPS to efficiently coordinate care with mobile crisis teams, have access to a regional or statewide behavioral health bed registry to identify available and appropriate beds,

and have the ability to schedule follow-up appointments to ensure ongoing care following a crisis episode.¹⁰ Hotlines should also offer text and chat services to make the services more accessible.

According to a study by the Pew Research Center, 81 percent of Americans own smartphones, which are equipped with GPS “that can transmit geographic coordinates in real-time”.^{11 12} Integrating GPS technology and access to a behavioral health bed registry into a crisis hotline call center can help crisis counselors quickly identify an individual’s location and either dispatch the nearest available mobile crisis team, or guide the caller to the nearest crisis receiving and stabilization facility if the crisis cannot be triaged over the phone. Georgia is one example of a state that has built a comprehensive “Air Traffic Control” model of technology into their crisis system that incorporates GPS technology and access to a behavioral health bed registry, as recommended by the *National Guidelines*.

The Georgia Crisis and Access Line (GCAL) provides callers with crisis intervention services, relies on GPS to efficiently dispatch mobile crisis teams, accesses the state’s bed registry to identify available crisis or detox beds, and connects individuals with follow-up appointments to ensure a continuum of care following the immediate crisis.¹³ GCAL uses proprietary dispatch software that provides Georgia’s crisis providers “with the ability to immediately locate and communicate with mobile teams in the field” that enables providers to conduct secure, electronic assessments with or without an internet connection, which is crucial for areas of the state where broadband connectivity may be unavailable.¹⁴

While Tennessee does not operate their call center in the Air Traffic Control model prescribed by the *National Guidelines*, the state does use a caller-ID system to geo-route calls to a local provider based on area codes. Callers without a known location are routed to a centralized call center that can then transfer callers to a local provider. Other states are exploring adding either geo-routing incoming calls or incorporating GPS services into their hotlines, and developing crisis bed registries to enhance efficiencies; however, budgetary and resource limitations presented by COVID-19 have delayed these efforts (Lee, personal communication, July 1, 2020).

Several states interviewed for this report noted that their states’ centralized crisis hotlines operate in tandem with emergency/after-hour call lines sponsored by local community providers. This duplicative arrangement prevents maximum utility of a centralized state crisis hotline, and can serve to overburden local providers, especially in smaller, rural communities, which can lead to high levels of employee burnout and turnover. For example, a former provider from a remote village in Alaska described a time when he was the only clinician available to answer and respond to crisis calls in the community during a six-month period. During this time, he had to constantly be available and in reach of his phone, even while trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials. A centralized call center that is promoted and utilized across the state could help absorb some of these misdials and alleviate some of the pressure on providers, especially in rural areas where workforce issues prevail (Owens, Chipp, personal communication, July 1, 2020).

SMHAs may face barriers when establishing statewide crisis hotlines. It was noted during the interview with Colorado’s Office of Behavioral Health that there is reluctance among both individuals in need of care and law enforcement officers in smaller communities to call into an

anonymous state crisis hotline. The reluctance is fueled by a sense of resentment that someone “in the big city would actually know about my life and my problems” (Lee, personal communication, July 1, 2020). This can lead to more after-hour emergency calls to local community providers, when the Colorado Crisis Services Hotline could just as easily direct the caller to appropriate care and dispatch appropriate crisis services (Lee, personal communication, July 1, 2020). To encourage use of its statewide hotline, New Mexico’s SMHA waived the state’s unfunded requirement for local providers to operate their own emergency call capability. The only thing the SMHA required of providers was a memorandum of understanding with the statewide call center (Lindstrom, Wynn, personal communication, June 9, 2020).

Crisis Text Lines

In addition to statewide hotlines, SMHAs are also trying to reach youth and young adults by operating crisis text lines, which are recommended as part of SAMHSA’s *National Guidelines* to effectively “engage entire communities into care”.¹⁵ According to 2012 research from the Pew Internet Survey (the most recent data available), teenagers send an average of 100 texts per day, and 63 percent indicated they exchange text messages every day.¹⁶ The rate of texting is significantly higher than other forms of daily communication. Thirty-nine percent of teens call on their cell phones every day, 35 percent socialize face-to-face outside of school, 29 percent rely on messaging through social media, and 22 percent use other instant messaging or chat platforms.¹⁷

Several states interviewed for this report, including Colorado and New Mexico, have recently implemented crisis text lines as a way to engage more people with crisis services, particularly youth and young adults. In Colorado, when someone engages with their text line, they will receive a response from a live person. Between July 2019 and June 2020, Colorado Crisis Services received 16,460 texts into its crisis text line. Of these, 29.4 percent were from adolescents between the ages of 13 and 17, 26 percent from adults age 18 to 25, 27.7 percent from adults between the ages of 26 and 39, and 12.8 percent from adults ages 40 to 59. Fewer texts were received from youth under age 12 (2.6 percent), likely due to a lack of access to cell phones, and only 1.6 percent of texts were from adults ages 60 and over.¹⁸ Text messages primarily originated from the state’s more urban counties, including Denver, El Paso, Arapahoe,

Adams, and Jefferson Counties.¹⁹ The Office of Behavioral Health makes available monthly reports showing the utilization of their text services throughout the state.

While crisis text lines are effective at engaging youth and young adults, as evidenced by the data from Colorado, reports indicate that it can cost three times as much to implement a crisis text line when compared to the cost to implement a voice only crisis hotline due to the additional human resources required to respond to the texts (Lindstrom, Wynn, personal communication, June 9, 2020). To avoid this additional cost, yet still reach youth and young adults in need of crisis services, New Mexico recently launched an asynchronous crisis text line, meaning that instead of relying on humans to respond to texts, a botⁱⁱ responds and is able to connect individuals to appropriate levels of crisis care.

Emotional Support Lines for Healthcare and Frontline Workers During COVID-19

In addition to general behavioral health crisis hotlines and text lines, New Mexico established a dedicated support

line for health and behavioral health providers, and other frontline workers who may be anxious and overwhelmed as a result of their positions in the context of COVID-19. New Mexico's Healthcare Worker and First Responder Support Line was established in response to the increased burden faced by frontline workers during COVID-19 pandemic (Lindstrom, Wynn, personal communication, June 9, 2020). New Mexico publishes detailed utilization reports monthly on its Crisis Line website.ⁱⁱⁱ Utilization data are available for the Crisis Call Line, Support Line, Warm Line, and Core Service Agencies calls. Since its launch in May 2020, the support line has received 129 calls from healthcare workers and first responders.²⁰ Between May and June, 69.7 percent of these calls were related to COVID-19.²¹ The support line is staffed by professional counselors with the New Mexico Crisis and Access Line. Figure 3 shows a flyer used to promote the New Mexico Healthcare Worker and First Responder Support Line. Tennessee also established a support line for healthcare workers working the frontlines of the pandemic; however, unlike New Mexico, Tennessee's support line is staffed by volunteers and does not provide clinical, medical, or therapeutic services.²²

Figure 3: New Mexico Healthcare Worker and First Responder Support Line Flyer



988: The Future of the National Suicide Prevention Hotline

ⁱⁱ A bot is a computer program designed to simulate a human interaction.

ⁱⁱⁱ <https://www.nmcrisisline.com/resources/public-awareness/>

The National Suicide Prevention Lifeline was established in 2005 through a SAMHSA grant.²³ The national Lifeline connects callers in need to one of 170 crisis centers nationwide.²⁴ Currently, people can access the national Lifeline by calling 1-800-273-TALK; however, in July 2020, the Federal Communications Commission (FCC) voted unanimously to adopt 988 as the new three-digit dialing code to “increase the effectiveness of suicide prevention efforts”.²⁵ ²⁶ The new three-digit number will go into effect in spring 2022, after an 18-month implementation period.²⁷

While a short, easy-to-remember number will facilitate access to crisis services nationally; setting up the telephone network across the country will take some effort. In many parts of the country, telephone carriers and VoIP (voice-over internet providers) “should be able to implement the new code without major delay or expense;” however, there are some parts of the country that use 988 as part of their seven-digit dialing codes.²⁸ Transitioning these phone numbers in time for the implementation of 988 may take some time, and if not handled carefully may cause confusion for callers in the process.

National Crisis Text Line

Established in 2013, Crisis Text Line is a 501(c)(3) non-profit based in New York and is available for individuals across the U.S., Canada, the U.K., and Ireland to connect immediately with a crisis counselor.²⁹ The service is programmed with different code words used by different entities, allowing the entity to track data on text utilization. In the U.S., individuals can text HOME to 741741 during a crisis to receive help from volunteers at the Crisis Text Line in a crisis. The National Alliance on Mental Illness promotes texting the word NAMI to 741741. In the context of COVID-19, many states have used this number (e.g., in Michigan, texting the word RESTORE to the same number helps track data related to utilization). Crisis Text Line works in partnership with nearly 200 state and local agencies, “as well as universities and nonprofit services” to connect people to care.³⁰ Since August 2014, the Crisis Text Line has exchanged more than 142 million messages.³¹

Crisis Text Line relies on an algorithm that combines the power of technology and data to prioritize calls. An algorithm reviews incoming text messages for flag words to determine how quickly a text should be answered, and the likeliness that the counselor will need to call 911. The algorithm found that for texts that contain the word “military” the counselor is twice as likely to have to call 911 than when the word “suicide” is used; the sad face/crying emoji results in calls to 911 four times more likely than texts with “suicide”.³² Texts with the word “pills” result in calls to 911 16 times more often than texts that contain the words “suicide” or “overdose”.³³ The algorithm is learning and improving with each new text, resulting in better response times and care for individuals texting in a crisis. Reports on utilization are available at www.crisistrends.org.

Using Technology to Improve Mobile Crisis Response

Mobile crisis response teams consist of mental health professionals who respond to behavioral health crises in the community at the request of first responders or crisis call lines. The *National Guidelines* recommend that mobile crisis teams be “available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner”.³⁴ Using GPS technology, as described above, can improve response times by identifying the nearest available mobile crisis response team. However, many states interviewed for this report require teams to respond within two hours or more for those in rural

areas, which can seem lengthy for an individual experiencing the crisis and for other first responders who are taken away from their normal service when waiting for a mobile crisis team to respond. Technology can be used to expedite response times, and remotely meet the needs of the individual in crisis. South Carolina and Colorado are implementing and exploring strategies that use technology to improve mobile crisis response and meeting people in the community where the crises are occurring.

In terms of statewide reach and responder composition, South Carolina provides mobile crisis response teams in each of its 46 counties, where master's-trained clinicians are available to respond to crises 24 hours a day, seven days a week. In Charleston County, a highly populated and large county, the mobile crisis response team initially only received an average of five calls per month from local law enforcement or emergency medical services (EMS). After discussions between the county and the EMS teams, it was revealed that EMS did not utilize the services of the mobile crisis response teams because it often took too long for the mobile crisis teams to respond. EMS teams found it was easier and faster to transport an individual in crisis to an emergency room at a nearby hospital; however, ERs are more costly and are more likely to result in an inpatient admission that are crisis interventions, and are usually not the most appropriate setting unless the individual in crisis was also experiencing a medical emergency or needed more comprehensive assessment. The EMS team and the county discussed using technology to improve response times, and a partnership between the state and the EMS program in Charleston County was formed. The result of these discussions is a formalized process that begins when EMS is called to respond to a psychiatric emergency, they first evaluate whether the crisis is medical or psychiatric in nature. If medical, the ambulance will transport the individual to the appropriate level of care; if psychiatric, the EMS crew calls their supervisor to respond in an SUV. Once the supervisor responds, the ambulance is sent back out into service, and the supervisor connects the individual in crisis through the VIDYO telehealth app on their tablet to the mobile crisis response team. The mobile crisis response team is then able to evaluate and triage the crisis virtually, and can make recommendations on next steps. Service is immediate and allows for more appropriate use of EMS time and resources and reduces the number of referrals to emergency departments in the county. This approach also reduces the need for mobile crisis teams to travel long distances to reach individuals experiencing a crisis, and allows individuals in crisis to receive services quickly. Since this program has been implemented, the county has experienced an increase in calls from EMS to mobile crisis from five to nearly 85 per month, and the county has seen a 58 percent decrease in ED use for individuals in psychiatric emergencies (Bank, Blalock, personal communication, July 7, 2020).

Colorado's Office of Behavioral Health (OBH) is considering a model similar to South Carolina's, but instead of deploying masters-level clinicians to respond to individuals in the community in crisis, it would rely on volunteer, trained citizens (often bachelor's-level clinicians or peer specialists) who carry tablets to virtually connect people in crisis to care. Colorado requires there be at least one mobile crisis response team that can respond to crises within two hours in each of the five regions of the state. While each region has met the minimum obligation for the number of teams, there are multiple mobile crisis response teams in urban areas, and only one serving the more rural and remote areas of the state, making it difficult for mobile crisis teams to adhere to the two-hour guideline. OBH has heard from communities in the more rural areas that they have concerned citizens wanting to help respond to crises, but do not know the most

appropriate way to provide help. The state is exploring training these citizens, who are bachelor's-level providers or peers, to carry a tablet to an individual in crisis that can be used to connect the individual to a masters-level clinician via telehealth services. Unfortunately, the COVID-19 pandemic has delayed progress in these programs, and future budgetary decisions at the state level may determine the fate of these programs.

Reaching people in crisis in the community means meeting them where the crisis is occurring. Often times, people will seek out care in emergency departments at local hospitals. This can serve to overwhelm EDs, result in costly services, and prevent timely treatment for the individual in crisis. Recognizing this as an issue, and not the most appropriate use of the mobile crisis response teams, South Carolina's Department of Mental Health has supported the use of telepsychiatry in EDs since 2009. The state has contracts with 25 EDs across the state to provide telepsychiatry services to individuals experiencing psychiatric emergencies. These services are available from 7:00 am to midnight, 365 days per year. Rather than take resources away from the ED to serve individuals experiencing a medical emergency, or have the individual in crisis end up lingering in the ED, the ER doctors put psychiatric patients in a virtual line to receive telepsychiatry services from one of a group of 25 psychiatrists. Since its implementation, nearly 70,000 patients have received this service. Research on the program shows that patients who have participated in this program are twice as likely to attend their follow-up appointments at community mental health centers, and approximately half as likely to return to the ED or require psychiatric hospitalization when compared to those who receive traditional psychiatric services through the ED (Bank, Blalock, personal communication, July 7, 2020).

SMHAs and clinicians have increased their use of telehealth and voice-only telehealth services to deliver mobile crisis response to adjust to the social-distancing requirements of COVID-19. After years of reluctance to incorporating telehealth services into their practices because of fears relationships between client and provider will be hindered, many SMHAs have actually found that providers and clients alike enjoy using telehealth services. SMHAs have heard that the no-show rates are zero, as people no longer have to overcome barriers (including transportation) to receive services. The increased use of telehealth has also led to more engagement with an individual's familial supports, since everyone is home to participate in telehealth appointments. One state expressed that, "if there is a silver lining to this whole pandemic, it has been to force the hand of telehealth and move us into the next century." (Tennessee call)

Using Technology to Improve Access to Crisis Receiving and Stabilization Facilities

As part of an effective crisis continuum of care, the *National Guidelines* recommend that states provide short-term (23-hour) crisis stabilization facilities. According to 2015 and 2020 State Profiles data, 90 percent of states provide crisis stabilization services, offering either less-than-24-hour stays, or more-than-24-hour stays (note, the distinction between 23-hour and 24-hour stays was not made in the 2020 State Profiles).³⁵ In order for these services to be effective, individuals in crisis and first responders need to be aware of the availability of mobile crisis lines, mobile crisis response, and crisis receiving and stabilization facilities. As discussed above, crisis hotlines can combine the use GPS technology to identify the location of an individual in crisis, with the use of a behavioral health bed registry to identify the nearest available crisis stabilization bed to meet the caller's needs and improve care coordination.

Behavioral health bed registries are "regularly updated web-based electronic databases of available beds in behavioral health settings".³⁶ As of 2019, 19 states had active behavioral

health bed registries.³⁷ To expand the availability of bed registries in the U.S., SAMHSA’s Technology Transfer Initiative (TTI) 2017 grant funded 23 states to establish new or enhance existing behavioral health bed registries. A review of TTI state efforts shows that the most common type of beds included in a behavioral health bed registry are beds in crisis stabilization units (18 of 23 states). Bed availability data are most often updated twice per day (9 states), and are available primarily to authorized users (13 states), including participating hospitals, mobile crisis teams, emergency departments, local provider agencies, and call centers.³⁸ Bed registries implemented by the TTI states follow one of three models: search engines, referral systems, or referral networks (taken from the 2020 *TTI Crisis Bed Registry Report*, currently under review):

Web-based search engines: Most TTI states (15 of the 23) implement or are expanding web-based search engines, where users are able to visit a website to access information on crisis bed facilities, including their locations, available services, and contact information. In these platforms, users call or contact the facility through means other than the website.³⁹



Referral Systems: Two states are implementing or expanding bed registry referral systems. These systems provide users with regularly updated information about bed availability. In addition, they also allow authorized users to submit HIPAA-compliant electronic referrals to a secure bed using pre-set forms and protocols. The entire referral process can be timed, documented, and monitored.⁴⁰



Referral Networks: Six states are implementing bed registry referral networks. In these platforms, bed registry websites provide regularly updated information on bed availability, support users to submit HIPAA-compliant electronic referrals to secure a bed, and support referrals for behavioral health crisis and outpatient services to-and-from service providers who are members of the referral network. As with referral systems, the process of referrals can be tracked.⁴¹



Bed registries have been especially helpful to identify bed demand and availability during the COVID-19 pandemic. A review of data from the TTI states show that psychiatric bed capacity in some states was significantly decreased to accommodate for social distancing guidelines to reduce the spread of the virus; fortunately, demand for these services decreased during the pandemic as people sought to limit their exposure and avoided treatment in inpatient settings.⁴² However, the COVID-19 pandemic has also delayed the development of bed registries in at least seven states.

The Future of Technology in the Delivery of Behavioral Health Crisis Services

Beyond telehealth and telepsychiatry services, opportunities for the use of technology in crisis services are continuing to grow. Mobile and wearable devices, such as smart phones, tablets, and activity trackers (e.g., FitBit, Garmin, and Apple Watches), as well as advances in artificial intelligence offer new ways for individuals, clinicians, and researchers to access services,

monitor symptoms, and research changes in both physical health indicators and social behaviors that may predict impending behavioral health crises.

With 81 percent of the population owning smartphones, crisis services applications (“apps”) offer a convenient way for individuals to immediately access care. According to the National Institute of Mental Health (NIMH), apps offer a good entry into mental health care, and may engage clients at a younger age into treatment. Many apps are also free or cost less than traditional care, eliminating the barrier and fear of being unable to pay for treatment. Apps will also allow for objective data collection, including information about location, movement, and phone use, which can be added to an algorithm to predict immediate need and overall demand.⁴³

Researchers at the University of Colorado Boulder are studying how to apply machine learning to psychiatry through the development of a speech-based mobile app to help providers monitor their clients and identify changes in mood and wellbeing before they experience a crisis.⁴⁴

Considerations

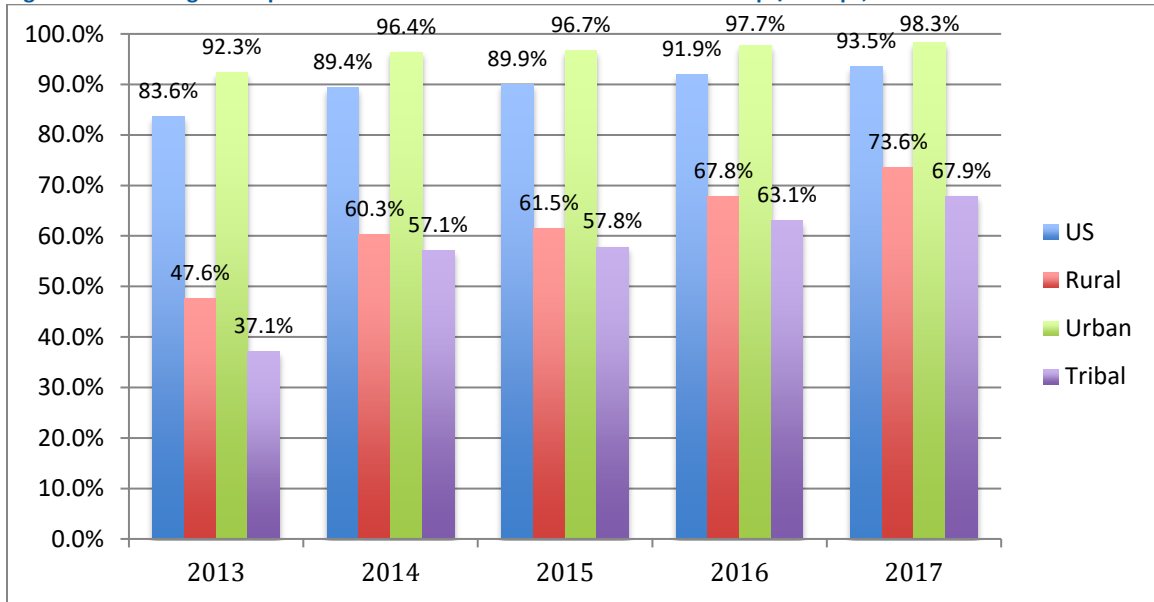
Technology offers much promise in improving access to behavioral health crisis care. However, when considering which technologies to implement, a variety of considerations exist that can influence the effectiveness, safety, and security of the technology in use.

Broadband Access

The availability of broadband and cellular technology, especially in rural and frontier areas of the U.S., will help determine the success of any crisis services aided by technology. Inconsistent broadband connectivity in rural and frontier areas was identified as an area of need during each of the phone interviews conducted for this report.

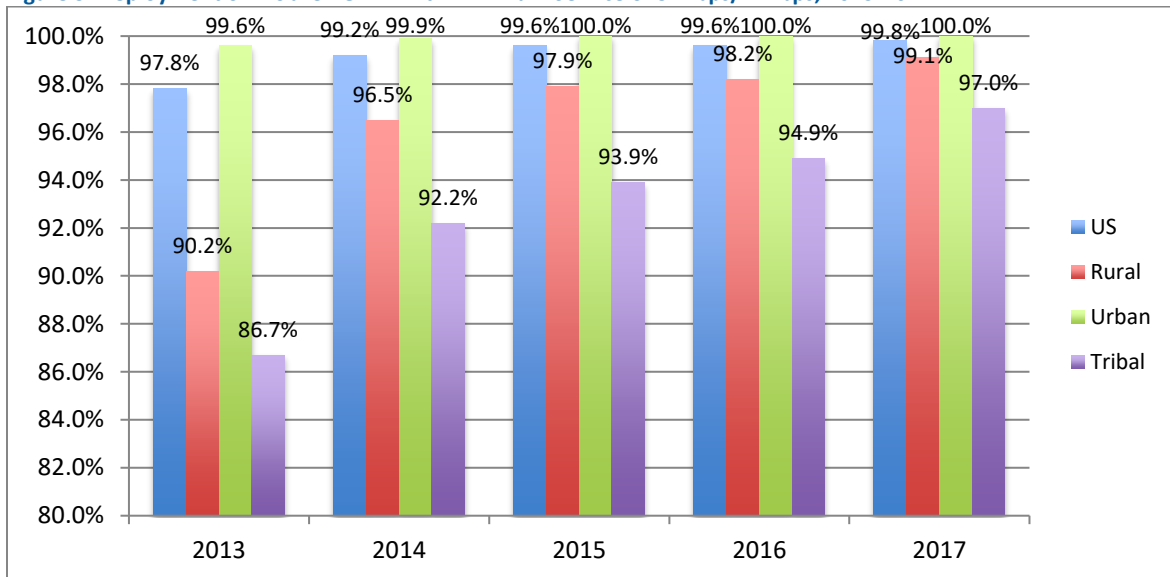
According to the Federal Communications Commission (FCC), the minimum fixed-broadband requirement is 25 Mbps download speed and 3 Mbps upload speed.⁴⁵ Data from the FCC show that this minimum level of broadband access has significantly expanded across all areas of the U.S., including rural and tribal areas, since 2013, although access in rural and tribal areas still lags behind urban connectivity. See figure 4.⁴⁶

Figure 4: Percentage of Population with Fixed Broadband Services of 25 Mbps/3 Mbps, 2013-2017



In addition to calculating rates of fixed broadband availability across the U.S., the FCC also monitors the availability of cellular technology. The minimum performance benchmark for mobile services is 4G LTE, within minimum speeds of 5 Mbps download, and 1 Mbps upload.⁴⁷ This level of mobile access is more widely available across all areas of the U.S., including rural and tribal areas, than fixed broadband services. See figure 5.

Figure 5: Deployment of Mobile 4G LTE with Minimum Service of 5 Mbps/1 Mbps, 2013-2017



While broadband connectivity, both fixed and mobile, is improving, and appears to be available throughout both rural and urban areas of the U.S., the experiences of individuals living in these areas may not align with the information available from the FCC. According to a 2018

Bloomberg report, the FCC’s connectivity map (available online^{iv}), which maps the availability of broadband access by address, is inaccurate because it relies on Census blocks to calculate connectivity at a given address. Within Census blocks, which tend to cover small areas in urban communities and large tracts of land in rural areas, the availability of broadband can vary quite a bit. According to the report, “just because your closest neighbors have broadband doesn’t guarantee you’ll have any”.⁴⁸ While the FCC purports that 21.3 million Americans lack access to broadband connectivity, research from BroadbandNow estimates that the number of Americans without broadband access is closer to 42 million, when taking into account the disparities within Census blocks.⁴⁹ The FCC data also do not consider limitations accessing broadband services due to the associated costs, and inability of some individuals to afford these services.

Staff from South Carolina’s SMHA pointed out that COVID-19 is highlighting the need for expanded broadband connectivity across all areas of the state, and SMHAs across the U.S. can partner with other agencies, including departments of education, to lobby their legislatures for expanded broadband connectivity.

Financing

State and local government general funds remain the major funder of the behavioral health crisis continuum in most states and thus availability of state funds limits the ability of many states to expand their use of new technologies. While face-to-face and telehealth crisis services provided by mobile crisis response teams and at crisis receiving and stabilization facilities are generally reimbursable through Medicaid and private insurance, crisis systems have had limited success in getting reimbursed by insurers, because often crisis services are not considered emergency services by insurance companies. Many states rely on state general and local funds to support these two encounter-based services to ensure sustainability. However, for services provided through state-operated crisis hotlines and text lines, the responsibility for funding these services often falls solely to the SBHA, as many calls are anonymous, and Medicaid and private insurance are resistant to reimburse for non-encounter services, even though many users of these services may participate in private insurance or Medicaid. Therefore, these hotlines often become a “free good” for insurance companies to rely on. States interested in establishing an “Air Traffic Control” type crisis hotline and referral systems may benefit from working with their State Medicaid Agency and State Insurance Commissioner to explore opportunities to get insurers to contribute to the costs of implementing this essential crisis technology.

New Mexico’s Behavioral Health Services Division was able to work with the state’s Medicaid division to secure reimbursement for calls to the state’s crisis line. However, callers must provide identifiable information, including their Medicaid enrollment status. Most call centers avoid this practice, as they want to ensure the anonymity of their callers. However, half of the callers to New Mexico’s crisis line self-identified as being enrolled in Medicaid; therefore, the state was able to secure the 50 percent match on half of the callers, resulting in 25 percent of the call center’s costs were subsidized by Medicaid. (Lindstrom)

Another challenge related to the implementation of telehealth services is that, prior to COVID-19, CMS stipulated that only specific providers were eligible to bill for telehealth services. In normal times, clinical psychologists and clinical social workers are not eligible to bill for

^{iv} FCC Connectivity Map available at <https://broadbandmap.fcc.gov/#/>

psychotherapy services that include medical evaluations or management services. However, in response to the current pandemic, CMS has waived some of the requirements for billing. As of March 1, 2020, under the CARES Act, CMS now allows all Medicaid-eligible providers to bill for the provision of telehealth services, including masters-level clinical psychologists and social workers.⁵⁰ This flexibility allows states to better serve individuals and increases access to crisis care. Each state interviewed for this report expressed appreciation for the changes, and advocated making the changes permanent, beyond the public health crisis. Long-term strategies on the use of telehealth and who can deliver these services is an important consideration.

Privacy Concerns

Mental health providers must abide by the Department of Health and Human Services' Privacy Rule, which "defines and governs the use and disclosure of protected health information (PHI)".⁵¹ Providers must also adhere to the Security Rule, which "sets the standards for securing patient data that is stored or transferred by electronic methods".⁵² These rules apply to providers whether they are delivering services face-to-face or through virtual means. For telehealth services, providers must ensure that data are fully encrypted, and that video recordings of the sessions are not stored.

While empowering "providers to serve patients wherever they are during" the COVID-19 pandemic, HHS's Office of Civil Rights (OCR) has reinforced the requirement that these security regulations be followed during the public health crisis.⁵³ OCR guidelines state that "a covered health provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public-facing remote communication product that is available to communicate with patients".⁵⁴ Apps approved by the OCR, so long as they agree to enter into a business associate agreement with the provider, include: Skype for Business/Microsoft Teams, Updox, VSee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet, Cisco Webex Meetings/Webex Teams, Amazon Chime, GoToMeeting, and Spruce Health Care Messenger.⁵⁵ Additionally, many providers are delivering crisis services from their homes during the pandemic, it is important that they are able to provide telehealth services in a quiet area away from members of their household to ensure confidentiality and the privacy of the individual receiving services. (Chipp)

Although they do not specifically offer crisis services, other technologies that promote mental health and wellness can serve as cautionary tales that underscore the need for strict security guidelines that adhere to "the core values of professional therapy [that include] strict confidentiality and patient welfare".⁵⁶ There is concern among researchers that some behavioral health and wellness apps "are corporate platforms first [and] offer therapy second".⁵⁷ Talkspace, launched in 2014, is an app that connects individuals through text and chat with a licensed therapist. is being scrutinized for "questionable marketing practices" and for treating client transcripts as data resources that can be mined to promote the services without concern for client confidentiality.⁵⁸ In addition, there is concern that private, for-profit companies such as Talkspace are driven by revenue, rather than concern for the wellbeing of their clients. A report by the New York Times found that Talkspace had employees write false reviews of the company to improve its ratings and encourage more sales, and "gave employees burner phones to help evade the app stores' techniques for detecting false reviews".⁵⁹ Of similar concern, a 2019 study released by Privacy International found that 76 percent of mental

health websites in Europe, including those with depression screeners, would pass “answers and results of mental health check tests direct[ly] to third parties for ad-targeting purposes”.⁶⁰ This indicates that these sites “treat the personal data of their visitors as a commodity,” and do not “take the privacy of their visitors as seriously as they should”.⁶¹ Such deceitful practices can contribute to a feeling of uncertainty and a lack of trust in technologies that can effectively help people in crisis, inhibiting their use.

Efficacy and Safety of Technological Applications

While there is a lot of hope and opportunity surrounding the future of technology for the delivery and enhancement of crisis services, there is very little regulation on app design, and the safety and effectiveness of these new technologies.⁶² More research needs to be done to determine which apps are safe, effective, and reliable. This is an opportunity for state and federal policy makers and advocates to research the efficacy of apps and establish regulations that promote confidence in their use. Apps also need to be studied to ensure they are culturally competent and do no harm. If certain apps are determined to be effective at predicting and mitigating behavioral health crises, and connecting individuals to care, states may decide to invest in these apps as a way to offset some of the challenges associated with the delivery of crisis care and behavioral health workforce shortages experienced by communities across the U.S.

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Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

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***Addressing Substance Use in Behavioral Health Crisis Care:
A Companion Resource to the SAMHSA Crisis Toolkit***

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Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

Introduction

A comprehensive crisis response system has an opportunity to direct the turning point of a behavioral health crisis for the better. In a webinar hosted by the National Association of State Mental Health and Program Directors (NASMHPD) on the recently published Substance Abuse and Mental Health Services Administration (SAMHSA) “National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,”¹ the United States Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance Katz, stated that “crisis services and systems play an integral role in the delivery of care ... provide acutely needed care and they also serve as a very important entry point for so many people in to the mental healthcare delivery system ... [and] serve as a means of immediate mental health intervention by trained professionals.” In essence, for individuals experiencing a behavioral health crisis, first impressions are important. As an illustrative point of reference, the American Psychological Association, Dictionary of Psychology includes in its definition of the word crisis: “a turning point for better or worse in the course of an illness.”² Especially for individuals with substance use disorders (SUD), crisis response may be the first and only chance to get it right, and impact not only the outcome of the crisis itself, but the entire recovery process.

The publication of SAMHSA’s Toolkit for Behavioral Health Crisis Care (hereafter referred to as the SAMHSA Crisis Toolkit) serves to coalesce a national effort to draw attention to the importance of crisis response for behavioral health. In 2005, the Technical Assistance Collaborative published “A Community-Based Comprehensive Psychiatric Response Service”,³ an informational and instructional monograph that laid the foundation for identification of essential service components in the crisis care continuum. In 2016, the National Action Alliance published the “Crisis Now”⁴ policy paper which identified exceptional practices desired in crisis services. NASMHPD has consistently voiced the need to

¹ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

² VandenBos, G. R. (2015). APA dictionary of psychology (2007 ed.). Washington, DC: American Psychological Association.

³ Technical Assistance Collaborative, Inc. (2005). A community-based comprehensive psychiatric crisis response service. Boston, MA: Technical Assistance Collaborative. <http://www.tacinc.org/knowledge-resources/publications/manuals-guides/crisis-manual/>

⁴ National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. <https://www.sprc.org/resources-programs/crisis-now-transforming-services-within-our-reach>

prioritize crisis response for adequate funding, emphasizing community solutions to better address psychiatric needs outside of institutional based care in its 2017 paper “Beyond Beds.”⁵ And now the SAMHSA Crisis Toolkit serves to give the national voice of leadership in a call to action.

It is essential that the “Anyone” from “Anyone, Anywhere, Anytime” cited in SAMHSA Crisis Toolkit include substance use disorders meaningfully. Substance use disorders cannot be an afterthought in our approach to crisis care. Full integration of mental health and substance use disorders in treatment needs to be embraced across the continuum, which includes the crisis system. We know that 7.7 million adults have co-occurring mental and substance use disorders. Of the 20.3 million adults living with a substance use disorder, 37.9% also had a mental illness. Of 42.1 million adults living with a mental illness, 18.2% also had a substance use disorder. Only 9.1% of those with co-occurring conditions received both mental health care and substance use treatment.⁶ And the percentage of people that receive the simultaneous *recommended* care for both is even lower.⁷ An assessment of factors that prevent systems from embracing full integration of SUD must include screening for the presence of negative perceptions or attitudes related to SUD. Such perceptions can manifest in prejudicial attitudes about and discriminatory practices against people with substance use disorders. These and other forms of stigma at the organizational and individual levels pose major challenges to the integration of SUD into crisis response systems.

Of great significance in the SAMHSA Crisis Toolkit is the clear inclusion of substance use crisis within the behavioral health definition. It could be interpreted that previous descriptions of crisis care focused solely on mental illness, excluding substance use diagnoses. There is no doubt now that funding, policies, planning and operationalization of a community-based crisis system needs to incorporate the specific needs of individuals with co-occurring mental health (MH) and SUD as well as individuals with substance use only diagnoses and crisis needs related to substance use itself. This report highlights states and programs that are demonstrating success integrating substance use disorders in the three core services described in the SAMHSA Crisis Toolkit – crisis call centers, mobile crisis response services, and crisis stabilization services. This report also identifies the essential principles that are crucial for effective integration, as well as practices that are more specific to the SUD population not identified within the SAMHSA Crisis Toolkit but may be useful for consideration of implementation.

Person-Centered Care: Integrating Mental and Substance Use Disorders within the Crisis System

Crisis care cannot be diagnosis dependent, and the “no wrong door” approach is therefore critical, especially when there remains such a fragmentation of SUD and MH treatment delivery systems. Historically, the entire continuum of care for behavioral health from prevention to recovery, including

⁵ Pinals, D. & Fuller, D. (2017). Beyond beds: The vital role of a full continuum of psychiatric care. Arlington, VA: Treatment Advocacy Center and Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

⁶ Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

⁷ Substance Abuse and Mental Health Services Administration (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

crisis intervention, has segregated care for mental and substance use disorders. The SAMHSA Crisis Toolkit “Interview 6 with Nick Margiotta” illuminates this fragmentation.⁸ The interview provides his account of a frustrating effort to access help for an individual in crisis who was turned away from psychiatric care because they were actively using substances, only to be subsequently turned away from substance use disorder care because they were suicidal. This cycle of denying care due to active symptomology of co-occurring disorders is a clear demonstration of a poorly integrated system of care. As noted by NASMHPD in its 2019 Technical Paper “Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now?”, much work had been done beginning in the late 1980’s through early 2000s to support an organized implementation process for integrated services for mental illness and substance use disorders. Then as attention focused on costs and negative outcomes associated with comorbid physical and behavioral health conditions (specifically mental and substance use disorders), momentum shifted to integration within the physical health realm, as if mental health and substance use integration were completed.⁹ It was not.

Low perceived need and barriers to care access for both disorders likely contribute to low treatment rates of co-occurring disorders.¹⁰ Individuals with substance use disorder often do not perceive the need for help, as the illness is often accompanied by a denial of its existence.¹¹ A moment of crisis may open the window of opportunity to break through and engage individuals to see the consequences of continued substance use more clearly and plant the seed of hope for recovery. Intervention at the time of crisis using evidence-based practices such as motivational interviewing combined with seamless connection to treatment and effective follow up may increase the rates of treatment initiation for a population typically hard to engage. Understanding the stages of change model prepares crisis responders to identify interventions that will have the greatest impact. This report offers specific examples of programs and States that have implemented person-centered approaches for individuals with substance use disorder through a crisis response system.

As described further in this report, universal incorporation of Screening, Brief Intervention and Referral to Treatment (SBIRT) throughout the continuum of care can improve our identification of substance misuse and use disorders. It is critical that our crisis response system be fully prepared to address substance use disorders from triage to connection to care. Screening and assessment tools need to be inclusive of substance use and connections to care need to include referrals made to appropriate levels of care within the SUD treatment continuum, including medication-assisted treatment (MAT). As

⁸ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit, pp. 73-55. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁹ Minkoff, K. & Covell, N. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What’s known, what’s new, and what’s now? pp. 4-5. Alexandria, VA: National Association of State Mental Health Program Directors.

¹⁰ Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

¹¹ American Society of Addiction Medicine (2011). Public policy statement on relapse in healthcare and other licensed professionals. Chevy Chase, MD: American Society of Addiction Medicine.

https://www.asam.org/docs/default-source/public-policy-statements/111pip_relapse_4-11.pdf?sfvrsn=b274212a_0

concluded by the National Academies of Science, Engineering, and Medicine, MAT prevents death, stabilizes patients, and should be available to all people – including people interacting with the crisis system.¹²

Core Services and Best Practices

The SAMHSA Crisis Toolkit identifies three essential elements of an effective behavioral health crisis response system incorporating a no wrong-door, integrated approach: crisis call centers; crisis mobile teams; and crisis stabilization facilities and services. This section identifies examples of states and/or programs that have effectively and meaningfully integrated substance use or co-occurring disorders into these core components of a crisis response system. It is important to note that SUD integration is most effective when integrated throughout the entire service delivery system. Some states, such as Georgia, have achieved integration across the three domains. Other states are evolving to become more inclusive of Co-occurring Disorders (COD) and SUD. For example, Delaware is in the process of re-procuring its crisis response system to comprehensively include SUD in all response services. Washington requires its central crisis administrator, the Behavioral Health Services Organization, to manage both SUD and MH crisis and has invested in cross-training its mobile crisis responders to develop and improve the competencies for addressing the needs of individuals with SUD experiencing crisis.

Regional Crisis Call Centers

People contact crisis lines for different reasons. Individuals who are feeling overwhelmed and unable to cope reach out in desperation seeking help and hope. Family members, teachers, friends, faith-based leaders, loved ones, and co-workers also call crisis lines seeking help for someone else and guidance on how to support the individual. A crisis call responder must provide a compassionate presence and quickly assess the needs of the caller as well as safety risks and concerns. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide, accident, medical complications, and other causes. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.¹³ Additional risks associated with substance use disorders include non-suicidal accident, injury, victimization (including intimate partner violence) and trauma sometimes related to increased risk-taking behavior. Crisis lines must be equipped to take all calls; therefore, to adequately address needs of individuals using substances, with or without a co-occurring mental illness, training for call responders must include substance specific information. Crisis responders need to assess for risks specific to substance use, such as acute intoxication, withdrawal requiring medical monitoring or management, or overdose in order to adequately triage and determine appropriate response and referral options.

The SAMHSA Crisis Toolkit establishes minimum expectations for a regional crisis call services which include: 24/7 operation; a workforce of clinicians and trained team members overseeing triage; ability to answer all calls; ability to assess suicide and other danger risks; and ability to connect individuals to

¹² National Academies of Sciences, Engineering, and Medicine (2019). Medications for opioid use disorder save lives. Washington, DC: National Academies Press. <https://doi.org/10.17226/25310>.

¹³ Esang, M. & Ahmed, S. (2018). A closer look at substance abuse and suicide. *American Journal of Psychiatry*, 13(6): 6-8.

mobile crisis teams as well as facility based care. Examples of crisis call centers that meet these expectations as well as combining real-time service availability and scheduling capacity include New Mexico’s NMCAL, Colorado’s Crisis Services and Support Line, Georgia’s GCAL, Behavioral Health Response in St. Louis, and the New York City NYC Well program.

For states and municipalities with crisis call services geared for mental health conditions, one option is to integrate SUD-specific capacities and competencies into the existing system. For example, Delaware has developed a comprehensive hotline workflow chart to incorporate SUD as well as social needs or emotional support. Retraining its crisis staff, Delaware is working to ensure individuals with SUD are connected to the right level of care using their real-time open beds platform, the Delaware Treatment Referral Network.

In addition, many states provide substance use-specific hotlines. A crisis for individuals with primary substance use may present differently than individuals with primary mental health or co-occurring disorders. Crisis response for these individuals often involves connections to a specialty addiction treatment system that may be hard to understand or navigate. The caller may present with a defined desire to discontinue their use of alcohol or other drugs. For this reason, substance use specific crisis lines have been developed in many states. For example, the Indiana Addiction Hotline is available 24/7 for individuals seeking addiction treatment services in Indiana. Referral to state-approved agencies is provided by master’s degree counselors with bilingual capabilities. Hotline counselors can directly transfer calls to a treatment provider when available. While Tennessee has made significant investment in building a community-based behavioral healthcare system that is co-occurring capable, it also provides a SUD specific hotline. The Tennessee “red line” offers not only a warm handoff to treatment services; it also makes a real-time connection to “lifeliners” – individuals in recovery, employed by local behavioral healthcare providers.

Mobile Crisis Team Services

Community-based mobile crisis services provide face to face interventions for individuals in crisis with trained clinical professionals and peers. These teams meet the person where they are, at the time of need, reaching the individual in the community in order to achieve the best outcome for that person. Historically, mobile crisis teams have been components of community mental health centers (CMHCs), serving a population with primary mental health diagnoses. Across the country, CMHCs have varying capabilities – and deficiencies – related to addressing co-occurring disorders and substance use primary diagnoses. However, there are several strong examples of states and programs that developed mobile crisis team services to meet the needs of individuals with SUD experiencing crisis.

For example, the Georgia crisis response system incorporates all three of the essential services described by the SAMHSA Crisis Toolkit and integrates substance use disorders throughout its services. The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) established a clear guide outlining the appropriate use of mobile crisis teams (MCT) in the community.¹⁴ MCTs are

¹⁴ Georgia Department of Behavioral Health and Developmental Disabilities (undated). Guide: Using mobile crisis services in lieu of an order to apprehend. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Guide%20to%20Mobile%20Crisis%20Services.pdf

dispatched to respond to SUD crisis after determining this as the appropriate response as outlined below. The Georgia DBHDD acknowledges SUD as a core component of the mobile crisis system by articulating the intent of mobile crisis:

- De-escalate crisis situations;
- Relieve the immediate distress of individuals experiencing a crisis situation;
- Reduce the risk of individuals in a crisis situation doing harm to themselves or others; and
- Promote timely access to appropriate services for those who require ongoing mental health or co-occurring mental health and substance abuse services.

Prior to dispatch of an MCT, the call center makes an effort to engage the individual in crisis in order to create an alliance, involve the individual in care decisions, and assess safety concerns. Individuals are screened related to substance use which includes type of substance(s) used, amount, and presence of withdrawal symptoms. Based on acuity, a decision is made as to whether an MCT is appropriate or if an individual needs a more intensive response involving emergency medical services and/or law enforcement. For example, the MCT will be dispatched as long as the individual is not in active withdrawal from alcohol, benzodiazepines or barbiturates as the associated risks require medical intervention. Alternatively, opioid withdrawal may be appropriately responded to by MCTs that can provide the connection to the appropriate level of care with the ability to provide MAT induction.

In addition to determining clinical appropriateness for an MCT response, there are other community collaborators to facilitate MCT responses. For example, when MCT is the appropriate response, established guidelines help determine when to request varied levels of support from law enforcement, and when it is safe for MCTs to respond alone. This support ranges from asking law enforcement to accompany, follow behind, or be on standby for the team. MCTs are uniquely positioned to address SUD crises in the community when team members have received specific training in SUD risk assessment.

While not aligning with the best practices detailed in the SAMHSA Crisis Toolkit, **co-responder models** in which behavioral health specialists respond to crisis calls in collaboration with law enforcement exist in many states. There are generally two approaches to the co-responder model: an officer and behavioral health specialist ride together in the same vehicle for an entire shift; or the behavioral health specialist is called to the scene and the call is handled together. Aside from reducing costs, diversions of this sort are extraordinarily important for minimizing the criminalization of mental illness and substance use disorders and ensuring people are treated in the least restrictive environment possible. Also, identifying high volume time periods can help maximize this approach given the funding required to support the co-responders. In this way, co-responder models represent a promising tool to help achieve the goals of the American with Disabilities Act as reflected in the *Olmstead* decision for individuals with mental health and substance use disorders.¹⁵

In response to the opioid crisis, many co-responder programs have been established in states, with a concerted focus on outreaching to the SUD population post-overdose. In Rhode Island, the Hope Initiative is a statewide collaboration between law enforcement and substance use professionals to help

¹⁵ Martone, K., Arienti, F., & Lerch, S. (2019). *Olmstead at 20: Using the vision of Olmstead to decriminalize mental illness*. Access: *The TAC Blog*, September 2019. Boston, MA: Technical Assistance Collaborative. Retrieved from: <http://www.tacinc.org/blog/september-2019/september-2019-olmstead-at-20-using-the-vision-of-olmstead-to-decriminalize-mental-illness/>

guide those in need toward recovery. These teams respond to individuals who have recently survived an overdose as well as responding to community referrals for outreach from friends and family members. If engaged individuals are interested in treatment, the team will provide transportation if needed. Treatment referrals and transportation include access to MAT. The outreach teams continue follow up with individuals who may not be interested in services at point of first contact to offer support and recovery resources. Teams will also provide support to family members impacted by the addiction. West Virginia has taken steps to expand the statewide capacity of similar co-responder models called Quick Response Teams. Quick Response Teams are composed of emergency response personnel, law enforcement officers and a substance use treatment or recovery provider who contact individuals within 24-72 hours of their overdose to offer and assist those individuals with recovery support including referrals to treatment options.¹⁶ And the Massachusetts Post Overdose Support Teams program involves teams of first responders, public health advocates and harm reduction specialists returning to the site of a non-fatal overdose to provide follow-up services to overdose victims and their families.

Crisis Receiving and Stabilization Services

Behavioral health crisis centers serve as an alternative to emergency departments for an individual experiencing a mental health or SUD crisis. These centers are staffed 24/7 with a multidisciplinary team of behavioral health specialists, typically including access to peers, nurses and prescribers and they receive referrals, walk-ins and first responder drop-offs. Crisis centers are designed to address the behavioral health crisis, reducing acute symptoms in a safe, warm and supportive environment while observing for safety and assessing the needs of the individual. Over the last two decades, crisis centers have been expanding across the country, evolving to become more comprehensive, recovery-oriented, and welcoming to individuals receiving care as well as first responders and other referral sources.

Crisis stabilization centers vary in their approach to individuals presenting with co-occurring or primary substance use disorders. On one hand, some have established criteria that exclude individuals who may need withdrawal management services (detoxification), representing a clear opportunity for improving this pillar of the crisis response system to better meet the needs of individuals with SUD experiencing crisis. However, many crisis stabilization providers are connected to detoxification programs and can coordinate rapid admissions for crisis center patients who require that service. In areas where methamphetamine use is prevalent, such as California, Hawaii, and Georgia, crisis providers have become skilled in addressing methamphetamine induced psychosis, recognizing the need to treat the psychosis first and then connect individuals to the right level of care.

For example, to improve the clinical capacity to address both MH and SUD, the Department of Public Health in Los Angeles County instituted incentives to promote workforce enhancements by providing increased rates for agencies with increased levels of licensed clinicians on staff. LA County inpatient detoxification programs can address mild symptoms of psychosis that are often a part of the treatment for methamphetamine. An adequately trained workforce is a key element in effectively addressing SUD in a crisis setting. Crisis centers often employ peers with lived experience with substance use disorders as well as peers with lived experience with mental illness. Training the crisis response workforce in evidence-based practice for SUD can improve outcomes. In early stages of interaction with a SUD population, incorporating the transtheoretical model of behavior change to assess stage of change and guide the use of evidence based practice such as motivational interviewing has demonstrated

¹⁶ <https://dhhr.wv.gov/News/2018/Pages/DHHR-Awards-Funding-for-Quick-Response-Teams.aspx>

improvement of treatment engagement and retention rates. In Pima County, Arizona, leaders recognize that the number of individuals with behavioral health conditions in the correctional system represents a problem that cannot be addressed solely through legal means. The Tucson Police Department invested grant funding for comprehensive training in Motivational Interviewing and Trauma Informed Care. This training empowers officers to play a role in encouraging individuals to make recovery oriented decisions. In the provision of SUD crisis response, meeting the individual where they are is both a literal and figurative imperative.¹⁷

The “Rediscover Assessment and Triage Center” (ATC) is a regional crisis center located in Kansas City, Missouri that addresses both mental health and substance use disorder related crises. Originally established through collaboration with the criminal justice and hospital healthcare systems, the center has expanded to include walk-ins and referrals from community based providers. Case management and connection to peers are areas of significant focus at the triage center. As a regional service, peers come in from across all of the mental health agencies. The ATC dedicates equal attention and resources to both disorders. At the ATC, individuals with opioid use disorders (OUD) are offered induction on buprenorphine or methadone and connected to opioid treatment programs (opioid treatment programs are the sites legally allowed to offer methadone for OUD) in the community. Rapid access to MAT offered through onsite inductions can drastically increase the rates of follow-up and continuity of care and save lives. As ATC is a Certified Community Behavioral Health Center (CCBHC) and operates an opioid treatment program (OTP), their ability to provide continuity of service in the community is enhanced. The success of this program has led to plans for expansion in the state.

The Crisis Response Center (CRC) in Tucson, Arizona provides another example of a comprehensive crisis receiving and stabilization Center. Established in 2011, CRC has a longstanding history of providing services in coordination with community stakeholders through implementation of a no wrong door policy and has access to a comprehensive treatment system for SUD available 24/7. The CRC and Community Bridges provide 24/7 access to detoxification and 24/7 access to medication assisted treatment (e.g. Methadone and Buprenorphine induction) in outpatient settings through community partners. CRC provides access to MAT 24/7 for individuals with high acuity co-occurring mental health need. Individuals presenting at CRC receive assistance with accessing the appropriate level of care, including care coordination, transportation, and a warm handoff.

The SAMHSA Crisis Toolkit identifies short-term residential facilities as an additional element in the system of care. While not necessarily meeting the definition of a “crisis” facility required to take all referrals, these programs are often referred to as crisis stabilization units (CSU) and involve longer stays, usually between 4-7 days. In general, these programs serve individuals who need a longer period of time to return to the community but do not require a hospital-based level of care. Like receiving and stabilization centers, CSUs vary in their ability to address co-occurring or SUD primary patients. In West Virginia, CSUs are facilities with less than 17 beds that accept individuals with MH, SUD and co-occurring disorders. The CSUs provide psychiatric stabilization services, withdrawal management, and induction on buprenorphine for OUD. Individuals who are more appropriate for, or prefer methadone, are transported to the nearby OTP for methadone induction and then daily for continued dosing. While

¹⁷ Carroll, K., Ball, S., & Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel, L., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence*, 81(3). 301-312.

early in implementation, the state is already seeing positive outcomes related to MAT induction, including reductions in readmissions.¹⁸

Core Principles and Essential Partnerships

Beyond the three components constituting a comprehensive crisis response system as described in the SAMHSA Crisis Toolkit, there are core principles and essential partnerships necessary for effectively addressing co-occurring and SUDs before, during, and after crisis. These principles may be incorporated into services described above; however, for the SUD population, there are key nuances for consideration.

The SAMHSA Crisis Toolkit identifies six core principles that, when fully implemented, represent excellent crisis care systems that incorporate best practices:

- Addressing Recovery Needs;
- Significant Role for Peers;
- Trauma-Informed Care;
- Zero Suicide/Suicide Safer Care;
- Safety/Security for Staff and People in Crisis; and
- Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services.

The identified principles of **Trauma Informed Care, Zero Suicide/Suicide Safer Care, and Safety/Security for Staff and People in Crisis** directly apply to individuals with SUD in crisis and are thoroughly addressed in the SAMHSA Crisis Toolkit. The remaining principles require additional exploration with respect to how they relate to SUD specifically.

Applying Core Principles to SUD: Addressing Recovery Needs

The principle of **Addressing Recovery Needs** deserves expanded consideration for a SUD population. *Recovery is possible*. This statement has such significance in the world of substance use disorders. It is easy to give up hope and hard to have compassion for one whose disorder is understood as a moral failing as opposed to a health care condition. For many years, and unfortunately to a significant extent to this day, society has viewed SUDs in this light. This belief is reflected in the oft-heard statement that a person with SUD does not want to change. This is an unfortunate variant of the “Stages of Change” construct in substance use treatment, which typically recognizes the enormous importance of motivational techniques to help people move from one stage of readiness for change to another.

A large percentage of those admitted to SUD treatment cite legal pressure as an important reason for seeking treatment. And some expert sources suggest that outcomes for those who have choices where participation might eliminate some legal consequence to enter treatment are as good as or better than those who were not. In addition to legal consequences, outside influences are also relevant- such as views of families, employers, significant others, desire to not compromise parenting, etc. Individuals with such outside influences, such as those who face some legal consequences if they are in the criminal justice system tend to have higher attendance rates and in remain in treatment for longer periods,

¹⁸ Interview with West Virginia Bureau for Medical Services official. May 2020.

which can have a positive impact on treatment outcomes.¹⁹ Implementation guidance suggesting pursuing a “no-force-first” approach is important in SUD crisis, but must not negate the important role that the criminal justice system has had for those facing criminal legal consequences on connecting individuals to care. This is especially the case when such legal “pressure” can itself be seen as a motivational force rather than an unwanted mandate. Indeed how the legal pressure is formulated as part of the treatment can be a crucial difference if presented as a motivational opportunity rather than something being imposed on one who is “not ready.” These types of conversations to aim toward engagement can be nuanced, and it is useful to have training in techniques like motivational interviewing, even to help individuals make decisions where there can be criminal justice consequences to a particular decision about treatment engagement.

Applying Core Principles to SUD: Significant Role for Peers

The **Significant Role of Peers** in crisis response for individuals with SUD can differ from roles of peers in the traditional MH system. Despite the prevalence of co-occurring disorders previously noted, there continues to be some division amongst peers defined as having MH or SUD lived experience.

The nascent yet growing recovery movement has been game-changing for individuals affected by substance use disorder, and the power of peers with lived SUD experience sharing their experiences, hope, and resilience has had significant impact not only on affected individuals but also on the system of care as a whole. Despite a foundation of addict helping addict through traditional 12 step programs, the SUD delivery system was slow to engage the power of peers throughout the continuum. With the launch of the SAMHSA Access to Recovery (ATR) discretionary grant program in 2004, peers with SUD experience were increasingly considered to be essential members of the overall system of care. The Connecticut Community for Addiction Recovery (CCAR) led the nation in the development of training, standards, and the activation of peer experience to influence care.²⁰ In addition, Georgia has a rich history of peer involvement in the continuum of care for mental health. However, even there, the number of peers working throughout the continuum with SUD lived experience is significantly less than those with MH lived experience. As is the case with virtually every state, Georgia seeks to increase the number of SUD peers in their crisis system, as they do not yet have enough who are trained and certified to meet the need.

The opioid crisis has prompted states to consider new ways to leverage and employ the SUD recovery community to share hope and resilience with individuals who are hard to engage and at risk.

Pre-crisis programs like AnchorMore in Rhode Island deploy Peer Recovery Specialist to overdose hotspots to engage high-risk individuals.²¹ Weekly team calls identify areas where overdoses have been most prevalent and may convene more often if there is a marked increase in an area not previously

¹⁹ National Institute on Drug Abuse (last updated April 2014). Principles of drug abuse treatment for criminal justice populations — a research-based guide. Retrieved on 3/27/20 from <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide>

²⁰ Connecticut Community for Addiction Recovery (2010). CCAR history (2000-2010). Retrieved on 5/27/20 from: <http://ccar.us/about-ccar/history/ccar-2000-2010/>

²¹ Waye, K. M., Goyer, J., Dettor, D., Mahoney, L., Samuels, E. A., Yedinak, J. L., & Marshall, B. D. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behavior* 89, 85-91. doi:10.1016/j.addbeh.2018.09.027

identified. Teams of peers are sent to these areas and dispense Narcan kits as well as fentanyl test strips. During these interactions, peers are establishing connections with active users and will provide referral to treatment and recovery services when individuals are interested. This program has demonstrated a high rate of engagement for services with an at-risk population.

Peers have also been deployed to respond to crises, including overdoses, in EDs. While preferable to address crisis in community-based settings, the nature of SUDs may necessitate the use of ED in crisis, and it is important to have SUD-focused supports across settings in the crisis continuum to effectuate the “no wrong door” approach. Individuals who have overdosed or those whose substance use has resulted in serious injury must receive appropriate medical care first. In the wake of the opioid crisis, EDs have become an important component of the crisis system in addressing SUD. Many states have incorporated peer response to overdose survivors and other individuals with SUD presenting in EDs and have seen this crisis point as a successful point of intervention and engagement for care. For example, Kentucky implemented the Bridge Program which not only provides peer support post overdose, but also involves hospitals providing induction on MAT. Pennsylvania integrates peers in community based care management teams that reach out to clients in EDs post overdose, but also extends outreach to correctional facilities, primary care settings and other community-based settings. The aim of the outreach is to engage individuals in their successful Center of Excellence program, expanding access to MAT, providing case management to address other social determinants of health, and encouraging continued involvement with health and mental health treatment.

Crisis receiving stabilization centers, such as The Restoration Center in San Antonio, Texas employ peers, identified as recovery support specialists to provide follow up care for individuals discharged from the crisis centers. These peers provide services to individuals up to 45 days post crisis which include assistance in obtaining housing, accessing medications, transportation to appointments, peer support, follow up phone calls and welfare checks.

Applying Core Principles to SUD: Crisis Response Partnerships

Effective response to SUD throughout the crisis care continuum entails developing **Crisis Response Partnerships** with partners and in settings above and beyond those described in the SAMHSA Crisis Toolkit. As noted previously, EDs can provide a place of engagement for individuals with SUD. Intervention efforts can extend beyond connecting individuals with SUDs to peers. Forty percent of ED visits are due to trauma, and of these, between 40% and 50% are alcohol related. Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ED settings allows an opportunity for identification, engagement and intervention. Massachusetts’ Project Assert uses health promotion advocates (HPAs) to perform SBIRT as part of routine emergency department care. These encounters with HPAs provide patients with the opportunity to explore change through non-judgmental conversations combined with access to health and treatment services. EDs can also be an effective site for treatment initiation.²² A study published in 2015 demonstrated the impact of MAT induction within an ED setting for individuals presenting with Opioid Use Disorder (OUD). This study concluded that ED-initiated buprenorphine, “compared with brief intervention and referral, significantly increased engagement in formal addiction treatment, reduced self-reported illicit opioid use, and decreased use of

²² Massachusetts ED SBIRT Initiative: <https://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-hospital-emergency-department/>

inpatient addiction treatment services.”²³ In California, the Bridge Program supports hospitals to provide buprenorphine and embeds Recovery Support Navigator staff in EDs with the goal of meeting individuals with SUD where they are and improving connections to care following an SUD-related ED visit.²⁴ The Bridge Program shows comparatively high rates of completed follow-up visits to community-based providers among patients who received buprenorphine and Recovery Support Navigator services in the ED.²⁵

Forming partnerships with first responders also have the potential to achieve significant impact on assisting individuals experiencing SUD crisis in areas of crisis prevention, response and post crisis outreach. For example, the Safe Stations program initiated in Manchester, New Hampshire has now been replicated in cities across the country. The Safe Station program provides fire stations as open doors for individuals seeking help for substance use disorders, 24/7. Fire Department personnel conduct a brief medical assessment before connecting these individuals to treatment and recovery resources. Similarly, partnerships with law enforcement also represent a promising opportunity for responding to the needs of individuals with SUD experiencing crisis. The Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery based on the Angel Program established by the Gloucester Police Department in Massachusetts in 2015.²⁶

Financing Strategies

There are several federal funding authorities that states can leverage to finance crisis care systems, including those that deliver services for individuals with co-occurring and SUD-only diagnoses experiencing crisis. States can use traditional federal funding sources available for mental health-oriented crisis response services to achieve progress towards a more fully integrated crisis care system. Given the patchwork nature of mental health and SUD crisis service funding highlighted in the SAMHSA Crisis Toolkit, states can develop a braided funding approach to finance system improvements and pay for service provision.²⁷ In a braided funding approach, policymakers coordinate the use of multiple, discrete funding authorities to support a single strategy while retaining the identity and expenditure data specific to each authority.²⁸ SAMHSA has identified strong examples of states that braid funding sources to develop crisis service systems and provide crisis care, including with state general funds, federal grants, and various Medicaid authorities.²⁹

²³ D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, 313(16), 1636–1644. <https://doi.org/10.1001/jama.2015.3474>

²⁴ <http://www.californiamat.org/matproject/california-bridge-program/>

²⁵ California Bridge Program. *Barriers, Gaps, and Opportunities*. Treatment Starts Here convening. January 2020.

²⁶ The Police-Assisted Addiction and Recovery Initiative: <https://paarius.org/about-us/>

²⁷ Page 36

²⁸ AGA Work Group on Blended and Braided Funding, operating under the auspices of AGA's Intergovernmental Partnership (2014). *Blended and braided funding: A guide for policy makers and practitioners*. Alexandria, VA: Association of Government Accountants.

<https://www.agacgfm.org/AGA/Intergovernmental/documents/BlendedandBraidedFunding.pdf>

²⁹ Substance Abuse and Mental Health Services Administration (2014). *Crisis services: Effectiveness, cost effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and

Discretionary SAMHSA grant funding opportunities can be used to pay for certain costs of crisis care systems not covered by payments from health care plans, such as infrastructure and “startup” costs associated with developing crisis care system capacities, crisis response care for uninsured individuals, and components of crisis response care that are not included in individual plan coverage. States can use the annual Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant programs to develop and enhance crisis response systems with SUD-specific capacities.³⁰ In addition, states (and often providers) can apply for other SAMHSA grant funding opportunities to implement crisis response efforts with SUD-specific capacities. States are leveraging the State Opioid Response (SOR) grant funding opportunity to implement some of the best practices described in this report. For example, California and West Virginia are allocating SOR funding to scale up the Bridge Program and Quick Response Team SUD crisis interventions described above to meet individuals with SUD literally where they are and improve connections to care following an SUD-related crisis event.³¹

States can also design their Medicaid program to maximize federal matching funds and secure a sustainable source of funding for crisis response services in ways that account for local circumstances. There are longstanding federal policy and regulatory options at states’ disposal to cover crisis response services for Medicaid beneficiaries with SUD, including the core components described in the SAMHSA Crisis Toolkit. For example, components of crisis call center, mobile crisis response, and crisis stabilization services can be covered under Medicaid:

- in the state plan through the rehabilitation, other licensed practitioner, and clinic services at Section 1905(a);
- in the state plan through the home and community-based services option at Section 1915(i);
- in the home and community-based services waiver programs at Section 1915(c); and
- as administrative costs, especially for crisis call centers.³²

In addition, states have additional flexibilities to receive federal Medicaid funding for crisis stabilization services provided in facilities that meet the definition of an institution of mental disease (IMD) and would otherwise be excluded for federal Medicaid reimbursement. Specifically, in states delivering crisis services through risk-based managed care, federal Medicaid funds are available for capitation payments to managed care plans whose enrollees receive psychiatric and SUD crisis residential services provided in IMDs as an “in lieu of” service so long as the length of stay is less than 15 days.³³ In addition, states can apply for the Section 1115 demonstration opportunity announced in 2018 that offers federal Medicaid funding flexibilities for mental health services provided in IMDs, including crisis stabilization

Mental Health Services Administration. <https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848>

³⁰ FFY 2020-2020 Block Grant Application (Community Mental Health Services Block Grant Plan & Report and Substance Abuse Prevention & Treatment Block Grant): https://www.samhsa.gov/sites/default/files/grants/fffy_2020-2021_block_grant_application_and_plan.pdf

³¹ California MAT Extension Project: California Bridge Program (updated April 2019). Retrieved on 5/28/20 from: <http://www.californiamat.org/matproject/california-bridge-program/>

³² U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf>

³³ 42 CFR 438.6(e)

services.³⁴ Notably, the 2018 guidance identifies improved availability of crisis response services, including crisis call centers, mobile crisis response, and crisis stabilization services, as a milestone that states must meet over the course of the demonstration.

Impact and Lessons Learned from COVID-19

The COVID-19 pandemic has created a new set of challenges for policy makers and providers serving individuals with SUD, including those who may experience a crisis episode. Yet amid these challenges are key opportunities to leverage for developing comprehensive crisis response systems designed to meet the needs of individuals with SUD experiencing a crisis, and mitigate disparities in public health and crisis care that are being brought to the forefront during this pandemic.

For one, individuals receiving MAT are at increased risk for morbidity and mortality caused by interruptions in their pharmacotherapy as discontinuing MAT often leads to relapse and overdose.³⁵ Despite federal agencies such as SAMHSA and DEA issuing guidance offering states and providers considerable flexibility for maintaining access to medications, access to certain SUD treatment services has nevertheless been jeopardized during COVID-19. Intensive levels of care provided in congregate care settings such as inpatient and residential treatment programs have been especially impacted by COVID. For example, a survey of behavioral health providers reveals that 91 percent have reduced operations, with two-thirds closing at least one of their programs.³⁶ It is essential that the crisis response system be aware of these capacity limitations and develop strategies to maintain engagement with individuals if they must wait for admission.

Another important consideration for the crisis response system is the increase of substance use in general. A survey of patients, families, and individuals in recovery revealed that 20 percent of respondents have increased their substance use since the start of the pandemic, and 14 percent were unable to access needed services due to COVID-19.³⁷ Individuals in recovery may be challenged by increased stressors resulting from COVID-19, such as loss of a job and income, lack of child care, and increased isolation. Some data indicates increase in alcohol sales up to 32% compared to a same point in time one year prior, and several states show an increase in per capita alcohol sales in April 2020 compared to the prior 3-year April average.³⁸ Excessive alcohol use can increase not only susceptibility

³⁴ U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf>

³⁵ National Academies of Sciences, Engineering, and Medicine 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25310>.

³⁶ National Council for Behavioral Health. (April 6, 2020). "COVID-19 Economic Impact on Behavioral Health Organizations". National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?dof=375ateTbd56.

³⁷ Hulsey, J., Mellis, A., & B. K. (June 8, 2020). "COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD." Addiction Policy Forum. Retrieved from <https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-from-substance-use-disorder>; Meadows Mental Health Policy Institute. (April 28, 2020).

³⁸ Macmillan, Carrie (June 4, 2020). "Drinking More Than Usual During the COVID-19 Pandemic?" Yale Medicine. Retrieved from <https://www.yalemedicine.org/stories/alcohol-covid/>; National Institute on Alcohol Abuse and Alcoholism. "Alcohol Sales During the COVID-19 Pandemic". Retrieved from <https://pubs.niaaa.nih.gov/publications/surveillance-covid-19/COVSALES.htm>.

to COVID-19 but also severity. Alcohol use is also indicated in increased Intimate Partner Violence. The United Nations Secretary General called for measures to address the “horrifying surge” in domestic violence associated with government lockdowns and stay at home orders.³⁹ Increased use of alcohol and other substances during COVID-19 heightens the need for crisis responders to be fully aware of assessing and addressing SUD during intervention.

The associations between certain SUDs and COVID-19 risks are not fully known. However, there are several areas worth noting as data is still emerging. For instance, individuals who smoke or vape as a route of administration may be more susceptible to infection and face poorer prognoses due to respiratory health issues, which might include higher case-fatality rates. Conversely, COVID-19 positive individuals who develop compromised lung function could be at heightened risk of hypoxia associated with opioid and/or methamphetamine use given the potential for pulmonary damage associated with each of these conditions under various circumstances.⁴⁰ Harm reduction strategies such as “never use alone” and ensuring naloxone is available may not be effective or possible when individuals are socially distancing and sheltering-in-place consistent with public health guidelines.

As data is starting to come to light, some of the worst fears about the connection of the pandemic to the SUD population may be coming true. Suspected overdoses have increased by 191% in January-April 2020 compared to January-April 2019, according to the Overdose Detection Mapping Application Program, an initiative developed by a federal Office of National Drug Control Policy grantee.⁴¹ The COVID-19 pandemic is reinforcing the value of crisis response strategies especially tailored for individuals with SUD. During the pandemic, it will be critical to ensure overdose response teams as described earlier in this paper have sufficient personal protective equipment and funding to perform these vital engagement, follow-up and referral services to overdose survivors and their families.

Crisis Services for Substance Use Disorders Examined with a Racial Equity Lens

The COVID-19 pandemic is also reinforcing the need to address disparities inherent in the public health emergency and in the systems designed to address crises and SUDs. Research shows that racial and ethnic minority groups are disproportionately affected by the coronavirus and the resulting economic crisis.⁴² In addition, data that parses out the impact of various substances and access to services among racial and ethnic minority groups is shedding light on disparities in outcomes. Disparities in health care may actually have attenuated the impact of the “first wave” of the opioid epidemic associated with prescription opioids in the Black/African American community, as Black/African American patients are

³⁹ United Nations (April 6, 2020). “UN chief calls for domestic violence ‘ceasefire’ amid ‘horrifying global surge’”. UN News. Retrieved from <https://news.un.org/en/story/2020/04/1061052>.

⁴⁰ Volkow, Nora (July 2020). “Collision of the COVID-19 and Addiction Epidemic.” *Annals of Internal Medicine*, Vol. 173(1).

⁴¹ Alter, A., Yeager, C (May 13, 2020). “The Consequences of COVID-19 on the Overdose Epidemic: Overdoses are Increasing.” Overdose Detection Mapping Application Program. Retrieved from <http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf>.

⁴² Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>; Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire*, blog of the Urban Institute. Retrieved on July 16, 2020 from <https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity>;

29 percent less likely to be prescribed opioids for pain than white patients.⁴³ However, as part of the “third wave” of the opioid epidemic associated with skyrocketing rates of overdose deaths involving fentanyl, between 2011 and 2016 the Black/African American population experienced the highest increase in fatal overdose rates of deaths involving fentanyl.⁴⁴ Between 2015 and 2016, the rate of increase in overdose deaths was highest for the Black/African American population among all racial and ethnic groups. In addition, Black/African American individuals with OUD experience disparities in access to evidence-based treatment for OUD, with studies showing that buprenorphine-based treatment is less accessible and delivered less frequently to Black/African American patients than white patients.⁴⁵

American Indians and Alaska Natives (AI/AN) also experience disparities in both the COVID-19 pandemic and opioid epidemic. The AI/AN population is hospitalized for COVID-19 at five times the rate as the white population.⁴⁶ In addition, Tribal governments and communities are facing relatively greater economic devastation than many states during this severe fiscal environment. Because Tribes do not have tax bases similar to local and state governments, casino and other enterprise represent Tribes’ main revenue stream. As these industries have been put on hold as a public health measure, Tribes are grappling with even greater budget shortfalls than states; COVID-19 threatens to “completely reverse” the progress that Tribes have made in community economic development.⁴⁷ With respect to SUD, relevant data for American Indian and Alaska Native populations are often compromised by racial misclassifications in surveillance and vital statistics systems. The racial misclassifications – whereby AI/AN individuals are reported as belonging to racial/ethnic groups other than AI/AN – result in undercounting the true prevalence of health conditions among AI/AN communities. For example, a recent study matched drug and opioid-involved overdose-related death records from the Washington State Center for Health Statistics with the Northwest Tribal Registry, a database of AI/AN patients seen in Indian Health Service, tribal, and Urban Indian health clinics in Washington state. The Washington death records were corrected for AI/AN classification using the Northwest Tribal Registry data, and the corrected death records were then compared with federal CDC data. The comparison suggests that CDC data underestimate drug overdose mortality counts and rates among AI/AN by approximately 40%.⁴⁸

⁴³ Centers for Disease Control and Prevention. “Understanding the Epidemic”. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic/index.html>; Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA [Internet]. 2008 Jan 2 [cited 2019 Dec12];299(1):70-8.

⁴⁴ Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.; Centers for Disease Control and Prevention. “Understanding the Epidemic”. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic/index.html>.

⁴⁵ Ibid.

⁴⁶ Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>.

⁴⁷ Akee, R (April 10, 2020). “Re: allocation of COVID-19 Response Funds to American Indian Nations.” Harvard Kennedy School ASH Center for Democratic Governance and Innovation. Retrieved from: https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsIGNEDvfinv02.pdf.

⁴⁸ Seven Directions: A Center for Indigenous Public Health (September 2019). “An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure”. University of Washington. Retrieved from <https://www.nihb.org/docs/04092020/Environmental%20Scan%20of%20Tribal%20Opioid%20Response%20Booklet.pdf>.

Underestimation notwithstanding, AI/AN individuals still experience above-average rates of drug overdose deaths.⁴⁹

Disparities in public health and overdose deaths represent an opportunity for states to develop innovative, community-specific outreach and engagement strategies, especially for individuals with SUD experiencing a crisis. For example, Black/African American individuals were found to be three times more likely to die during a police encounter than white individuals, even though they were more likely to be unarmed.⁵⁰ Given the recognition of police violence as a public health risk by organizations such as the American Medical Association and American Public Health Association, states are more poised than ever to reallocate resources and responsibilities for crisis care services away from law enforcement and towards appropriate crisis response systems such as those described in the SAMHSA Crisis Toolkit and this brief.⁵¹

SUD crisis care during COVID-19 is revealing a confluence of disparities. Yet from crisis comes opportunity: this moment in time presents an excellent opportunity for policy makers to catalyze on public sentiment and political will to ensure crisis response systems are adequately funded and positioned to respond to behavioral health crises. The momentum provided by a heightened national and state interest in transferring public and social service functions from law enforcement entities to human service agencies also offers states a platform to continue evolving their crisis systems to adequately address the needs of individuals with SUD experiencing a crisis event.

Conclusions

Behavioral health parity requires some insurers that provide coverage for mental health and substance use conditions to ensure those benefits are subject to limitations that are not more stringent than similar benefits physical health conditions.⁵² The healthcare system can no longer tolerate services that are disparate for individuals with substance use disorders. SAMHSA's specific inclusion of SUDs in its Crisis Toolkit should serve as notice that service parity needs to exist in all behavioral health crisis response systems. The "Anyone" in the "Anyone, Anywhere, Anytime" from the SAMHSA Crisis Toolkit must include individuals with co-occurring SUDs or sole SUD diagnoses. The degree to which states' crisis response systems encompass SUD varies and states are continuously evolving these systems to meet needs.

A comprehensive system of crisis response can positively impact the entire continuum of care for individuals with SUD from prevention through recovery. Incorporating SUD meaningfully into a crisis

⁴⁹ Centers for Disease Control and Prevention. "Injury Prevention in American Indian and Alaska Native Communities." Retrieved from <https://www.cdc.gov/injury/fundedprograms/tribal.html>.

⁵⁰ DeGue, S. "Deaths Due to Lethal Force by Law Enforcement." *Am J Prev Med.* 2016 Nov; 51(5 Suppl 3): S173–S187.

⁵¹ Strazewski, L (June 8, 2020). "Why police brutality is a matter of public health." American Medical Association. Retrieved from <https://www.ama-assn.org/delivering-care/health-equity/why-police-brutality-matter-public-health>; American Public Health Association (November 13, 2018). "Addressing Law Enforcement as a Public Health Issue." Policy Number 201811. Retrieved from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>.

⁵² Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. The Mental Health Parity and Addiction Equity Act. Retrieved on 5/28/20 from: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

response system requires training of staff at levels, implementation of evidence-based screening and assessment tools, employment of peers with lived SUD experience, access to services that can support withdrawal management and medications to treat conditions such as OUD, and monitoring fidelity to evidence based practices as well as outcomes. Crisis providers should be able to demonstrate success of interventions with SUD and implement processes for continuous quality improvement with this population. Providers should also routinely assess staff for presence of negative perceptions or attitudes related to SUD, as stigma poses a challenge to strategic planning and implementation efforts to better meet the needs of individuals with SUD.

Effective partnerships are crucial for positive outcomes in crisis response. Partnerships ensure appropriate resources for preventing crisis, responding to crisis, and providing effective warm handoffs for care and continued recovery support. Including SUD in a behavioral health crisis response may require the system to expand these partnerships to include community based organizations and providers outside the historical networks. Law enforcement, EMS, health care providers, hospital systems, peer-based recovery organization and substance use specific treatment providers all have a critical role in SUD throughout the continuum. This call to action also requires SUD providers to come out from the shadows to be front and center as partners in responding to the emerging needs of individuals in crisis with SUD. It is no longer sufficient for the SUD treatment world to stand back and wait for individuals to show up at the door. The absence of SUD specific providers as active partners in the crisis system only perpetuates the potential for discrimination toward individuals with SUDs.

There is clear opportunity for all states to use and incorporate the SAMHSA Crisis Toolkit to improve, enhance and expand their crisis response systems to be more inclusive of individuals with SUDs. The potential for positive impact throughout the behavioral healthcare system, and most importantly for the individuals in need of care, their families, and their communities cannot be overstated.

Legal Issues in Crisis Services

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LEGAL ISSUES IN CRISIS SERVICES

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LEGAL ISSUES IN CRISIS SERVICES

Executive Summary Key Points

- Providers of crisis services offer necessary and critical aid to individuals and the community in times of behavioral health emergencies.
- For mental health providers of such services, it is important to understand the legal and regulatory issues pertinent to practicing in these settings.
- Issues discussed in this paper include civil commitment treatment orders, the role of guardians, restraint and seclusion, confidentiality, the criminal justice system, EMTALA, red flag laws, risk management, and how these important topics relate specifically to crisis services. This paper will also discuss the COVID-19 pandemic and its potential implications for legal issues related to crisis services.
- Understanding such key topics will aid the mental health provider in navigating the ever evolving and complex landscape of crisis services.

INTRODUCTION

National efforts from the Substance Abuse and Mental Health Services Administration (SAMHSA)¹ and the National Association of State Mental Health Directors (NASMHPD) are inspiring systems to examine and develop the availability of robust crisis services.

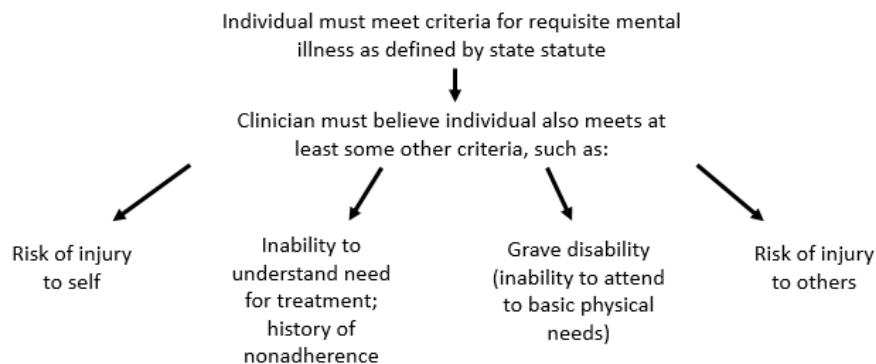
It is becoming increasingly clear that expanded crisis services are a critical part of the psychiatric care continuum for individuals and communities. Although they are important at any time, in the wake of recent events, such as various mass shootings, political unrest, and the COVID-19 pandemic, the need for these mental health crisis services is even more apparent. While the types of crisis services available in a community can vary,² the advantages to a robust crisis response system are numerous. Such a system can provide time-sensitive and efficient care for an individual in crisis and be an integral part of preventing harm that an individual may intend to themselves or others. Crisis services can be successful in diverting individuals from emergency departments when not needed and from entering a higher level of care, such as an inpatient setting, or from entering the criminal justice system. Effective crisis systems can also link individuals to community providers, connecting them to necessary resources that can help them stabilize with long-term supports. Navigating complex legal and regulatory issues, however, is an important element in crisis service delivery. In this paper, the authors describe key legal issues relevant to providers working in crisis settings as well as discuss implications for systems considering policies and practices related to crisis services. Although crisis services can start with a call or a text, this paper will describe legal and regulatory issues focused on crisis contacts that involve clinical assessments of individuals in crisis.

EMERGENCY INVOLUNTARY HOLDS, CIVIL COMMITMENT AND ASSISTED OUTPATIENT TREATMENT ORDERS AND CRISIS SERVICES

Providers of crisis services may encounter patients with a clear need for psychiatric treatment for mental illness. However, providing such treatment is not always simple. At times, individuals may be unwilling to engage in recommended care, and this may result in risks to themselves or others. It may also be that the individual is not unwilling but unable to engage in treatment, due to economic barriers, lack of transportation to appointments, or cognitive limitations. Whatever the reason, individuals with mental illness with continued treatment non-adherence can be caught in a problematic pattern. Such individuals may present to crisis centers or emergency rooms with acute symptoms. They may experience improvement in their crisis symptoms and be stabilized with treatment in an acute setting such as an inpatient hospital. However, such individuals may then relapse after discharge due to withdrawal or non-adherence to treatment, prompting their symptoms to return, the cycle to restart, and mental health providers to see them in a crisis setting once again.³

While the majority of mental health services should be and are provided on a voluntary basis, civil commitment laws, including inpatient hospitalization and mandated outpatient treatment (also frequently referred to as Outpatient Commitment or Assisted Outpatient Treatment [AOT]), provide legal authorization for involuntary psychiatric treatment for individuals with mental illness who also meet certain other criteria.⁴ These criteria vary from state to state, though every state in the United States utilizes some form of involuntary treatment authorized by civil commitment statutes.⁵ Although some states have separate civil commitment laws for substance use, many are not used and they raise other complicated issues beyond the scope of this paper.^{6,7} As such, civil commitment in this paper will therefore refer to those laws related to mental illness. A broad outline of common civil commitment criteria for mental illness can be seen in Figure 1.

Figure 1: Examples of Mental Illness Civil Commitment Criteria



Civil commitment laws typically take hold across three broad points in a time continuum.⁸ A behavioral health crisis may trigger the need for an emergency “hold” or hospitalization for evaluation, typically for a short period of time (e.g., 72 hours, though the duration varies across jurisdictions). These clinical, involuntary holds for evaluation differ from “police holds”, in which law enforcement officers can place an individual who appears to be publicly incapacitated into protective custody for the

purpose of taking them to an emergency room or appropriate facility.⁹ A second time point of reference can be inpatient civil commitment, where a judge orders involuntary hospitalization for an individual who meets the state's civil commitment criteria. The court-ordered inpatient commitment will be permissible for the period of time available by statute, and subject to renewals for individuals who continue to meet those criteria. A third time point or form can be outpatient civil commitment, or AOT, which is a method of providing involuntary, court-ordered mental health treatment in the community. Despite utilizing civil commitment statutes, national surveys shows that clinicians involved with civil commitments may lack knowledge about statutory criteria.¹⁰ This may be especially problematic and relevant for providers of crisis services, where, due to the emergent nature of crises, involuntary detention or treatment may be considered necessary to mitigate risk.

Some crisis settings allow for involuntary detention under these types of laws, while others do not. If they do not, and if the individual appears to require a higher level of care but does not choose to accept it on a voluntary basis, the crisis provider may need to initiate a civil commitment process. The individual in crisis then might need to be transported to an emergency department on a petition (also called an application for hospitalization), which is a document that can be completed by any involved person detailing the basis for bringing an individual in for evaluation. Here again states vary, but in general there is broad authority to petition for evaluation, followed by process either through the courts or, if petitioned by allowable parties with special relationships to the individual (e.g., clinicians, law enforcement), to have the individual directly transported to the evaluation site. Often this is an emergency room or a designated crisis evaluation site. As crisis services evolve, part of that evolution will include whether crisis hub sites are able and appropriately staffed to manage involuntary patients. Regardless, once at the evaluation site, a clinical review would certify that the person still meets involuntary commitment criteria. Civil commitment laws require periodic reviews, and at any time the individual may consent to services voluntarily, negating the need for civil commitment. Individuals undergoing court-ordered inpatient commitment are also usually entitled certain due process protections under state and federal law, including the right to an attorney and the right to challenge their commitment before a judge or judicial authority.¹¹

Regarding outpatient civil commitment, in general, AOT orders could be appropriate for individuals described above, particularly those with mental illness who have a history of persistent non-adherence to treatment and who therefore continue to pose some risk of harm. AOT programs, authorized by law in 47 states and the District of Columbia, were designed to motivate an individual, via the courts' authority, to participate in treatment.¹² Research has noted that AOT programs may be able to break the problematic pattern of treatment nonadherence for certain individuals. AOT programs, when continued for at least six months, appear to increase treatment engagement while significantly reducing hospitalization rates as well as re-arrest for select participants when compared with similar community services provided without court oversight.^{13 14} Much of AOT's effectiveness is thought to be secondary to the presence of a court order and the intensive community supervision.¹⁵ The American Psychiatric Association's position statement on AOT notes that not all individuals are appropriate for AOT, but that involuntary outpatient treatment programs have demonstrated their effectiveness when "systematically implemented, linked to intensive outpatient services, and prescribed or extended periods of time" for persons clinically evaluated and identified as appropriate for this type of court-ordered treatment.¹⁶

Crisis services provide an integral role for the individual on an AOT. An individual on an AOT who is in crisis may encounter a variety of crisis service providers. For example, law enforcement officers often act as first responders and extensions of the court when the provisions of an AOT order have been violated. They can be responsible for executing “pick up” orders on an individual who has been court-ordered to receive community-based services. These orders from the court can authorize an individual’s transport and even temporary hold in a crisis center or psychiatric facility for evaluation. Individuals on an AOT may also encounter providers in a crisis center or psychiatric emergency room after a symptom relapse. Ensuring robust collaboration between law enforcement, providers of crisis services, and an individual’s community-based AOT providers is essential, and may help in averting repeat hospitalizations, criminalization, and even in improving treatment engagement. Importantly, providers of crisis services considering involuntary outpatient treatment for their patient should also be cognizant of potential racial and ethnic disparities in practices. One study explored racial disparities in outpatient civil commitments, noting that African Americans are more likely than whites to be involuntarily committed for outpatient care in New York.¹⁷ The authors note that depending on perspective, some providers could see this overrepresentation as positive, given it provides a potentially underserved population more access to treatment, while others could perceive this as negative, given the aspect of coercion and loss of an individual’s autonomy. Other issues regarding disparities in the public mental health system as a whole, and access to voluntary services in particular, are also relevant to interpreting this study’s findings. Providers of crisis services considering involuntary commitment should therefore be vigilant in their awareness of potential racial disparities and bias, as well as other pre-existing social determinants such as poverty and how public mental health care is structured and financed. Furthermore, with all this in mind, clinicians should work to provide culturally sensitive practices during patient interactions with a goal of maximizing engagement voluntarily before involuntary treatment is recommended. Voluntary engagement should always be the first priority.

Of note, providers of crisis services should also be mindful that Psychiatric Advance Directives (PADs) for an individual may be present. These directives, laid out by individuals with mental illness during a time of stability, outline their preferences for treatment and may help preserve an individual’s autonomy in a time of crisis.¹⁸ Such advance instructions may be a method of communication of choice when an individual is deemed to lack decision-making capacity and may include the identification of a proxy decision-maker. Although they are still relatively new, PADs may allow other opportunities for accessing treatment without court involvement.

THE ROLE OF GUARDIANS IN CRISIS SERVICES

Mental health providers working in crisis services may come across individuals who cannot legally make their own treatment decisions, such as individuals with designated court-appointed guardians who are authorized to make such decisions on their behalf. These “incapacitated persons” require careful consideration when it comes to all manner of mental health services that require informed voluntary consent, which usually would require the person to have capacity to provide it. Providers should therefore be mindful of several considerations when an individual under guardianship presents in crisis. For example, asking an individual to sign a release of information in order to obtain collateral information is common practice in psychiatric settings. A mental health provider must be

cognizant of the individual's guardianship status when asking for record releases, however, as the guardian's consent may be required.

As noted, guardians also have potential roles to play when inpatient psychiatric hospitalization is recommended for an individual in crisis. Generally, for people not under guardianship, the individual would be evaluated and, if inpatient psychiatric hospitalization was recommended, an assessment of the individual's competency to voluntarily consent to hospitalization would be conducted. Following such an assessment, the individual, if deemed to have decision-making capacity, would be offered a voluntary admission with informed consent. However, the process can be more complicated with someone who is not authorized to make their own treatment decisions. The ability of a guardian to provide the necessary consent to psychiatric hospitalization or treatment varies from state to state.¹⁹ If a state's statute does not permit the guardian to consent to voluntary hospitalization on behalf of the incapacitated person and involuntary commitment is pursued, it may make it difficult to locate an inpatient setting for an individual who would benefit from treatment, but does not meet involuntary state commitment criteria.

In contrast to the states that do not allow a guardian to authorize an individual's psychiatric admission, other states allow the guardian to consent for the individual's psychiatric admission (or restrictions on consenting to psychiatric facilities are not specifically addressed in statute).²⁰ Still other states allow the guardian to consent as long as the individual under guardianship also assents to hospitalization.²¹ Variations continue, with some states allowing a guardian to consent to an incapacitated person's hospitalization but only after obtaining a specific court authorization.²² With all this taken into account, a mental health provider recommending voluntary hospitalization for an individual under guardianship should be familiar with the relevant state statute in which they practice.

RESTRAINT/SECLUSION IN CRISIS SERVICES

Providers in crisis services can be faced with the scenario of caring for an individual in crisis who is acting in an imminently dangerous or agitated manner. Jurisdictional practices differ with regard to whether seclusion or restraint is legally authorized in particular crisis settings. In cases of acute agitation where there is concern that an individual could imminently harm themselves or others, where permitted, restraint or seclusion might be considered, though use of restraint and seclusion is controversial and must only be utilized as a last resort when less restrictive interventions fail. Numerous studies have pointed to the dangers of seclusion and restraint, including serious injury or death, loss of dignity, and psychological trauma to patients, as well as psychological and physical injuries to staff.²³ As a result, non-coercive de-escalation strategies should be first line and could begin upstream even with improving the therapeutic milieu to decrease potential precipitants to agitation.²⁴ Studies are beginning to identify specific strategies that may be key to reducing or eliminating seclusion or restraint, including strong leadership, procedural changes, staff training on specific issues, consumer debriefing, regular progress feedback using data to inform policy, and changes to organizational culture.²⁵ It is also critically important that crisis services be designed to be trauma-informed with staff training on seclusion/restraint prevention.

Making every effort to prevent seclusion and restraint and manage agitation with less restrictive strategies should be a core feature of a successful crisis service. If those interventions fail, there are

many considerations regarding seclusion and restraint that a crisis setting must first deliberate. First, whether a crisis setting is authorized to utilize restraint or seclusion varies. State licensure and laws will generally dictate whether a crisis site is eligible or ineligible for any hands-on holds of patients or any other type of restraint or seclusion. Hospitals and emergency rooms, in contrast, will be authorized to utilize these interventions and this may be one of the factors that is assessed when determining the level of care needed for the safest management of an individual's symptoms. That said, as previously noted, de-escalation and seclusion/restraint prevention can significantly reduce the use of these coercive and traumatizing strategies across the crisis continuum.

Where seclusion or restraint is allowable, regulatory structures must be followed. Restraint and seclusion in inpatient psychiatric treatment settings are among the most highly regulated practices in mental health, as the risks to patients can be severe with use, though failure to use restraint or seclusion in emergency situations can also result in adverse outcomes.²⁶ Providers should be mindful that seclusion or restraint is not a treatment per se, and as such, there should be every effort to minimize time in seclusion or restraint. Providers should also be mindful that certain racial or ethnic groups may be viewed as more violent, and that such misconceptions about racial groups could have serious repercussions related to the use of seclusion or restraint in particular populations.²⁷ Once a patient has gained control, implementing multiple strategies can be helpful at improving outcomes in managing future aggressive behavior. These strategies could include, but are not limited to, patient and staff debriefings and review processes aimed at examining the behavior leading to seclusion or restraint, as well as quality improvement initiatives examining overall seclusion and restraint utilization patterns.²⁸ A detailed exploration of possible preconceived notions in providers and education about cultural awareness and sensitivity could also be performed in order to help identify and eliminate racial or ethnic bias in the use of seclusion or restraint.

CONFIDENTIALITY AND DUTY TO PROTECT OTHERS IN CRISIS SERVICES

Confidentiality in patient encounters can be a complex issue for mental health providers. Mental health providers are usually aware of major regulations governing confidentiality and privacy which stem from codes of professional practice, state statutes, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).²⁹ HIPAA is a federal law passed with the intent to protect individual health information. It requires a patient to authorize release of medical information prior to any distribution and necessitates that patients be informed how their medical information will be utilized. If an individual is in a crisis service for substance use needs, then the federal law, 42 C.F.R. Part 2 is the prevailing federal statute that requires strict maintenance of confidentiality. It is considered more restrictive than HIPAA for many reasons, including that it has criminal sanctions attached.³⁰ Despite these laws and regulations surrounding privacy and confidentiality, however, providers of crisis services may find themselves in acute situations where these tenets conflict with a patient's safety or the safety of others. For example, an individual may be brought to a crisis center by law enforcement after making homicidal or suicidal statements but refuse to answer provider questions or authorize a release for collateral information. The provider is then left without an adequate understanding of the circumstances and may be unable to make an informed risk assessment or provide appropriate treatment recommendations. In such situations, a mental health provider must weigh the patient and public's safety with the consequences of violating that person's privacy.

Providers of crisis services should be aware of potentially mandatory disclosures for threats of serious and imminent harm made by the patient. There is state to state variation on whether such “duty to warn” disclosures are required or simply allowed.³¹ The reference to the “duty to warn” statutes arose from the 1974 landmark case *Tarasoff v. Regents of the University of California*, in which the California Supreme Court determined that a provider may have the duty to break confidentiality and warn a potential third party under certain circumstances, such as when the patient reveals ideas about harming the third party.³² The Court revisited this ruling two years later in 1976. At that time, they noted that mental health professionals had a “duty to protect” an identifiable victim, and that warning the intended victim might be only one way to fulfill the duty to protect.³³ While the *Tarasoff* cases and subsequent California legislation only applies to practitioners in California, states have adopted variations on these themes. Crisis service providers should be aware of their state statute and provisions when an individual enters their care. If threats are identified, the crisis provider may need to take steps that can reasonably lead to protection of a third party or the public at large, which can include warning the identified third party, voluntarily or involuntarily hospitalizing the individual if clinically indicated, or notifying law enforcement of the threat under appropriate circumstances. Crisis service providers would do well to have policies and procedures for handling these types of situations and may need to seek legal counsel or clinical consultation on a case by case basis.

Crisis service providers should also be aware of other exceptions to confidentiality. For example, notable exceptions exist for disclosures required by law, such as mandated reporting of child abuse^{34 35}, disabled persons abuse or elder abuse.³⁶ Mandated reporters are spelled out in state statutes, but typically include professionals working in crisis services, including social workers, physicians, nurses, therapists, law enforcement officers, and other health-care workers.³⁷

ROLE OF CRISIS SERVICE PROVIDERS IN STATES WITH RED FLAG OR EXTREME RISK PROTECTION ORDERS

A mental health provider working in crisis services may come across individuals who are thought to present a risk of harm to themselves or others. Access to a firearm for such individuals may increase their risk. What, then, should crisis services providers do when confronted with such an individual who owns guns? Although the answer requires a case by case multifactorial analysis and would likely involve a careful firearms-related risk assessment, obtaining collateral information, or a potential inpatient hospitalization to allow such risk assessment to be done in a higher level of care, several states have also recently passed laws allowing the permissible, temporary removal of firearms from an individual during a crisis. These laws, variably called gun violence restraining orders (GVROs), dangerous persons firearms seizure, risk-based gun removal, extreme risk protection orders, or “red flag” laws, allow for the temporary confiscation of firearms from an individual when there is a “red flag” raised by others.^{38 39 40} These “red flags”, or concerns, center around the belief that the individual in question presents a risk of harm to themselves or others and that having access to a firearm could result in elevating that risk. “Red flag” laws are currently implemented in some form in seventeen states and the District of Columbia,⁴¹ and have the benefit of addressing risk while ensuring that those with mental illness are not unfairly stigmatized, as these laws are not directly connected to mental illness or a previous civil commitment. In other words, anyone who presents the requisite “red flag” of risk could be subject to firearm removal provisions in those states where such laws exist.

Providers practicing in crisis settings should be familiar with their state procedures, allowances, and prohibitions regarding high risk individuals who have access to firearms. Depending on the state in which they practice, crisis providers should know whether it is permissible to report their concerns to police to initiate the firearm removal process or whether they can encourage family members or others to do so (including the patient themselves). According to Connecticut and Indiana data regarding their risk-based gun removal laws, the most frequent circumstance that led to firearm removal involved self-harm, with less frequent circumstances involving concerns about harm to others or a combination of the two.^{42 43} Data indicates that in both the aforementioned states, the most common action taken by police at the time of firearm removal was transport to the hospital for psychiatric evaluation.^{44 45} Thus, these situations were not likely initiated by crisis services, but resulted in crisis assessments. While the goal of these laws is to decrease the risk of violence toward self or others by removing the tools by which the individual might harm themselves or others—a so called “means reduction”—often they provide an opportunity for the individual to connect with treatment services as well. A review of the clinician’s role in this topic is summarized by Kapoor et al.⁴⁶

THE ROLE OF LAW ENFORCEMENT, LEGAL REGULATION OF CRISIS SERVICES, AND THE CRIMINAL JUSTICE SYSTEM

Providers of crisis services may see all manner of individuals in a behavioral health crisis, including those who are currently involved with the correctional or criminal justice system. Studies indicate that such individuals are high utilizers of crisis settings due to mental health and substance use concerns.⁴⁷ It may be likely that clinicians working in crisis settings could see such individuals at a time of transition, called “reentry,” when a person is leaving jail or prison. This transition period is high-risk, with studies indicating a death rate, including death from suicide, that is much higher than the general population.^{48 49} States are also expanding access to community-based services for pre-trial defendants, such as those in outpatient competence to stand trial restoration programs, and these individuals may at times need crisis services.⁵⁰ Crisis providers should be aware of an individual’s legal situation and attempt to facilitate communication with appropriate resources for mental and physical health follow-up to prevent the individual’s return to the correctional system. Collaboration with community mental health providers who are knowledgeable about both the psychiatric and legal crises an individual is experiencing may help divert an individual away from the criminal justice system and into treatment in the mental health system. Crisis providers should also be aware of possible racial or ethnic disparities related to patients that could be involved in the criminal justice system. For example, some research indicates that individuals with mental illness who are from an ethnic minority group may be more likely to be referred to the criminal justice system rather than the mental health system.⁵¹ Clinicians should work to increase their awareness and cultural competence regarding this population they may be serving.

In many cases, individuals with current involvement with the criminal justice system may come in contact first with law enforcement officers during a behavioral health crisis. There is increasing discussion about shifting police response in nonviolent circumstances to a behavioral health responder. In the meantime, one model for enhancing police responses involves the use of Crisis Intervention Team (CIT) trained officers as they are trained in de-escalation and understanding issues pertaining to individuals with mental illness.⁵² The CIT program was originally developed to improve police response

and improve safety in interactions with individuals experiencing mental health crises, with the additional goal of providing improved access to mental health services or diverting individuals with serious mental illness away from the criminal justice system when appropriate.^{53 54} Studies show that CIT-trained officers had an increased knowledge about mental illness and treatments, less stigma, better de-escalation techniques, and better referral decisions compared with non-CIT officers.^{55 56} In some communities, law enforcement officers have made efforts to partner with mental health staff for calls, which can also be helpful at reducing negative outcomes.

CRISIS CENTERS AND EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the United States Congress in 1986.⁵⁷ The intent of EMTALA was to guarantee nondiscriminatory public access to emergency medical care regardless of an individual's ability to pay. This in turn was to prevent the practice of patient "dumping", defined as the "denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere."⁵⁸ In short, EMTALA aimed to prevent hospitals from transferring patients who could not pay without consideration of their medical stability.⁵⁹ EMTALA requires all hospitals receiving Medicare funds to screen, examine, and stabilize a patient prior to a transfer taking place. In addition, EMTALA notes the receiving hospital must agree to the transfer and have facilities to provide the necessary treatment.

There are three criteria that must be met before a facility could be held liable for an EMTALA violation.⁶⁰ First, the facility must be licensed as a hospital under state law. Second, it must participate in Medicare. Finally, it must operate a dedicated emergency department (DED). Although it is usually readily apparent if a facility is licensed as a hospital and if it participates in the Medicare program, the third criteria could be less clear. The Centers for Medicare and Medicaid Services (CMS) define a DED as a department that is licensed as an emergency department, a department that presents itself to the public as a provider of emergency services, or a department that sees at least one-third of its visits for the treatment of emergency medical conditions on an urgent basis without a previously scheduled appointment.⁶¹ This includes ambulatory outpatients who may present on an unscheduled basis to psychiatric intake centers. Thus, while Medicare-participating hospitals are required to comply with EMTALA requirements, a freestanding, walk-in Crisis Center or Crisis Stabilization Unit (CSU) could also potentially qualify.

Mental health providers working in psychiatric crisis services, including at freestanding Crisis Centers or CSUs, should be aware of EMTALA mandates and how they related to state licensing authorities. Although many walk-in crisis services focus on resolving a crisis in a less intensive setting on an urgent basis, at times, hospitalization may be recommended as necessary given the severity of the patient's crisis. If so, providers should be mindful of issues related to patient stability and transfer. Carefully considering the transport of the patient in crisis is also important, and assuring the safest method available (i.e., ambulance vs. patient car) should be the goal.

COVID-19 RELATED LEGAL ISSUES RELEVANT TO CRISIS SERVICES

COVID-19 has presented numerous challenges to health care systems around the world. While the medical complications related to COVID-19 are often prominently discussed, the mental health impact of COVID-19 also has critical bearing on individuals and communities. More than one-third of Americans noted that the COVID-19 pandemic was having a “serious impact” on their mental health, according to a survey by the American Psychiatric Association released March 25, 2020.⁶² Given ongoing implications related to the global pandemic, providers of behavioral health services, particularly crisis services, should be cognizant of COVID-19 related mental health issues that they may be encountering in individuals presenting in a behavioral health crisis. Such issues include social isolation resulting from quarantines, economic and financial concerns secondary to lockdowns, and stress related to job-loss or food insecurity.

Behavioral health providers should also be aware of COVID-19 specific implications for policies and practices related to crisis services. The full impact of COVID-19 on legal issues related to crisis services is not yet known, though there are many potential repercussions. For example, individuals presenting to a walk-in crisis center or psychiatric emergency room may require hospitalization or a transfer to a higher level of care given the severity of their crisis. However, arranging a safe and expedient transfer to a psychiatric bed may not be simple when factoring in COVID-19. It is possible that crisis providers may be asked to test individuals and consequently wait for COVID-19 test results prior to transferring patients to another facility in order to prevent possible transmission of the virus. This could result in longer emergency room boarding times in an era when some states are already being sued over bed waits.⁶³

Crisis providers may also, as previously noted, be evaluating and treating individuals who are still actively involved in the criminal justice system. Jail and prison populations may be particularly vulnerable during this pandemic, given close living quarters, the potential for overcrowding, the difficulties with social distancing, and this population’s increased rate of chronic medical comorbidities compared to the general population.⁶⁴ It is not yet clear at the time of this writing whether persons with severe mental illness in a behavioral health crisis, who are also positive for COVID-19, will be more likely to be retained in jails instead of eligible for diversion into the community. Providers of crisis services should continue to communicate regularly with liaisons in the community who are aware of a patient’s physical and mental health as well as legal status.

In addition, although many crisis services moved to video, it remains important that in-person services be available, and that proper PPE and infectious disease protections and protocols be implemented. This is critical as crisis services must ensure proper staffing and evaluation capabilities to mitigate the risk of liability in those assessments. Another potential example of COVID-19 impacting legal issues related to crisis services arises when considering the management of an acutely agitated patient in a crisis setting. While some crisis facilities may be allowed to utilize restraints as noted above, attempting to restrain an agitated and likely un-masked patient—especially one with an unknown COVID-19 test status—could put both the patient and the crisis staff at significant risk. It is also important to note that public health codes, such as those outlined by the Centers for Disease Control and Prevention, define isolation and quarantine differently than restraint and seclusion.⁶⁵ Restraint and seclusion are regulated by Centers for Medicare & Medicaid Services and require least restrictive alternatives to be addressed, as opposed to isolation and quarantine, where infection control is the key

concern. Overall, in the COVID-19 context, crisis providers should work not only toward the first-line de-escalation strategies discussed above in this paper but should also be diligent in practices such as mask-wearing for all involved.

RISK MANAGEMENT AND LIABILITY WITH CRISIS CENTERS

Working with individuals in crisis can be a positive and rewarding clinical experience in that crises can typically resolve with thoughtful communication and timely intervention. However, issues of liability can be an area of ongoing concern for providers who work in crisis settings. Issues of liability are particularly relevant when deciding to discharge a patient from a crisis setting. The decision to discharge should only occur after a determination of the appropriate level of care the individual needs, decided after a careful risk assessment based on the available information. Carefully and thoroughly documenting the decision, the considerations that went into the decision, and the recommendations made is of utmost importance and can help protect the mental health provider against liability should there be an unfortunate event after discharge, such as a patient suicide.⁶⁶

In general, several elements must be present for the plaintiff in a case to prove medical malpractice. These elements are commonly referred to as the “four Ds”. They include duty, dereliction, damages, and direct causation.⁶⁷ Duty is established from the doctor-patient relationship, and dereliction, often cited as negligence or deviation from the standard of care, must directly lead to the damages.⁶⁸ In addition, for the plaintiff’s case to prevail, there is also the condition that the suicide should have been foreseeable.⁶⁹ Thus, the issue of liability will often hinge on whether the mental health provider appropriately assessed the risk that a suicide would occur, emphasizing again the importance of thorough clinical documentation.⁷⁰

A clinician should therefore weigh the available information and use their professional judgment combined with clinical practice guidelines, while clearly documenting their reasoning and considerations in order to best protect themselves from liability.

CONCLUSION

Providers in crisis settings offer necessary and critical services to individuals and the community. While working in such high-stakes settings can be emotionally taxing, it can also be rewarding. Crisis services provide opportunities for early intervention and treatment during a behavioral health crisis prior to more severe consequences occurring. Providers should be aware of key legal issues relevant to crisis service evaluations, with focus specifically on statute in the state in which they practice. These legal issues are also ever evolving, as highlighted with recent events related to COVID-19 and a renewed attention to racial and ethnic disparities. Although the work is complex, being mindful of the current legal landscape can help a crisis service provider protect themselves from liability while working to achieve the best outcome for the individual in crisis.

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Introduction

Mental health crisis services are a critical component of the behavioral health service continuum. Comprehensive behavioral health crisis systems can reduce the time individuals in crisis are stuck in emergency rooms, can reduce unnecessary psychiatric hospitalization by diverting clients to appropriate levels of care, and reduce suicides and other negative outcomes. In this paper, I review information gleaned from interviews of representatives from State Mental Health Authorities (SMHAs). During these interviews, SMHAs described how they work to expand and improve their crisis services continuum.

States differ widely on the definition of a mental health crisis; the nature, extent and comprehensiveness of the crisis services available; and the organization and financing of such services. The Substance Abuse Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*ⁱ provides a model for states to organize their crisis services after. In most states, crisis services are largely funded by the state through the SMHA. In some states, that burden is shared with Medicaid, local governments, private insurers, and other funding sources. The Center on Budget and Policy Priorities estimates that Fiscal Year 2020 budget cuts resulting from the COVID-19 epidemic have been 10 percent and will rise to 25 percent in Fiscal Year 2021ⁱⁱ. Despite state mental health services being an essential state service, the recessions of the 2000s have shown that SMHAs are likely to experience targeted budget cuts as states balance their budgets. To support crisis services, SMHAs may have to expand crisis funding sources, including working with insurance leaders and others to include crisis services as essential benefits to be covered by all insurers.

Unlike a medical emergency, there is no official definition of a mental health crisis. In the *Best Practice Toolkit*, “crisis services are for anyone, anywhere and anytimeⁱⁱⁱ.” In the Crisis Now model that informs the *Toolkit*, crises are defined by the person experiencing the crisis; so long as he or she believes themselves to be in need of urgent support^{iv}. There are other definitions used across the country which will be described later. The lack of an official definition inhibits the billing of crisis services, in some states, to private insurance and Medicaid. If a state wants to increase funding by Medicaid and private insurance, it may be able to work with their SMHA, State Medicaid Agency, State Insurance Commissioners and private insurers to support including more crisis services as essential insurance services.

An earlier paper, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, found that

“The most frequently reported funding sources for crisis services are state and county general funds and Medicaid waivers. Although states finance crisis services in different ways, many are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status.”

This paper discusses how mental health crisis services are funded in 2020 and how the burden of funding those services can be more broadly shared by Medicaid and private insurance. It will give an overview of mental health crisis service systems, show how the service systems are funded, and show how funding individual service types are funded.

Methodology

The 2020 National Association of State Mental Health Program Director’s (NASMHPD’s) Technical Assistance Coalition (TAC) papers focus on various aspects of mental health crisis services. The NASMHPD Research Institute (NRI) developed this paper on financing by reviewing the literature and available national data, and then conducting semi-structured interviews with key state staff about the organization and structure of their state’s crisis service systems. This methodology was used in the development and writing of the papers *Using Technology to Improve the Delivery of Behavioral Health Services in the United States* and *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the United States*. Many of the responses informed other aspects of financing relevant to this paper. Similarly, prior interviews had taken place by NRI in a review of current trends in state’s development of inpatient bed registries, and information from those interviews was also used to inform this paper.

Information about crisis services and the relationship between the SMHA and the State Medicaid Agency was taken from the 2015 and, preliminary 2020 NRI State Profiles System data collection project.

The SMHAs that provided information for this paper were Alaska, Arizona, Colorado, Delaware, Florida, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Ohio, South Dakota, and Utah. In the paper, a distinction is made between states, SMHAs, and State Medicaid Agencies. State refers to the entire state crisis service effort and state funding, which is not always SMHA directed, and non-Medicaid state funding. SMHA is the mental health agency. Medicaid refers to the State Medicaid Agency.

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Overview of States

A continuum of mental health crisis services is provided in all states; however, the organization and types of services provided are not the same from one state to another, and sometimes vary from one region in a state to another.

In a 2020 survey of SMHAs currently being conducted by NRI, out of 24 states that had already responded, most SMHAs (19) work with law enforcement to train crisis intervention teams (CITs); directly provide services, including 24-hour crisis hotline services (15), mobile crisis teams (16), and crisis stabilization beds (16). Crisis clinics are provided in half (12) of the responding states, while a few (3) supported behavioral health services in emergency departments.

The biggest difference between SMHAs is how direct their relationship is with the providers of crisis services. In states with the most direct relationship, services are either provided by state staff or by providers directly contracted by the state. Most states organize crisis services regionally but with varying degrees of control of services. In states with the least direct relationships, city/county /regionally based and/or tribal governmental organizations contract out the services to local providers based on standards mandated by the state. In some regionally organized states, the city or county governments in the regions provide funding for services to augment state, Medicaid, and other funding.

All states participating in the interviews are dedicated to providing high-quality and responsive crisis services to their populations to the best of their ability and resources. SMHAs are faced with the challenge of providing behavioral health crisis services in varied settings, including those with high and low population densities; disparities in broadband access; with variations in the amount of funding available to support these services; and disparities in available behavioral health workforce. Many SMHAs also provide services adapted to the linguistic and cultural differences within their state. In Delaware and Nebraska, Medicaid manages their own crisis service systems that cover their own patients. Arizona then braids Medicaid, SAMHSA block grant, state general and county funds into the crisis system to offer a resource that can accept all referrals. Arizona has reimbursement rates for services that represent their true costs.

All states interviewed are converging towards the same point but the paths they have to take to get there can be very different as is their pace. States with centralized control of services are not likely to change, nor are states with decentralized control. Expanding Medicaid under the Affordable Care Act (ACA) can lessen the burden states have in using state general funds for crisis services by decreasing the number of people uninsured, but not all states have expanded Medicaid.

Funding Sources

State Funding

State general funds are the primary way that mental health crisis services are funded and are often the funding of last resort. States typically pay for the 24/7 infrastructure critical to the functioning of a crisis system: crisis call lines, mobile crisis teams, crisis receiving and stabilization centers, and often for CIT training. State funds are especially important, even when services can be billed to Medicaid and private insurance or when there are local or other funds supporting services, because they are often used to fund the basic infrastructure of crisis services.

Crisis service systems have developed and evolved differently across the states. The services have to be established, staffed, and trained, and these start-up costs are often not billable to Medicaid, and rarely to private insurance because they do not define them as services. Effective crisis services are provided immediately when a person is in need^{vi}. In areas with a high population, crisis service providers across the spectrum of service types may have a high enough service volume that they are constantly providing direct services that could be billable. In areas with low populations the services still need to be available at all hours but there may be down time between crises leaving the staff unable to bill for services. As a result, state general funds, through the SMHA, are usually the primary source of funding for the establishment and availability of crisis services, especially call centers and mobile teams.

Medicaid

As with SMHAs, no two State Medicaid Agencies are alike. In 2018, most State Medicaid Agencies were part of a larger state agency (76 percent), more than a fifth (22 percent) were stand-alone agencies, and one reported to a board of directors. Half of the directors of State Medicaid Agencies were political appointees, and the other half were civil servants. The priorities of State Medicaid Agencies vary by state. For example, only thirteen directors reported that behavioral health changes, such as carving-in behavioral health services into managed care contracts and redesigning outpatient treatment, was a priority. With the average tenure of a State Medicaid Director only 21 months, and the states dealing with the current COVID-19 pandemic, by the time you are reading this report it is likely that the priorities of some Medicaid Agencies have changed^{vii}. There are major differences in the populations covered by Medicaid. As of July 1, 2020, 36 states have expanded Medicaid coverage, two states have approved but not yet implemented the expansion of Medicaid, and 13 states have not expanded Medicaid coverage under the Affordable Care Act (ACA)^{viii}. Medicaid expansion decreases the number of uninsured individuals by expanding Medicaid eligibility requirements.

There are differences in how the care is organized because State Medicaid Agencies determine how care is delivered and paid for, within the bounds of federal rules. Most states (40) have Managed Care Organizations (MCOs) that organize care, usually with multiple MCOs organized regionally. Using risk-based contracting, the MCOs provide care at a set per-member, per-month payment. In many states with MCOs, not all Medicaid enrollees are covered under an MCO. Mental health and substance use disorder services are sometimes carved-out, meaning that mental health is not included in the MCO's coverage. In 2018, in 17 states carved-out outpatient mental health services and 15 states carved out inpatient mental health services in at least parts of the state^{ix}. Some MCOs are operated by large private insurance companies including UnitedHealth Group, Centene, Anthem, Molina, Aetna, and WellCare^x.

By using waivers or provisions, State Medicaid Agencies particularize the Medicaid rules under which they operate. There are a variety of waivers available, and states, through their waiver applications, particularize their waivers. A 1915(b) waiver permits states to implement service delivery models, such as MCOs, and to implement the terms of the waiver in specific parts of the state rather than statewide. A 1915(c) waiver permits states to use Home and Community-Based Services (HCBS) to provide care in a non-institutional setting. An 1115 waiver permits states to waive some Medicaid statutes related to program design as part of an experimental, pilot or demonstration project. These waivers have time limits, need to be approved by the Centers for Medicare and Medicaid Services (CMS), and states interested in continuing them must apply for renewal before they expire^{xi}.

The Mental Health Parity Act of 1996 required that the amount spent on mental health benefits be no less than those for medical and surgical benefits offered by insurance. The law exempted businesses that did not provide mental health coverage, businesses with fewer than 50 employees, and if implementing parity would increase premiums by at least one percent.^{xii} Parity did not expand to the level desired by Congress so this law was superseded by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 which requires that insurers guarantee that benefits for mental health and substance use disorder (MH/SUD) services are no more restrictive than those for medical and surgical benefits^{xiii}. The MHPAEA was amended through the ACA to have even broader application to include individual health insurance coverage.

There is ambiguity regarding coverage of certain key components of behavioral health as compared to medical services. For example, ambulance and paramedic services for primary healthcare are covered by Medicaid if it is a medical emergency and the provider is licensed by the state. Medical transportation for non-emergencies is covered if there is a statement by a doctor that the service is required^{xiv}. Medical emergencies are defined for Medicaid by §424.101 as being "inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services." In many states, there is a lack of transportation for behavioral health crisis services other than law enforcement. One state interviewed indicated that state general funds are used to reimburse law enforcement agencies when transporting individuals experiencing a behavioral health crisis.

One of the issues with Medicaid coverage is that there is no official definition of a mental health crisis rather definitions vary from place to place. Below are examples of definitions other than the Crisis Now definition related above.

- Arizona Complete Health, a Medicaid MCO, says “A crisis is defined by the person going through it. If a situation exceeds a person's coping skills, they are in crisis^{xv}.”
- Mississippi’s Department of Mental Health defines a mental health crisis as “any situation in which someone’s behavior puts them at risk of becoming unable to properly provide self-care, of functioning in the community, or maybe even of hurting themselves.^{xvi}”
- In Washington County, Pennsylvania, a mental health crisis is “an immediate stress-producing situation, which causes acute problems of disturbed thought, mood or social relationships requiring immediate intervention.^{xvii}”

The relationship between SMHAs and Medicaid does not follow one model. In a few states the SMHA is part of the Medicaid Agency. In the other states they are closely split between being in the same umbrella department or in different state departments^{xviii}. Medicaid is a significant payer of mental health services^{xix} but not necessarily for crisis services in all states. In Florida, Kentucky, and Nebraska, Medicaid, and private insurance, when possible, is billed first, and state general funds pay for the uninsured. Seven of the states interviewed had either Medicaid Managed Care Organizations (MCOs) or Accountable Care Organizations (ACOs) that organized Medicaid funded services. Of these, six used MCOs/ACOs to provide crisis services. In Delaware, Kentucky, and Nebraska there were parallel crisis service systems, one paid for by Medicaid, and one largely paid for by the state. In Kentucky, only behavioral health providers who are allocated state crisis funds must provide 24/7 crisis services to anyone who presents in need while the other providers may choose how and to whom they provide crisis services. In other cases, crisis service providers had difficulty getting Medicaid to reimburse for services rendered to patients covered by Medicaid.

Though mental health crisis has no Medicaid definition, there are billing codes that can be used for mental health crisis intervention services.

- H0030 – Behavioral Health Hotline Service
- H0031 - Mental Health Assessment, by Non-Physician
- H0035 - Mental Health Partial Hospitalization, Treatment, Less Than 24 Hours
- H2011 - Crisis Intervention Service, Per 15 Minutes
- S9484 - Crisis Intervention Mental Health Services, Per Hour
- S9485 – Per Diem Mental Health Crisis Services
- T1016 – Case Management, Each 15 Minutes – used by Arizona to bill Medicaid for crisis calls
- T2034 – Crisis Intervention, Waiver, Per Diem

In order to bill Medicaid for crisis services, it is not enough to assign a billing code to services provided. State Medicaid Agencies need to recognize the provider or service type that meets their definitions of a billable service and qualified provider. How comprehensively crisis services in a state can be billed to Medicaid is dependent on a variety of factors including the relationship between the SMHA and the providers of crisis services to Medicaid, the specific waivers in place in the jurisdiction and their provisions, as well as the capabilities of providers related to meeting the requirements for billing Medicaid. Within any given state, these factors can vary by region, making a comprehensive array of fundable crisis services through Medicaid challenging.

In states where Medicaid coverage has been expanded, the number of uninsured individuals is reduced, which can shift the funding burden from the SMHA and on to the State Medicaid Agency for those individuals covered by the expansion. The expansion of Medicaid did not determine whether or not states were able to bill Medicaid for specific crisis services since some states that have expanded Medicaid coverage to more people still do not bill Medicaid for these services and some that have not expanded do bill Medicaid for specific services.

If Medicaid is not currently supporting billing for behavioral health crisis services in a state, the SMHA, and their crisis service provider networks, can work with their state's Medicaid agency to build necessary rules and definitions required to allow for the billing of crisis services.

Private Insurance

Mental health crisis systems, in many states, have a problem passing Go and collecting their \$200 from private insurance. Some states remarked that they did not believe anyone was able to successfully bill private insurance. However, of fifteen states, nine reported that private insurance was successfully billed for some crisis services, but only two of those reported more than limited success in billing private insurance. Below are some specific findings gleaned from interviews with state experts. Below are some findings gleaned from interviews with the SMHAs.

- Arizona: Regional authorities that operate crisis services are required to coordinate third party liability/benefits and have had success albeit limited in collecting from private insurance.
- Colorado: Colorado is in the initial stages of gathering data in an effort to better work with the state's Division of Insurance on commercial providers becoming more responsible for the payment of crisis services.
- Florida: Providers are usually able to bill private insurance, including for crisis services.
- Maryland: Private insurance is billed, on a limited basis, for some services; however, coverage varies by insurance company and by region within the state. It is up to the provider to bill private insurance. When the insurance companies pay it is for a service and not for the infrastructure that makes the service possible.
- Minnesota: Private insurance does not pay for crisis services because they do not see them as emergency services. However it has happened that insurance has paid for

services because providers are supposed to bill private insurance first. The SMHA is having their Department of Commerce review the coverage refusals.

- Mississippi: Some providers certified by The Joint Commission are able to bill private insurance for crisis services.
- Nebraska: Regional Managed Care Organization (MCOs) are able to bill private insurance and have collected from them though sometimes the payment has been delayed.
- Ohio: It is the responsibility of providers to collect from private insurance.
- Tennessee: Providers have been able to collect from private insurance. They speculated that their success could be due to the provider being part of a larger provider group.

The ability to bill private insurance for crisis services is something that states can improve in collaboration with the SMHA, State Insurance Commissioners, insurance companies, and advocates. With insurers acting as MCOs/ ACOs in some states, their familiarity with the efficacy of crisis services may increase. Utah has not been able to bill private insurance but that may change now that two of their major insurers in the state are their MCOs/ACOs. They are also considering levying an assessment on private insurance to pay for crisis services. Another way is to have the state agency that governs insurance mandate the coverage for behavioral health crisis services, as a way to meet parity requirements. Continued advocacy in this arena is needed. Parity theoretically began in 1996, yet there is no uniform way to address private insurance coverage for MH/SUD crises similar to how these are addressed in medical and surgical types of crises.

Local Funds

All SMHAs interviewed organized crisis services regionally. Many states organized the provision of care through MCOs/ACOs with the bulk of the direction coming from the SMHA and the funding coming from state general funds and or Medicaid. In half of these states, local governments, which can be counties or groups of counties, were required to pay for a portion of the services. In South Dakota, services are organized, funded and provided locally with state general funds used to provide training. In Ohio and South Dakota counties and regions have the responsibility for providing crisis services and contribute some of the funding. In all states with local funding, there can be great regional differences in the services provided. Regional differences in access to services can also exist in states with limited or no regional funding since the needs and population densities of regions can vary greatly within a state.

Other Funding Sources

While most funding for SMHA crisis services comes from state general funds, Medicaid and local funds, states have also found other ways to pay for these services. Six of the SMHAs used SAMHSA Mental Health Block grants to help fund services, often to support service infrastructure. Other funding sources included the Indian Health Service, Tricare, NAMI, the United Way, self-pay, and private grants.

Crisis Services

Hotlines and Warm Lines

Crisis hotlines are an essential element of a mental health crisis service system. For people in crisis, hotlines connect them with care directly from hotline staff, are often able to dispatch a mobile crisis team, or make a referral to a community service based on the needs of the individual. In some states, the hotlines can make appointments for outpatient treatment. Hotline services are usually organized regionally, with service areas corresponding to the service areas of regional community provider systems. In some states, the hotlines are the same provider as the National Suicide Prevention LifeLine provider in the area but not in all cases. In one state, the hotlines funded by the state were only for people aged twenty-five and under. In another state, the call center staff also staff the mobile crisis teams.

Funding for these services has two components, infrastructure and services. Hotlines need to be available all the time but the service may not be used all the time. They also are usually available to anyone regardless of insurance and age. All the SMHAs used state general funds to support some or all of the cost of their hotlines. In seven states, hotlines received funding from Medicaid, though in two of the states, Medicaid operates separate hotlines for their beneficiaries. The ability of SMHAs to engage Medicaid in supporting the infrastructure costs of having hotlines available 24/7 varies greatly with seven states receiving no Medicaid funding, to states that rely heavily upon Medicaid funding. In Tennessee, TennCare (the named Medicaid program) provides most of the funding hotline funding. Private insurance did fund some centralized hotline services. In Ohio, some insurers operated their hotlines only for their own beneficiaries within their insurance plans. Other sources of funding were local funds in three states, mental health block grant funds in three states and the United Way in one state.

Warm lines are phone lines, usually operated by peers, which provide early intervention and emotional support. Warm lines exist in eight of the states interviewed, not always with statewide coverage and are usually funded by the SMHA though one state indicated that federal funds were also used to support this service. When necessary, callers to warm lines should be transitioned to a hotline.

Mobile Crisis Teams

Mobile crisis teams are a community-based service that travels out to meet an individual in crisis wherever they are. Model teams include a licensed and/or credentialed clinician who assesses the person in crisis and connects them to appropriate treatment^{xx}. Ideally, the teams are available at all times statewide and to anyone, but that is not always the case. Coverage can be difficult to provide in rural and frontier areas because of distances teams must traverse and the difficulty in staffing teams. Many states reported mobile crisis teams involved two individuals, a licensed behavioral health clinician and a peer specialist (often with state sponsored training/certification).

To provide services in rural areas in Colorado, some places use paramedics who are trained to do an initial screening and then, if appropriate and with the consent of the patient, connect the patient, via a tablet, with a telehealth provider who interacts with the patient and then informs the paramedic about

the next treatment steps. Minnesota also uses similar, web-based mobile crisis counselors. In Delaware, the teams have access to OpenBeds, a treatment referral website that allows the teams to make appointments for follow-up services at all levels of care. In Delaware mobile team staff are also the call center staff and it is often the case that the staff providing the mobile service took the crisis call. Delaware also has a separate and parallel service for Medicaid patients. Florida's mobile crisis services are targeted at people twenty-five and younger.

Funding for these services has two components, infrastructure and services. Infrastructure consists of establishing and training the teams, as well as providing (and funding) the transportation operational elements. Teams need to be available even when they are not on a call and this is difficult in rural and frontier areas with low crisis volumes. Teams are organized regionally and often consist of staff dedicated to this task, often with a peer as part of the mobile team. In areas with staffing shortages and low volumes of crisis, the teams may be local clinicians who volunteer their services, much like members of a volunteer fire department or the crisis providers are on-call and are paid when they provide services.

State funding is essential to the provision of mobile crisis services, especially for infrastructure. Medicaid pays for mobile crisis services, in some way, in all states interviewed for this review, except for South Dakota. A limitation in almost every state in billing for mobile crisis services was that reimbursements are usually limited to the time the crisis team is actually with the client and does not include time traveling to or from the client nor the time between responding to clients. Many states have Medicaid 1115 waivers but only Alaska and Arizona reported that they use their waiver to fund mobile crisis services. Five states reported that counties provide funding for these mobile crisis services, especially in Ohio and South Dakota where the counties and regions have primary responsibility for the provision of crisis services. Private insurance did not play a great role in the funding of mobile crisis services especially for the infrastructure. Where private insurance did pay, it was usually because the state made an effort to try to collect or there was a special arrangement in one region with a local insurance company. In Minnesota, private insurance does not pay for mobile crisis services because they do not deem them to be emergency services.

Crisis-Receiving and Stabilization Services

Interviewed states tended to have one of two models of crisis-receiving or stabilization services, under-24 hours receiving and stabilization services, or short-term crisis residential programs that typically have a few beds that serve individuals in crisis for up to 72 hours. The labeling of these service types can be confusing in cross-state comparisons as CMS allows states to develop their own definitions for the crisis service array.

The *Toolkit* recommends the crisis-receiving model developed as part of the Crisis Now model with facilities that provide under-24 hour services staffed by multidisciplinary teams. These facilities offer no-wrong door access and accept all walk-ins and drop-offs by first responders and mobile crisis teams^{xxi}. Many states with crisis stabilization facilities do not follow the Crisis Now model and instead support crisis residential programs that have beds that provide crisis stabilization services for up to 72 hours

All the states interviewed have at least one facility providing some version of crisis stabilization services. Eight of the states have at least one facility that followed the Crisis Now model, which is a comprehensive crisis service system comprising and coordinating crisis services at all levels of intensity, and two states are working to establish such facilities, which provide comprehensive crisis services, while five states have crisis stabilization facilities with beds that provide more than 24-hour services. Missouri has an under-24-hour facility in Kansas City that is connected to the local court system but otherwise depends on hospitals emergency rooms with enhanced capabilities for serving people in crisis. Utah has one pilot facility that is similar to the Crisis Now model but with no walk-ins, otherwise there are units attached to hospitals which often do not accept Medicaid patients.

Funding for stabilization facilities of any type varied not always following the *Toolkit* model. Medicaid provided funding for this service in fourteen of fifteen states and the state general funds in eleven states. In five states, local funds were used to support services. Private insurance provided funding in six states though not always much. In Florida and Kentucky, crisis providers are required to bill private insurance and Medicaid first and only bill the state as a last resort.

Crisis Intervention Teams (CIT) Focused on Training

Crisis Intervention Teams (CIT) began in 1988 with a partnership between the Memphis Police Department and the local chapter of National Alliance for the Mentally Ill (NAMI) to provide training for a police unit to specialize in responding to people with mental illness. CIT guides the interaction between law enforcement and people with mental illness^{xxii}. The training and the establishment of teams has expanded across the country, but is not universally available. The University of Memphis' CIT center reports that there are 2,645 local CIT programs and 351 regional programs^{xxiii}. CIT programs are in all but four states, but, within those states where it is available, many counties and municipalities do not have any CIT programs. Only in Maine does every county have a program. In Ohio, all but one county has a program^{xxiv}. Law Enforcement is organized very locally on a municipal level so, even in counties with CIT programs; it is very possible that not all jurisdictions within a county have teams.

Funding for CIT training most often came from state general funds (nine states) followed by local funds (three states). Other funding sources included local NAMI chapters, private grants, a state university and federal funds. The CIT training also often has volunteer educators who contribute to the training elements. The infrastructure of CIT extends beyond training to include partnerships, policies, and practices, generally stems from the originating law enforcement department.

Policy Implications

Crisis services are essential to the health of people with mental illness, substance use challenges, and those with no prior histories but who find themselves in suicidal crisis or extreme emotional distress. Crisis services divert individuals from hospitalization and ensure the least restrictive treatments are available to people experiencing crises. Fewer hospitalizations reduce costs for states^{xxv}. These labor and resource intensive services most often rely on state general funding through SMHA, local funds, and, to

a lesser degree, Medicaid funding. Where the services exist, they should be, and most often are, available to everyone regardless of their insurance status.

States that do not have funding from Medicaid or private insurance proportionate to the coverage of the persons served by crisis services can choose to have the burden shared more fairly. The Parity Acts of 1996 and 2008 declare that this burden sharing is legally correct. Each state, with their unique characteristics, will have to take different paths towards greater burden sharing. What is politically possible in one state may be anathema in another.

There are billing codes that can be used to bill Medicaid for crisis services and Medicaid is billed for the provision of some crisis services in some states. The crisis service providers need to be certified to bill Medicaid. The State Medicaid Agency and the SMHA could agree to plans that move states towards greater Medicaid funding (including helping support the 24/7 infrastructure of the crisis system) such as a bundled rate that would cover infrastructure costs. Achieving this may require changes in the provider service system, regulations, or a new Medicaid waiver. In states where the SBHA has direct control over their provider system and those with a more direct relationship with their Medicaid Agency, there may be greater facility in transitioning towards enhanced Medicaid funding. This may be more challenging in other states with indirect control of provider systems or a less integrated and collaborative relationship between the SBHA and Medicaid.

Private insurance covers the majority of the population, yet provides only a spotty minority of the funding for crisis services. The Parity Acts indicate that this should not be so. Private insurance usually pays for face-to-face treatment and not for transportation, which in a rural state can be significant for a mobile crisis team. They also usually do not pay for the time a crisis call team might spend waiting for a call. Utah is considering levying an assessment on private insurance to fund crisis services.

States govern how private insurance operates within their state. This governance is generally not in the same agency as the SMHA or Medicaid and so any changes to the rules governing private insurance necessarily means collaboration with another state agency and possibly the support of the Governor and Legislature. There are complex federal and state rules that can make such policy shifts difficult. There also might be political pressure exerted by insurance companies to inhibit changes that will cost them money. In some states with Medicaid Managed Care and where Medicaid funds crisis services, the MCOs/ACOs are operated by divisions of private insurance companies that often do not pay for crisis services for their customers not covered by Medicaid.

That mental health crisis services are not considered emergency medical services remains an explanation used by some private insurers to deny reimbursement. Nevertheless, services that are not reimbursed by Medicaid or private insurance are largely paid for by state general and local funds. It is appropriate that crisis services have a broad definition: if a person feels they are in crisis then they are in crisis. It is not necessary that the clinical definition and a more restrictive insurance definition be the same. If there are two definitions, states may be able to more successfully pursue reimbursement for crisis services, albeit not all services provided, and thereby shift more of the burden for funding crisis

services onto private insurers when appropriate. Alternatively, one state is exploring levying a fee on private insurers to fund a portion of the crisis service system.

Conclusion

In the context of the COVID-19 pandemic, there is increased awareness of the need to consider emotional well-being as a critical element that requires support and often immediate attention. It is timely that the SAMHSA Crisis Services Toolkit brought further attention to the need for crisis services even prior to the pandemic. Every state has a different service system, political structure and traditions. They are not starting at the same place, nor are they changing at the same pace. If one state can have Medicaid and private insurance share the burden, and the Parity Acts indicate that they should be doing so, then all states can. Any plan that increases the burden sharing for crisis services must be particular to a state and may require systemic reorganization and not just regulatory changes.

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ⁱⁱⁱ National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. (2020). SAMHSA - Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

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^{vi} National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. (2020). SAMHSA - Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

^{vii} State Medicaid Agency Operations Survey: Seventh Annual Survey of Medicaid Directors. (2019). National Association of Medicaid Directors. <https://medicaiddirectors.org/wp-content/uploads/2019/11/100-copies-NAMD-Operations-Survey.pdf>

^{viii} Status of state Medicaid expansion decisions: Interactive map. (2020, May 29). KFF. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

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- ^x 10 things to know about Medicaid managed care. (2019, December 16). KFF. <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>
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- ^{xiii} Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343
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Crisis Services: Addressing Unique Needs of Diverse Populations

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CRISIS SERVICES: ADDRESSING UNIQUE NEEDS OF DIVERSE POPULATIONS

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CRISIS SERVICES: ADDRESSING UNIQUE NEEDS OF DIVERSE POPULATIONS

Executive Summary

Crisis services constitute an array of activities, from phone or text lines to crisis assessment centers outside of emergency rooms and include emergency services embedded in more traditional hospital and emergency department settings. These services employ and treat a diverse population with unique individual needs that warrant consideration. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit issued in early 2020 calls for crisis services to be ready to serve anyone who needs the services. The National Association of State Mental Health Program Directors (NASMHPD) has focused its technical assistance papers in 2020 on crisis services and has similarly called attention to critical issues related to access to care for diverse populations encountering crisis services.

As crisis services receive increased attention and expand, considerations for diversity among populations served and among the workforce needs to be at the forefront of the minds of program leaders and policy makers. Although most crisis services treat adults ranging from 18 to 65 years of age, youth and older adults frequently present in crisis settings. Additionally, individuals with neurodevelopmental disabilities, complex and co-occurring substance use and medical conditions, and other characteristics must also navigate the crisis mental health and substance use system. Racial, ethnic, and sexual minorities experience barriers to mental health and substance use care in crisis settings just as they do in their daily lives. Structural racism, discrimination, stigma, and racialized legal statuses including criminal justice involvement and immigration also require special consideration. With the lens of experience during the COVID-19 pandemic, these issues have been further highlighted.

This paper discusses the considerations, challenges, and implications of treating these diverse populations in any of the varied crisis settings. Although each population is discussed in turn, owing to the complexity of such population health perspectives, this paper also considers intersectionality in these diverse populations. Older adults from racially and ethnically oppressed groups, younger adults with intellectual and developmental disabilities, and immigrant groups with language barriers are some of the ways in which these intersecting identities pose unique challenges for ensuring a robust and comprehensive crisis services system that continues to promote equity and quality care to all individuals in a person-centered manner. With that in mind, the following recommendations stem from this paper's review of extant literature and practices related to crisis services and the vision for what is needed in the future.

Recommendations

Recommendation #1: Community stakeholders providing crisis services must be familiar with available funding mechanisms to access appropriate financial, clinical, and material resources to support a diverse mental health workforce and unique patient populations with psychiatric needs.

Recommendation #2: Crisis services must employ a systems-based approach to focus on early intervention with individuals of all ages, including youth at risk of mental health crises and older adults. Services must be available at every level of the crisis system in order to support youth in school, community, residential, or hospital settings, while simultaneously considering the multiple complex needs including coordination with referring programs and facilities for older adult populations. This

approach to individuals across the lifespan should have as a goal to minimize the crisis, prevent suicide and other negative outcomes and link individuals to other care as needed.

Recommendation #3: Clinicians may provide more culturally competent care by demonstrating an awareness of historical trauma in racial, ethnic and experiential minority populations. By encouraging patients' narratives in crisis settings, clinicians may foster a welcoming and supportive environment for patients from historically marginalized communities.

Recommendation #4: Clinicians should consider mental health stigma in communities of color, while identifying and addressing barriers to psychiatric care for racially and ethnically oppressed persons. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment that explores the roles of family, culture and religious beliefs may be helpful in addressing barriers to mental health services.

Recommendation #5: Crisis services should be familiar with their state's immigration policies and available systems of support and potential funding mechanisms to promote the health of undocumented persons with mental illness and substance use challenges. This includes addressing undocumented persons' fears about their legal status and the institutions duty to privacy and confidentiality under state and federal guidelines.

Recommendation #6: Clinicians providing crisis services should consider sexual identity as part of their biopsychosocial assessment in order to provide equitable treatment for a diverse population and understand personal narratives.

Recommendation #7: Clinical examination should include a broad assessment of individuals' functional strengths and limitations to provide individualized person-centered treatment.

Recommendation #8: A biopsychosocial approach is essential in determining the appropriate treatment for persons with complex needs who present in crisis. This includes consideration of how staff and physical environments may provide healing and supportive environments for persons with intellectual and developmental disabilities.

Recommendation #9: Crisis services must collaborate with community stakeholders to ensure early intervention for individuals with mental health and substance use needs and those at risk of suicide. These partnerships may help divert emergency department visits, focus on preventive and lifesaving care, and build alliances with other stakeholders.

Recommendation #10: Crisis mental health systems must assess for underlying medical comorbidities, and take lessons learned from the COVID-19 pandemic to ensure individuals served receive adequate treatment and medical care when needed, and collaborate with vulnerable patients' families, healthcare providers, and other support systems to provide appropriate care. In this way, as part of the continuum of care, crisis services should partner with local medical systems and vice versa to help patients access the best door to care as needed.

Recommendation #11: In order to account for the various structural barriers to accessing services, crisis mental health systems should emphasize the unique needs and differences among diverse populations to encourage individuals to engage in care, even as structural barriers may otherwise limit their access to such care.

Crisis Services: Addressing Unique Needs of Diverse Populations

Introduction

Over 55 million Americans suffer from mental health or substance use disorders in the United States and account for nearly 10 million hospitalizations annually.¹ Of the many types of crisis mental health services, emergency psychiatric hospitalization represents the highest level of clinical care for individuals with acute mental health needs. In 2017, the National Association of State Mental Health Program Directors called for the need to look “Beyond Beds” and consider an array of services across a continuum of psychiatric care to meet the needs of individuals with mental health conditions, including an examination of the crisis services continuum.² The previous policy efforts underscore the importance of providing a robust mental health system, from adequate psychiatric bed availability and mental health workforce to criminal justice system diversion and public policy changes.³

In recent years, communities have established and utilized a broad range of crisis services such as walk-in and free community clinics, crisis line telephone and texting services, mobile treatment centers, crisis stabilization units, observation, crisis residential services, and hospitalization. The Substance Abuse and Mental Health Services Administration introduced in early 2020 the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, in which it is articulated that crisis services must be available for anyone, anywhere, anytime.⁴ This means that such crisis services must address the needs of a large, diverse, and growing population. Individuals with complex care needs, including older adults, those with intellectual and developmental disorders (IDD), dementia and neurocognitive disorders, co-occurring medical and physical issues, and even infectious diseases as highlighted in the COVID-19 context, all can present themselves for crisis services. These individuals represent particularly vulnerable populations in the mental health system. Here we discuss the unique challenges and considerations for ensuring equity in providing crisis services for diverse populations in crisis mental health care.

As with any health care service—from primary care to advanced specialty care— person-centered care is critical to address the unique challenges of meeting complex care needs. To provide effective individualized treatments, mental health clinicians must (a) recognize the characteristic signs, symptoms and natural history of psychiatric illness; (b) appreciate the diversity of psychological differences among individuals across mental disorders; (c) account for the range of behaviors among individuals; (d) and understand how individuals' trauma and life-stories influence their illness experience and expression.⁵ By appreciating these perspectives in all mental health services, the mental health and substance use systems may better provide evidence-supported treatments alongside psychosocial interventions that account for patients' unique genetic, behavioral, and environmental characteristics.

Special Age-cohort Populations in Crisis Settings

Youth, Children and Younger adults

Crisis services are a “continuum of services” provided to individuals experiencing psychological distress across the life-course.⁶ Crisis mental health systems, however, are most adept at delivering services to adults between the ages of 18 and 65. There are unique challenges for community health systems caring for younger children and older populations requiring crisis services.

There is a growing number of children seeking psychiatric emergency care in the United States.⁷ Although the details of child and adolescent crisis services is beyond the scope of this paper, it is important to highlight that although many communities may have robust crisis systems for adults, they

may be less likely to have well-developed systems that meet the needs of a growing pediatric population.⁸ Like adults, children may exhibit symptoms of psychological distress, including suicidal ideation, mood disorders, behavioral changes, and the effects of substance use. Because of this growing need, communities and stakeholders must have a vested interest in expanding the range of crisis services to provide the most appropriate level and type of care⁹ for youth in crisis. Studies suggest that a full continuum of crisis services, including prevention, early intervention, response, and stabilization services, can divert youth from psychiatric emergency rooms, which may be associated with poorer clinical outcomes and increased cost of services.¹⁰ Community stakeholders providing crisis services must be familiar with available funding mechanisms to appropriate financial, clinical, and material resources to support the mental health workforce and patient populations with psychiatric needs. Knowledge of available resources, which include funding, community partners, schools, and referring institutions, is essential in ensuring a robust crisis services system for children and younger adults. Sharon Hoover and Jeff Bostic¹¹ have provided a more detailed review about crisis services for children and adolescents.

Older Adult Populations

There is also a large and growing older adult population in the United States. Older adults over the age of 65 are expected to account for 1 out of every five¹² individuals in the United States by 2030. For mental health services, there is an expected two-fold increase in geriatric patients with mental health disorders.¹³ Despite this increase in the elderly population, geriatric populations have a disproportionately low rate of utilization of mental health and crisis resources. Older adult patients with mental health diagnoses such as schizophrenia are particularly underrepresented among individuals utilizing public mental health systems.¹⁴ Some of this may relate to funding, policy and program architecture. This is especially true for many individuals who first present with mental health symptoms in their older years but may already be in care for medical conditions, as opposed to older adults who “grew up” in the public mental health system.

The American Association of Geriatric Psychiatry has characterized the shortage of geriatric mental health specialists as “a national crisis”.¹⁵ Older adults often have more complicated mood and affective disorders and are more likely to have comorbid medical and psychiatric illnesses that require careful coordination with other medical providers. Older individuals with chronic mental illness may also be less likely to achieve full symptom remission early in treatment.¹⁶ Moreover, they may require combinations of medications and other therapies that increase other risks such as drug interactions, shifts in mood states, or the risk of development of conditions like delirium or other medical complications.¹⁷ Suicide rates are highest among white males¹⁸ with increased risk among older adults with concomitant physical illness.¹⁹ Substance use significantly increases the risk of morbidity and mortality, with a two-fold increase in the risk of suicide among older adults with dual diagnoses.²⁰ Rural and unmarried elder persons may be particularly less likely to utilize crisis services.²¹ Despite these complex treatment and demographic considerations, treatment of older adults may be associated with low reimbursement rates for clinicians, creating a paradox that imposes additional barriers to accessing mental health care in the community. As crisis services expand across the country, it will be important to identify the unique needs of the older adult population and address barriers to their use of crisis services.

Older adults tend to have higher medical complexity than younger patients.²² It can be challenging to distinguish medical symptoms from psychiatric symptoms in this complex population. Comorbid physical conditions may be more prominent than underlying psychiatric symptoms in geriatric populations. These medical comorbidities also lead to higher risks related to polypharmacy, which may

contribute to worsening medical and psychiatric symptoms, especially in geriatric populations. In treating mental health disorders among geriatric populations, clinicians must also focus on the "competing demands" of underlying medical comorbidities that may simultaneously erect barriers to psychiatric treatment.²³ Comorbidities may include diabetes, hypertension, obstructive and other respiratory illness, cardiovascular diseases, cancer, immunologic and rheumatologic conditions, chronic pain, as well as vision and hearing deficits, to name a few. These conditions may require more coordination and accommodations to ensure individuals have access to their physical aids for ambulation, equipment, medications, and other supplies necessary to support the individuals with these conditions.

Additionally, in the array of crisis services where individuals spend time (as opposed to text lines or phone lines), regulatory requirements include minimum standards for patient census, safety, staffing, training, and medical personnel. There may be increased licensing requirements to provide services for older adult populations, with many of the facilities limiting treatment to patients who can attend to their own basic needs. Thus, functional impairment in activities of daily living and self-care, which is often more prevalent among geriatric populations, is an additional barrier to eligibility and access to crisis services. This is especially true if the crisis service is outside of a more traditional medical setting. Given these considerations may pose barriers to caring for aging populations frequently need additional medical services (e.g., care for medical, psychiatric, cognitive, and physical impairment), the current mental health system must continue to develop social and structural interventions that ensure access to high-quality crisis services to all individuals across the life course.

Older persons are considered a protected population and may require additional psychosocial support and case management needs. The increased vulnerability of elderly patients to undue influence and abuse may be due to the physical and cognitive changes associated with late-life. Elder abuse affects over 4.3 million persons each year and accounts for an estimated \$36 billion in losses to elderly individuals.²⁴ Moreover, studies suggest an "iceberg" effect, where the number of actual cases is likely higher than reported cases.^{25 26} Older individuals are at increased risk of physical and sexual abuse, neglect, and financial and material exploitation by strangers and individuals in positions of trust.^{27 28 29 30} Crisis mental health systems must be prepared to not only recognize the warning signs of different types of abuse but also be equipped to take the necessary steps to appropriately identify, support, reduce, and mitigate these issues. Minimally staffed crisis services serving more acute psychiatric patient populations may be less able to care for this population without further education, training and guidance. As crisis services evolve, careful collaboration with referring facilities to coordinate care during treatment and upon discharge will be essential for ensuring elderly patients receive appropriate care upon recovery.

Racially, Ethnically, and Experientially Diverse Populations in Crisis Settings

Racially and Ethnically Diverse Populations

To date, barriers to access to care for racially and ethnically diverse populations has been a major concern.^{32 33 34 35 36} Disparities in health care resources and outcomes among these populations create and maintain racial inequities in mental health care. For example, African American men are more likely to be diagnosed with personality disorders such as antisocial personality disorder despite evidence that the incidence of these disorders is relatively consistent across populations.³⁷ Black men are 13 times more likely to be routed to the criminal justice system for substance use issues than the general population, contributing to increased criminalization of mental illness and substance use particularly among oppressed populations.³⁸ Black youth are 2.5 times more likely to be diagnosed with

conduct disorder and five times more likely to be diagnosed with adjustment disorder than ADHD compared to their white counterparts.³⁹ These disparities may influence whether patients receive behavioral, pharmacotherapy, or are routed to criminal/juvenile legal systems.⁴⁰ Disparities in mental health outcomes in other population such as American Indians and Native Alaskans, are also well-documented.⁴¹ Thus, blacks and other minority or non-dominant populations may receive inappropriate treatments when presenting in crisis, further contributing to disparate health and social outcomes.

Indeed, in nearly every domain heretofore discussed (i.e., youth, geriatric, intellectually challenged, dual diagnosis, persons with disabilities, or the medically complex), racially and ethnically oppressed identifying persons face increased barriers to mental health and substance use services with consequent poorer health care outcomes. Black youth are less likely to seek care or be referred to psychiatric care.⁴² They receive suboptimal therapeutic and psychopharmacological treatments compared to their white counterparts.⁴³ The cumulative disadvantage of race in healthcare operates in tandem with other structural barriers to care, which dramatically limits the health outcomes for racially and ethnically oppressed youth, elderly, IDD, and medically complex patients.

As the current data is equivocal on the relative estimates of health services utilization among racial and ethnic subpopulations, further research is needed to fully understand use patterns across populations. Although African Americans face several barriers to mental health care, some studies estimate that they are half as likely to utilize professional mental health services^{44 45} irrespective of differences in class or access to resources. Some studies suggest that stigma, reduced access to care and family structure may explain the underutilization of mental health resources, while others suggest that discrimination and implicit bias may be at play. In a recent audit study, middle-class black clients were “considerably less likely than whites to be offered an appointment” for psychotherapy and psychological services compared to their white counterparts.⁴⁶ Such barriers to regular care may account for emergency and crisis mental health services utilization among African Americans.⁴⁷

A legacy of abuse and exploitation in medicine may also contribute to distrust in the health care system.^{48 49 50} Physicians and clinicians who demonstrate an awareness of such historical trauma while encouraging patients' narratives are more likely to provide culturally competent care and engage effectively with these patients, particularly in crisis settings.^{51 52 53} Clinicians must try to understand how cultural differences in stigma, religion, coping styles, mistrust of the medical system, and family^{54 55 56} influence the willingness of oppressed populations to seek mental health resources. These differences may explain why African Americans are more likely to find care from general physicians or religious figures.⁵⁷ Still, the evolution of more racially and ethnically conscious approaches to care may allow for expansion of more adept and racially-attuned crisis services. Indeed, there are opportunities to consider early examples of successful approaches to crisis services. For example, some researchers have found considerable success in “comprehensive, community-based, mobile-crisis intervention[s]” among indigent African American populations.⁵⁸ Clinicians should identify and address barriers that prevent racially and oppressed persons from accessing and benefitting from psychiatric care. Stigma remains high in many communities of color. A biopsychosocial approach to assessment and treatment, including social and religious history, may be helpful in addressing barriers and stigma related to mental health services.

Immigrant Populations

Racialized legal status is an under-recognized social determinant of health.⁵⁹ Immigrants and undocumented persons comprise a vulnerable population that often appears in crisis mental health settings. Certainly, not all immigrants are treated similarly. Immigrants' health status varies by ethnicity and citizenship, with undocumented immigrants experiencing a higher risk of affective and other mental health disorders.⁶⁰ These outcomes may reflect social and political stressors, decreased access to health care, and fears of deportation. Moreover, fears of legal consequences have both direct and indirect effects on immigrant health status: undocumented individuals are at increased risk of affective disorders and are less likely to interface with the health system if they feel their family's legal status may be criminalized.⁶¹ Just as funding varies by state, exclusionary immigration policies that erect additional barriers for immigrants seeking mental health and crisis services may also vary across states.⁶² Undocumented persons may fear involvement with the health system due to fears of detainment and deportation. Thus, when an acute mental health situation erupts, it is likely that individuals would be brought into contact with the crisis service system.

Even among immigrants and undocumented persons who seek access to care, mental health services are generally underfunded in the United States. In addition to reluctance to access traditional healthcare services of immigrants, undocumented immigrants have historically been ineligible for federal benefits and resources at the state and national level. There may be little to no funds earmarked for undocumented persons. At the federal level, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 further limited access to public health insurance and social resources for legal immigrants with fewer than five years of US residence.⁶³ Although the CHIP Reauthorization Act of 2009 allowed some states to extend benefits to legal immigrant children, the Affordable Care Act of 2010 continued the 5-year waiting period imposed in prior policies for legal immigrants. Although immigrants and undocumented persons may receive emergency care and some additional services through Medicaid, state and federal laws might create "perverse incentives" that favor acute care in emergency departments over providing crisis services in less acute settings.⁶⁴ Undocumented persons may benefit from unrestricted funding mechanisms, such as California's Short-Doyle Act of 1967⁶⁵ and other unrestricted state and local funds and safety-net programs. Crisis services should become familiar with their state's immigration policies and identify and utilize available funding mechanisms to promote the health of undocumented persons with mental illness. Moreover, they should address undocumented patients' fears about their legal status and protect patient's privacy and confidentiality under state and federal guidelines, given that individuals in crisis care may be concerned about a host of legal repercussions for a variety of reasons.

Linguistic Diversity

Lack of language concordance can present another potential barrier to accessing crisis services. In order for a crisis system to function as intended, meeting the unique needs of individuals across various community settings, demographics, clinical needs, and other contexts, it must be able to communicate effectively with the populations that seek crisis support. As with any hospital, clinic, or other healthcare facility, crisis programs along the crisis continuum should be accessible to individuals who may not speak the dominant language of the region. Moreover, various states and jurisdictions have enacted policies that require healthcare facilities to provide translation services for threshold languages. In California, for example, threshold languages are defined as languages spoken by 3,000 individuals within a county or that comprise at least 5% of the spoken languages in that locale.^{66 67} Threshold languages typically vary by region, and include Spanish, Russian, Vietnamese,⁶⁸ Mandarin Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, Farsi, Hmong, and others. Although these may be encompassed in legally mandated requirements, as noted in the SAMHSA guidance, a robust crisis system should strive to meet the basic

needs of all of its constituents in order to serve anyone who accesses these services.⁶⁹ These minimum requirements are also federally mandated for many facilities; the Civil Rights Act of 1964 requires federally-funded facilities to provide linguistic services, whether in-person or remote aids, to its constituents.⁷⁰ Nevertheless, these policies may not be frequently enforced and represent only a minimum requirement. As a true crisis system must meaningfully respond to the needs of its community, all crisis systems arguably must be able to provide culturally competent care and interpreter services. This should be available to facilitate care for individuals across the continuum of crisis services.

Sexual Minorities

Experiential minorities, including individuals who identify as lesbian, gay, bisexual, transgender, queer, asexual, intersex, and non-binary individuals (LGBTQAI2+) or other sexual minorities also face unique challenges navigating crisis and non-crisis settings. Existing data has not yet included these various identities, yet it does point to concerning trends that are relevant to crisis contexts. For example, LGBT populations are more likely to suffer from affective, anxiety, and substance use challenges than the heterosexual population (49) and approximately twice as likely to attempt suicide.⁷¹ Actual suicide rates for LGBTQAI2+-identifying individuals are not available given sexual orientation is not reported at death,⁷² but studies suggest that sexual minorities are four to six times more likely to attempt suicide resulting in injury that requires medical treatment.⁷³

LGBTQ-identifying individuals may face overt and implicit discrimination based on their sexual identity including discrimination in the clinical setting.⁷⁴ There may be additional concerns about safety and privacy for sexual minorities in crisis residential settings, issues which remain difficult to fully assess given the extent of variation across systems and institutions. Nevertheless, research suggests that crisis services tailored to LGBT populations may help mitigate suicidal behavior⁷⁵ and other symptoms. Clinicians and health systems should consider sexual identity as part of their biopsychosocial assessment in order to address the needs of this diverse population, improve access to care for experientially oppressed persons, and provide equitable treatment for a diverse population of individuals in need of crisis services.

Persons with Neurodevelopmental Disorders in Crisis Settings

Intellectual developmental disorder (IDD) encompasses a spectrum of disorders that limit intellectual functioning such as reasoning, learning, and integration (e.g., problem-solving), and adaptive behavior (conceptual, social and practical skills).⁷⁶ Autism spectrum disorder is one of the most common neurodevelopmental disorders, characterized by impairments in social communication, restricted and repetitive behaviors, and abnormal language development and ability, and may or may not be accompanied by intellectual developmental disorder. Neurodevelopmental disorders frequently co-occur with mental health disorders.

Psychiatric disorders such as major depressive disorder, bipolar disorder, and neurocognitive disorders may be three to four times more prevalent in the IDD population.⁷⁷ Individuals with autism spectrum disorders are at an increased risk of presenting with psychiatric emergencies.⁷⁸ Moreover, while inadequate bed availability has led to prolonged boarding times and delays in care for many individuals with mental illness,⁷⁹ individuals with IDD are at increased risk of longer emergency department boarding times.⁸⁰ Individuals with IDs often have more varied and complex presentations

when compared to the general population. Individuals with deficits in communication may have anxiety, mood, or psychotic experiences that manifest in aggressive, externalizing, or disruptive behaviors that may be poorly understood when presenting to crisis service providers less familiar with these underlying conditions or the individuals themselves. Deaf and other hard of hearing individuals also face additional barriers to crisis care and may be misdiagnosed as having intellectual or developmental disabilities.⁸¹

Given the rate of psychiatric comorbidities in the IDD population and the eligibility restrictions for developmental disability services (these state agencies have different names in different states), persons with IDD may also be inappropriately referred for psychiatric treatment.⁸² In these cases, psychiatric treatments for functional or adaptive behaviors where there is no mental illness may be ineffective at best and potentially harmful at worst. However, cognitive symptoms may often overshadow psychiatric symptoms among IDD populations presenting for crisis services, especially among individuals with a more severe cognitive disability. Individuals with more significant cognitive symptoms may be less adept at communicating the burden of their affective and psychotic symptoms, leading to crisis assessments that may not fully capture symptom severity.⁸³ Individuals with mild intellectual disabilities may often display a "cloak of competence," demonstrating functional and adaptive skills that may mask underlying cognitive and psychiatric impairment.⁸⁴ Crisis services must work with community mental health providers to create partnerships that divert emergency department (ED) visits, enable other care providers to recognize and intervene in crises, and build alliances with school systems.⁸⁵

Additionally, individuals with IDD may be particularly vulnerable to psychosocial stressors.⁸⁶ For example, self-injury may be a symptom of a psychiatric disorder or functional behavior in individuals with IDD to communicate pain, discomfort, and unhappiness. Similarly, aggressive behaviors may result from disinhibition that is seen in many psychiatric disorders or "escape-avoidance" behaviors commonly used in IDD populations to avoid activity.⁸⁷ In delivering crisis services, it is important to differentiate whether behaviors in individuals are employed to serve a purpose (i.e., functional) or are the result of some interactional environment and processing component. For example, environmental stimuli may include lighting, small spaces, and noise. Crisis services, which often treat patients with acute mental health needs, may be particularly overstimulating for this population. Additionally, since often behavior is the focus of attention for individuals with neurodevelopmental disorders, underlying mental health and medical conditions may be overlooked. Thus, clinicians' psychiatric evaluations should include a broad assessment of individuals' functional strengths and limitations to provide individualized patient-focused treatment.⁸⁸ A biopsychosocial approach is essential in determining the appropriate treatment for patients with complex needs. Crisis services must provide healing environments with appropriately trained staff to meet the needs of patients with IDD.

Many individuals with IDD may not be embedded in the systems designed to address their unique needs. Because of system structure and funding streams, individuals with mild to moderate disability, or disabilities that developed after adulthood, may not meet eligibility criteria for state developmental disability services, yet they are still likely to require psychiatric consultation and emergency services.⁸⁹ Given these trends, it is not surprising that individuals with IDD are more likely to use psychiatric emergency services compared to the general population,⁹⁰ and could benefit from an expanded crisis service continuum that is adept at understanding their needs.

Medically Complex Care in Crisis Settings

Underlying medical illnesses are common among persons with serious mental illness. This well-known fact—that persons with mental illness are likely to have other preexisting medical conditions—likely

contributes to the higher risk of death from chronic disease in individuals with chronic persistent mental illness. In fact, individuals with serious mental illness die 8-25 years earlier than the general population.⁹¹ The causes of these deaths are linked to accidents, homicide, suicide, and the increased burden of physical and medical illnesses.⁹² Also, persons presenting in crisis may present with depressed or elevated mood, changes in energy and motivation, impulsivity, agitation, and cognition. Cognitive changes are often the most difficult to assess and diagnose, and may arise from medical, neurologic, and psychiatric conditions including substance use disorders and normal age-related changes. Medical causes may include metabolic deficiencies such as hypoglycemia, thyroid disease, or electrolyte abnormalities, as well as trauma, epilepsy, and delirium, acute intoxication or substance withdrawal, to name a few. Altered mental status may include agitation, disinhibition, and psychosis from underlying psychiatric conditions, neurocognitive disorders, toxic metabolic causes, or medical conditions.

One challenge faced by individuals with complex medical needs is that crisis services such as residential and crisis stabilization units may restrict admission to them. Depending on the placement, an individual may be required to be "medically stable" or "medically clear" before admission. This status may be assessed by a recent history and physical exam, laboratory and imaging tests, documentation excluding infectious or communicable diseases (see below for more on this), and an assessment of the individual's physical ability or limitations. Persons must generally be able to move about independently (even with a wheelchair) and able to feed, groom, and care for themselves. These requirements are usually based on the limitations of crisis services in providing higher levels of medical care. These limitations can pose considerable barriers to access of crisis services for elderly, persons with chronic co-occurring psychiatric and medical conditions, complex substance use disorders, or disabled patients, as noted above, which often leaves these populations to have their mental health needs addressed within emergency rooms when that level of care for their mental health situation, or their medical situation, is not be needed.

Although crisis mental health and substance use services treat patients with a range of the above-mentioned acute psychiatric issues, many states require ambulances to deliver patients to hospital emergency departments for reimbursement as an "emergency", and often crisis services, such as crisis stabilization and crisis drop-off as well as crisis residential programs do not directly accept patients transported by ambulance for an emergency. Ensuring that individuals access the best door to care that is needed makes this an area ripe for further development. Consensus statements and state efforts have been established that help outline a common understanding of medical clearance as a way to manage some of the tensions and limit delays that can arise in this interface.^{93 94 95} These protocols can help delineate more clearly whether medical screening has been sufficient to allow for access to a crisis service especially after such screening in a hospital emergency department. They can also help minimize the risk of missing a critical underlying medical concern. Given the important balance to ensure proper safeguards for well-being of crisis service recipients, the interface with medical systems and the partnerships between crisis systems and medical systems is critical. Rather than operate totally in parallel, these partnerships should be established in intentional ways to help people access the best door to care as needed.

Infectious Diseases in Crisis Settings with Lessons Learned from COVID-19

Crisis services provide care for patients with increased risks of transmission of infectious and communicable diseases. Many individuals with severe persistent mental illness and serious substance use disorders are un-domiciled, may live in congregate living environments, residential settings, board and care facilities, multiple unit dwellings, dormitories, and other arrangements that may bring them

into close contact with other individuals with high-risk for communicable disease. Moreover, mental health and substance use care is often provided in shared spaces and groups that bring individuals in close proximity. While the global spread of the coronavirus disease 2019 (COVID-19) arising from severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has changed the landscape for all types and levels of medical care, its effect on mental health and substance use services has been dramatic.⁹⁶ Crisis services sites and even mobile crisis services vary widely in their funding, specific practices, state and local restrictions, and access to resources and supplies needed to provide infection-related safe care and limit the spread of communicable disease.

In general, crisis services must meet various Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), and other regulatory requirements and local and institutional policies regarding infection control. They must also be prepared as a critical part of a community's disaster response to help address the emotional needs of individuals who are dealing with trauma, shifting economics, substance use and a host of other factors. Yet the COVID-19 pandemic created an urgent need to re-tool practices to meet these requirements.

The care provided throughout behavioral health systems including crisis services has undergone dramatic shift in the context of COVID-19, with telecare becoming more widely used. Physical distancing is endorsed when care via video or telephonic interface can be provided safely and effectively. Strategies for acute psychiatric bed availability have ranged from reduced census levels to minimize the number of potential exposures to allocating beds for general medical use to meet the demands of potential surges in infections.⁹⁷

With regard to infection control, residential based facilities have long required screening documentation for tuberculosis. Now, more work will need to be added related to management of other infectious conditions. Given frequently evolving standards and requirements, the challenge of meeting new standards will require adapting to new information resulting in shifting expectations. These include identifying the types of resources needed and available, including sanitation practices and supplies, personal protective equipment (PPE), testing and laboratory access, and other materials.

The lessons of COVID-19 are many, and highlight the social, structural and infrastructural inequalities in various health systems. Many underfunded, understaffed and overtaxed systems have had difficulty providing services with greater need despite fewer resources. The burden of physical illness has had a disproportionate impact on ethically and racially oppressed persons, who as have been discussed earlier, face a number of barriers and systemic disadvantages when navigating the mental health care system. Perhaps more importantly, the health system's challenges in mounting a timely and effective response highlighted the vulnerabilities in behavioral health systems including crisis services. Logistical challenges in managing COVID-19 in settings that were not as readily geared toward infectious disease spread prevention, as well as persistent disparities in access to resources and health outcomes raised increased awareness of the community. Through advocacy and leadership, state and local behavioral health leaders have been able to respond to evolving trends in these areas. As crisis services develop, their ability to nimbly continue to operate, to use tele-practices as appropriate and still to be able to adequately assess individuals in need wherever they are will continue to be critical.⁹⁸ Crisis service supports will continue to necessitate certain instances when a face-to-face encounter is required in the crisis context, and when that happens, the providers will need to ensure proper protection from viral spread for staff and the person being assessed. As part of the care continuum, crisis services will undoubtedly continue to take lessons learned from this pandemic and apply them to the program design of the future.

Criminal and Juvenile Justice System involvement in Crisis Settings

Individuals with serious mental illness and substance use disorders are overrepresented in the criminal justice system,⁹⁹ and this is also true for the juvenile justice system.¹⁰⁰ Increasingly, stakeholders have advocated for addressing the under-recognized influence of underemployment and poverty, housing instability and un-domiciled status, educational, vocational attainment, residential segregation and environment mental health and criminal justice system involvement.¹⁰¹

Crisis mental health and substance use services often work alongside jail diversion programs, veterans' treatment, mental health and drug courts, and reentry programs.¹⁰² The sequential intercept model is a framework for understanding the criminal justice system as a series of decisions, inputs, and mechanisms along a continuum of penetration into the carceral system.¹⁰³ Whereas the model generally began at intercept with individual involvement with police often leading to arrest, scholars have more recently expanded this model to advocate for earlier intervention to include intercept 0, recognizing community crisis services as critical to diverting individuals from criminal justice system involvement.¹⁰⁴

Fully implementing crisis services would address many of the issues identified as needed at the intercept 0 to help route individuals of all ages into treatment in lieu of criminal-legal or juvenile justice involvement. The workforce and service design of crisis services must therefore be able to appropriately engage individuals who have been or are at risk of involvement in criminal justice and juvenile justice systems. There are numerous challenges to working across these populations.

One formidable challenge to community collaboration with these programs stems from differences in jurisdiction and funding. Jail diversion programs may be often local or county-run programs operating in conjunction with sheriffs, jails and courts. As crisis services are typically funded and regulated in a complex interplay of local, state and federal levels, they may prioritize resources differently.

Barriers to communication across prosecutorial, correctional, and criminal and mental health and substance use systems may impose additional obstacles to intervention and diversion. Individuals such as those found incompetent to stand trial are an example of a population that is often caught between these systemic issues.^{105 106} Barriers to communication and coordination has also been particularly exemplified recently during compassionate release initiatives as a result of the COVID-19 pandemic. Without careful planning for these populations, their risks related to other conditions including opioid use disorders, worsening mental health conditions as well as medical conditions could collide toward negative outcomes in the community or a return of mental health symptoms.¹⁰⁷ With the fear of viral exposure, many of these individuals also may not be accessing emergency or crisis services, or they will be accessing them when their needs are direr. Recent data highlighting increased opioid overdose rates¹⁰⁸ makes these concerns even more salient. Over time more will be learned about population outcomes as systems shifted responses to the epidemic. Still, crisis services undoubtedly serve as the safety net for those that have been involved in, or are at risk of involvement in criminal and juvenile justice systems and thus must offer opportunities for diversion from criminal-legal involvement.

Implications and Conclusions

In summary, crisis services work with a variety of unique populations whose needs warrant consideration and planning to make these services welcoming for anyone who presents with crisis needs. Individuals with severe and persistent mental illness or those with chronic substance use

disorders in crisis are only some of the populations served. Older adults, youth, individuals with neurodevelopmental disabilities, those with co-occurring complex medical conditions and others present in crisis as well. In addition, systemic issues including structural racism and developing services for vulnerable populations such as LGBTQAI2+ and immigrants must be addressed across the psychiatric care continuum including crisis services.

Although public health and community mental health systems cannot solve structural violence, poverty, and discrimination alone, crisis mental health and substance use systems need to help foster integrated systems of care that recognize these disparities and create safeguards against further perpetuating existing inequalities. As such, providers working within them must be aware of these unique threats and develop and implement strategies to mitigate the risk of worsening the risk factors that vulnerable populations already face. Finally, with the lessons learned from the COVID-19 pandemic, it is clear that crisis services will also need to be adept at dealing with infectious disease and partnerships with local health services with evolving policy and practice.

This review highlights some of the diversity reflected in populations that can present in crisis settings. A robust, comprehensive, and responsive crisis system should be equipped to address the needs of anyone who accesses it, regardless of the point of entry in the crisis continuum, and regardless of the individual's socio-economic status. Given this significant task demand, community stakeholders, mental health and substance use providers and clinicians, as well as crisis services programs must emphasize holistic person-centered care, value and prioritize health equity, protect patient autonomy, confidentiality, and preferences, and consider their community's cultural and demographic composition in providing crisis services. This requires more than understanding the social determinants of health or merely reflecting the culture of populations in services, as individuals with diverse needs often have more structural barriers that can make it more difficult to access care in mental health systems. Crisis services must not simply endeavor to provide evidence-based care using a biopsychosocial and cultural lens. In order to account for the various barriers to entry into care, crisis services should, in fact, emphasize these unique needs and differences among these populations in order to encourage individuals to engage in mental health and substance use support even as barriers may otherwise limit their access to such care. This will require partnerships and advocacy. The time is ripe to develop the crisis service continuum to meet these challenges.

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Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm

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Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm

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Perhaps the most potent element of all, in an effective crisis service system, is relationships.

To be human. To be compassionate.

We know from experience that immediate access to help, hope and healing saves lives.

- SAMHSA 2020,
*National Guidelines for Behavioral Health Crisis Care
Best Practice Toolkit*

Background

The lack of a comprehensive coordinated crisis response system for children and youth has resulted in inconsistent care, repeated emergency department (ED) visits and hospitalization, and arrests and detention for youth whose crises are responded to by law enforcement rather than behavioral health providers^{1 2 3}. SAMSHA has recently emphasized the importance of crisis services that are available to **anyone, anywhere, and any time**, and which do not lead to delays, detainment, or denial of services, or create undue burdens on those afflicted, or on EDs, law enforcement, or the justice system⁴. This vision is perhaps most critical for our youngest citizens, whose behavioral health challenges can often be prevented or identified early, yet are often neglected, at a high cost to society and to the quality of life of many children and families.

Behavioral health disorders are described as serious changes in the way children typically learn, behave, or handle their emotions, leading to distress and problems getting through the day.⁵ The prevalence of chronic behavioral health disorders continues to grow among youth, doubling in the past decade, and impacting 20–25 percent of school-aged youth^{6 7}. In children aged 3-17, the most commonly diagnosed behavioral health conditions in children are anxiety (7.1%), ADHD (9.4%), disruptive behavior disorders (7.4%), and depression (3.2%); these conditions often are comorbid, and are more common among children impacted by poverty and other social determinants of health^{8 9}. Suicide is currently the second most common cause of death in young people (ages 10-24) in the United States, and suicide rates in youth have increased 56% over the past decade, with the greatest increases occurring since 2014.¹⁰ People younger than 25 years of age account for 45% of the global burden of disease from behavioral health conditions.¹¹

With the rise in behavioral health disorders, we have seen a parallel increase in behavioral health crises among children and adolescents in the United States¹. These crises are typically addressed by engagement with EDs, law enforcement, or psychiatric inpatient care^{2 3}. Children in crisis are frequently

boarded for long periods in EDs or receive short inpatient stays, often resulting in readmission. Many concerns that result in hospitalization may have been prevented or better served via community-based care models with appropriate wraparound supports.

Challenges with the Current Child and Adolescent Crisis System

Limited prevention, early identification and intervention

Emotional and behavioral health challenges in children can often be prevented or diminished with early, immediate identification and action, yet our care systems often do not reflect this reality. The benefits of prevention and early intervention for physical health are now well-recognized. Routine screenings and checkups, and awareness of signs and symptoms that allow early detection and intervention, are increasingly implemented in pediatrics. Such routine screening and behavioral health checkups have lagged in child behavioral health,¹² with those under age 25 experiencing the greatest delay to initial treatment after initial symptom onset.¹³ Currently, less than half of children with a behavioral health condition receive any behavioral health treatment,¹⁴ resulting in estimated costs of approximately \$247 billion annually from this lack of behavioral health treatment.¹⁵ A number of factors, including persisting stigma and lack of providers, have slowed the emphasis of behavioral health early intervention, leading to much more costly downstream or late intervention, when behavioral health crises necessitate urgent, dense, and often lengthy interventions.¹⁶ The World Health Organization recognized that addressing childhood adversities, particularly those associated with maladaptive family functioning, such as parental mental illness, child abuse and neglect, would lead to a 30% reduction of any lifetime mental disorder, and a 39% reduction in child mental disorders.¹⁷ Moreover, these childhood risk factors and adversities contribute to children having further recurrence of mental disorders later in life.¹⁸ Promoting early detection of behavioral health symptoms and implementing prevention and early intervention strategies that enhance children's emotional and behavioral regulation slows and alters the progression and impacts of child mental illness.

Misuse of Emergency Departments (EDs)

Pediatric behavioral health ED visits nationwide have increased dramatically across the United States in recent years. EDs are typically the first point of contact for children having any type of crisis. Despite its frequency of use, the ED has become an unattractive option to manage behavioral health crises for multiple reasons.¹⁹ First, EDs have become overburdened with non-emergent, inappropriate behavioral health referrals. The ED has become a prime route for patients after hours, once clinics close, and at least one-third of these referrals are not truly urgent. Similarly, about half of the students sent by schools to the ED for behavioral health conditions are inappropriate (i.e., low severity of presenting complaint, low harm potential, absent suicidality or psychosis, and/or no recommended behavioral health follow-up).²⁰ Second, children with limited resources are routed to the ED amidst an escalation or conflict, yet rarely does ongoing behavioral health care result; children with public health insurance or no health insurance are four times more likely to seek mental health treatment at the ED than children with private insurance.²¹ Third, ED staff are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis, despite most behavioral health crises arising from aggressive outbursts or escalations.²² Fourth, despite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises.^{23 24} So behavioral health crises routed to the ED more often result in subsequent ED visits, more testing, longer stays, and boarding for hours to days until transfer from the ED to a suitable placement can occur.²⁵

Law Enforcement Involvement in Child Behavioral health Crises

As first responders, police are frequently accessed for behavioral health crises in children and families. Police are usually poorly prepared for managing behavioral health crises, and feel time pressured to

deescalate situations quickly or to then employ more familiar policing strategies, which too often lead to arrest and detention. An adult with a behavioral health condition is six times more likely to get arrested than someone without a serious mental illness,²⁶ and 16 times more likely to get injured or die during encounters with the police.²⁷ Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder,²⁸ 60% of children with an emotional disturbance will be arrested at least once within 4 years after leaving high school, and 39% report being on probation or parole.²⁹ Most police academies devote less than 1% of training to interactions with adolescents,³⁰ yet 20% to 40% of juvenile arrests are for “contempt of cop” offenses, such as questioning or “disrespecting” an officer.³¹ Incarceration of adolescents fails to decrease recidivism and compounds the negative impacts on the 60-70% of youth in correctional facilities who have significant untreated behavioral health problems.^{32 33}

Racism and Inequity

Despite many emotional and behavioral crises in children and youth resulting from unmet behavioral health needs, crisis events are often responded to with disciplinary or legal action, disproportionately affecting Black and Latinx/Hispanic students compared to White youth³⁴.

System challenges contribute to a preference for disciplinary versus behavioral health response, including implicit bias and racism among educators and health providers, and fewer behavioral health resources and instead greater law enforcement presence in communities of color³⁵. In schools, where most ED referrals for child and adolescent crises arise, educators are usually inadequately trained to identify and address behavioral health concerns³⁶. Further, “zero tolerance” policies remain common, despite evidence that they are counterproductive and disproportionately negatively impact youth of color³⁷. Ultimately, when youth of color experience emotional and behavioral health crises, they are often met with education and health systems that favor a discipline response over a behavioral health response. In addition, inequities in behavioral health care access, utilization, and quality persist for children and adolescents³⁸. Disparities are often attributed to challenges such as stigma, cost, and transportation, but also result from the systemic racism within our behavioral healthcare institutions that lead to limited access and poor quality of care for youth and families of color³⁸.

A paradigm shift

The challenges outlined above illuminate the need to reconfigure the behavioral health crisis system to better provide coordinated, specialized and equitable crisis prevention and intervention for all children and youth. In 2020, SAMHSA introduced national guidelines for behavioral health crisis care, calling for system transformation toward a more proactive, compassionate, efficient and effective system for those experiencing crises⁴. Core principles of the guidelines include addressing recovery needs, engaging peers, utilizing a trauma-informed and zero suicide approach, and collaborative partnerships with law enforcement, dispatch and emergency medical services (EMS). While many of the principles and practices apply across the lifespan, some additions and adjustments must be considered for application with children and adolescents and their families. Fortunately, the core principles of the new national guidelines align well with System of Care principles that have been adopted and adapted by many state and local systems for children and adolescents, including family- and youth-driven care, cultural and linguistic competence, preference for community-based services, and interagency collaboration³⁹.

Multiple current conditions uniquely position us to establish a comprehensive, high-quality child and adolescent crisis system: (1) the 2020 introduction of SAMHSA behavioral health crisis practice guidelines; (2) the recent Federal Communications Commission (FCC) approval of the 9-8-8 behavioral health crisis hotline (to expand our existing 9-1-1 emergency response); and (3) a multitude of lessons and innovations from the global COVID-19 pandemic to inform crisis system transformation. In this brief,

we offer best practice considerations for achieving a paradigm shift in our child and adolescent crisis system, away from a reactive and fragmented approach toward a full continuum of supports and services, built on the collaboration of child-serving systems and leveraging current technology. We will first highlight opportunities to “work upstream”; that is, to prevent crises before they occur and diminish them when they do arise by leveraging the natural support systems already available to children and families, including schools, pediatric primary care and community partners. We then outline child-specific considerations to augment the SAMHSA Crisis Best Practice Toolkit, with an emphasis on developmental attunement, youth and family engagement, and cultural responsiveness and equity. Finally, we derive policies from lessons learned in the context of COVID-19, including ways to harness and expand technology to augment care quality and access.

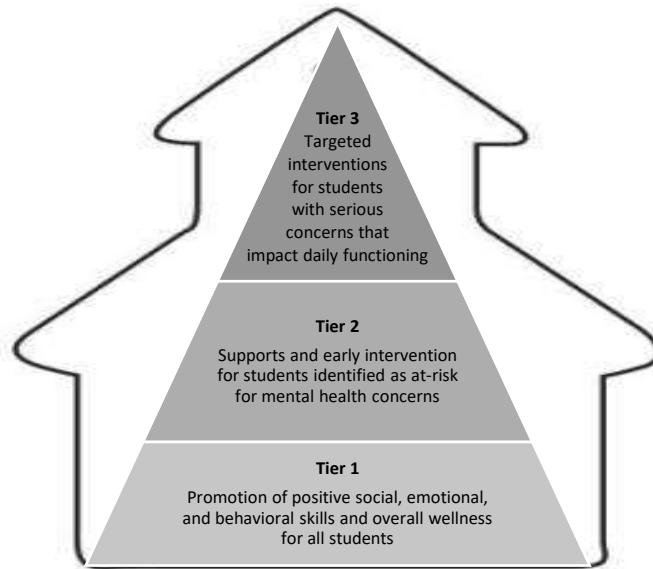
[Working Upstream: Prevention and Early Intervention in Child and Adolescent Crisis](#)

In a 2018 brief to the National Association of State Mental Health Program Directors (NASMHPD), states and communities were described as increasingly shifting delivery systems for children’s behavioral health to an upstream approach that minimized unnecessary use of acute care settings, such as emergency departments, psychiatric hospitals, and residential treatment facilities.⁴⁰ The brief described the value of Mobile Crisis Response and Stabilization Services (MRSS) as an approach that identified problems early, before intensive psychiatric care (e.g., inpatient or residential treatment) were needed. Moving further upstream than the MRSS, other resources and interventions exist that may both prevent and intervene early to diminish children’s emotional and behavioral health crises. Many mental illnesses that lead to behavioral health crises could have been identified and treated earlier in their trajectory, likely lessening the negative outcomes for children and families, including the experience of crises. Further, many of our youngest citizens, especially youth of color, experience disciplinary responses, such as juvenile services and incarceration, for behaviors that could have been prevented or best addressed with a behavioral health response³⁴⁻³⁸. This is a fundamental tenet in building a comprehensive behavioral health care system which cannot be overstated and should be a focus of every conversation regarding crisis response systems. Although we must address current failings in our current crisis response system for children, we should only do so while simultaneously building universal behavioral health promotion and early identification and intervention systems to minimize crises from occurring in the first place.

Schools

Increasingly, schools are installing *comprehensive school mental health systems (CSMHS)*, reflecting partnerships between education and behavioral health sectors to support a full continuum of behavioral health supports and services, from promotion to treatment⁴¹. CSMHS provide a full array of tiered services, often referred to as multi-tiered systems of support (MTSS; see Figure 1), including universal behavioral health promotion activities for all students, selective prevention activities for those most at risk to develop behavioral health conditions, and indicated early intervention services such as clinical assessment and treatment for those students who screen positive for behavioral health conditions. CSMHSs rely on meaningful partnerships between school systems and community programs so that children are supported by collaborative school-employed behavioral health professionals and community behavioral health providers.

Figure 1. Multi-Tiered Systems of Support (MTSS) in Schools



When treatment is delivered in the school setting, youth are far more likely to be identified early, and to initiate and complete care^{42 43 44}. Further, interventions delivered in schools have demonstrated positive impact on multiple of children’s psychosocial outcomes. Schools across the nation are increasingly delivering universal programming, with students participating in social emotional learning (SEL) programs demonstrating significantly greater social-emotional skills (e.g., emotion regulation), prosocial behavior and positive self-image, and significantly fewer conduct problems, emotional distress and substance use problems than their peers who do not receive such programming^{45 46 47 48}. Behavioral health treatments delivered in schools have demonstrated success at reducing mental illness, including anxiety and depression^{49 50}, post-traumatic stress^{51 52 53}, behavior disorders^{54 55}, and substance use problems^{56 57}.

An essential component of CSMHS is crisis prevention and response. The installation of a comprehensive MTSS has been demonstrated to reduce emotional and behavioral health crises⁵⁸. Despite many emotional and behavioral crises in schools resulting from unmet behavioral health needs, crisis events too often lead to unnecessary disciplinary or legal action by schools,⁵⁹ which disproportionately affects Black and Latinx/Hispanic students compared to White students⁶⁰. System challenges also contribute to disciplinary over behavioral health responses in schools, such as inadequate training of school staff to identify and address behavioral health concerns^{61 62}, overburdened educators and inadequate student instructional support staffing, and limited response mechanisms to support behavioral health interventions relative to typically well-specified disciplinary procedures⁶³. Successful school crisis prevention and response involves a comprehensive approach that installs a continuum of behavioral health supports and services, including universal focus on positive school climate and social emotional learning, behavioral health literacy for teachers and students, crisis preparedness for all school personnel, a focus on educator and school staff well-being, and availability of on-site school behavioral health providers, including both school- and community-employed professionals. Box 1 illustrates a

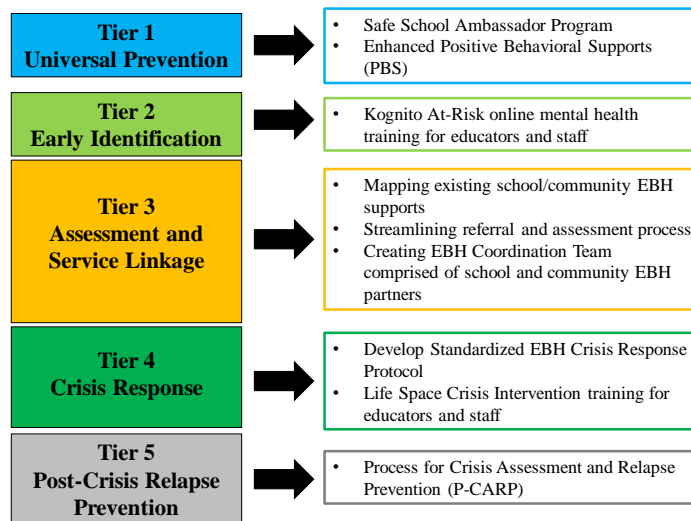
comprehensive school-based crisis prevention and intervention initiative recently studied as part of the National Institute of Justice Comprehensive School Safety Program.

Pediatric Primary Care

Pediatricians remain a trusted and frequently accessed avenue for children and families to obtain behavioral health support. Over 70% of children and adolescents under age 18 see a primary care provider annually,⁶⁴ and parents and youth report feeling comfortable discussing behavioral health

Box 1. The School Emotional and Behavioral Health (EBH) Crisis System was installed and studied as part of a randomized controlled trial (RCT) funded by the National Institute for Justice. As illustrated, at the universal level (Tier 1), the Safe Schools Ambassadors program offered peer training for students from various social groups in conflict management and bullying prevention. At Tier 2, an online virtual simulation technology trained teachers in how to support students experience psychological distress. In addition to creating clear referral, assessment and coordination of school and community behavioral health supports (Tier 3), all education staff received crisis response training using the Life Space Crisis Intervention program (Tier 4). Finally, a structured process was implemented for post-crisis response relapse prevention (Tier 5).

School Emotional and Behavioral Health (EBH) Crisis System



The system is now established as a “Promising Program,” with the initial RCT demonstrating increases in school staff knowledge and preparedness to address emotional and behavioral health issues and increases in student actions and behaviors to prevent mistreatment and improve school climate. Intervention schools also had 56% fewer suspensions, 75% fewer office referrals, and more on-site crisis response and threat assessments as opposed to off-site referrals to EDs or law enforcement. For more information:

https://www.crimesolutions.gov/ProgramDetails.aspx?ID=677&utm_source=govdelivery&utm_medium=email&utm_campaign=csreleases

issues with their primary care providers.^{65 66} Pediatricians may be particularly helpful in apprising families of a 9-8-8 system as that emerges, and in providing families de-escalation approaches and behavioral health checkups during routine physical checkups. For more complex issues, collaboration and behavioral health support for pediatricians by behavioral health providers has emerged as an effective approach, with improved behavioral health outcomes for youth compared to usual care.⁶⁷ The elements most effective for collaborative care include population-based care (systematic efforts to screen or track all patients for a condition and track outcomes), measurement-based care (using validated tools to identify and monitor responses to treatment of particular behavioral health conditions), and evidence-based behavioral health services (specific psychological interventions such as motivational interviewing, problem-solving, psychotropic prescribing, psychoeducation).⁶⁸ A guide for initiating collaborative behavioral health care within pediatric primary care has been devised by the American Academy of Child and Adolescent Psychiatry and is freely available on their website (https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf).

Multiple approaches have improved infusion of behavioral health promotion and early intervention into contemporary pediatric care. First, *child psychiatry access programs* (CPAPs) are a “facilitated referral model,” (coordinated care model) where pediatricians have rapid (within an hour) access to behavioral health providers located off-site, and who consult to pediatricians about mental conditions, including crises, but do not absorb the direct care of these patients. CPAPs have now been implemented in over 30 states in the past decade. The initial Massachusetts Child Psychiatry Access Program (MCPAP) has remained the model most states now emulate. Initial calls from the pediatrician are immediately triaged by a MCPAP care coordinator who either (a) provides the pediatrician viable behavioral health resources (e.g., a counselor appropriate for the child’s condition, who is geographically feasible, and who takes the family’s insurance), or (b) connects the pediatrician, within 60 minutes, to a MCPAP child psychiatrist, psychologist, or social worker to discuss the case and plan treatment. While the MCPAP behavioral health provider does not assume care of the child/family, they remain a consultation support for the pediatrician to manage the case, or until care is transitioned, if necessary, to a local behavioral health provider for ongoing treatment. Over 95% of Massachusetts pediatricians participate in the program, and satisfaction with services has remained high since creation of the program.^{69 70} There is now an existing national infrastructure, the National Network of Child Psychiatry Access Programs (NNCPAP) of now 30+ state programs, to support pediatric primary care physicians as they manage psychiatric issues of their patients.⁷¹ These programs initially relied on remote calling centers, but now many include face to face evaluations patients with unclear diagnoses, and also telepsychiatry meetings with patients. In addition, most of these CPAP programs maintain active websites (e.g., www.mcpap.org, www.dcmmap.org) with efforts to provide pediatricians effective screening tools for both general and specific behavioral health monitoring, and provide ongoing guides and recommendations to address common behavioral health concerns. These CPAP programs provide an alternative rapid route for children and families experiencing urgent behavioral health needs, and also an opportunity for mass distribution of relevant mental information (e.g., 9-8-8 information, de-escalation approaches for families) through the NNCPAP network that allows relevant information to be applied to specific regions or States.

Second, co-located models, in which behavioral health clinicians are housed in primary care settings to provide direct care and consultation provide another model where families can be more easily seen by a

behavioral health clinician on-site (or virtually by telehealth) familiar and more easily accessible to the pediatrician. Data are promising for on-site co-located behavioral health providers, with reports that 85% of patients follow through to attend their first appointment, and 84% of patients report showing improvement over a 6-month interval.⁷² Co-located providers appear effective in diverting patients from visits to the ED; over a six month period, embedded predoctoral psychology interns in one pediatric clinic were able to provide 184 “warm handoffs,” 250 same-day behavioral health consultations, 223 follow-up appointments, and to manage onsite 21/23 (91%) patients who reported suicidal/homicidal ideation (and who otherwise would have been referred to the ED for further evaluation).⁷³

Community Partners

Schools and primary care providers are parts of most communities and can serve a critical role in crisis prevention and response. Additional important partners for addressing behavioral health care are local community organizations, sometimes unique to the area. Identifying those community organizations that have aligned goals and interests is important for configuring a collaborative behavioral health system, including crisis prevention and response. Multiple types of organizations may enhance the collaborative care system for a community, such as:

- Mentorship programs (e.g., Big Brother/Big Sister)
- After school programs
- Recreation and parks programs
- Youth sports leagues
- Youth and family advocacy organizations
- Faith organizations, youth groups

To create a behavioral health crisis management system for children and adolescents, mapping the local resources to identify important partners can significantly expand local, familiar, trusted supports for both children and families who have experienced behavioral health crises.

Best Practice Considerations for Child and Adolescent Crisis Systems

Consistent with the premise described by SAMHSA that crisis services must be available to **anyone, anywhere, and anytime**, best practices indicate that a child and adolescent crisis continuum should be available 24/7 to all children, regardless of payer⁷⁴. A comprehensive crisis continuum includes screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination. These components, articulated in the 2018 NASMHPD *Making the Case for a Comprehensive Children’s Continuum of Care*, align with the 2020 SAMHSA practice guidelines for crisis behavioral health. The guidelines specify three organizing categories of support that must be embedded in any comprehensive crisis system:

- 1) Regional Crisis Call Hub Services (*Someone to Talk To*)
- 2) Mobile Crisis Team Services (*Someone to Respond*)
- 3) Crisis Receiving and Stabilization Services (*A Place to Go*)

We will describe each component briefly, followed by considerations for how to best fit these to the child and adolescent system context.

Regional Crisis Call Hub Services (*Someone to Talk To*)

Regional crisis call services allow for real-time access to a live person 24/7/365 to support those experiencing behavioral health crises. As of July 2020, the FCC approved a national 9-8-8 behavioral health crisis number, to be fully installed by July 2022, that will increase access to immediate crisis support via this one easily recognized and remembered number. Minimally, regional crisis lines are staffed by clinicians with expertise in behavioral health crises and suicide risk assessment, and who are equipped to triage callers to appropriate mobile teams or facility-based care, as warranted. Best practices call for regional crisis services to have Caller ID functionality, utilize GPS-enabled technology to dispatch mobile care when needed, utilize real-time bed registry data to connect to facility-based care, and schedule community-based follow-up care akin to a warm handoff following the crisis episode.

To meet the needs of children and families in crisis, regional crisis call hub services should consider the following:

- **Expand technology options for callers**, including the use of texting, telephone and telehealth. Children and adolescents may prefer to seek crisis support via texting or videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing.
- Akin to how we begin teaching children about 9-1-1 in preschool, **educate children in preschool and throughout K-12 schooling about how to access regional crisis call services** (e.g., OK2SAY program, <https://www.michigan.gov/ok2say/>), preferably as part of behavioral health literacy education in the curriculum. Education should emphasize help-seeking efficacy and destigmatizing of mental illness and seeking support.
- All regional center calls pertaining to child and adolescent concerns should be staffed by individuals with **specialized training in child and adolescent development and behavioral health and illness**. This would include an understanding of typical developmental milestones, how to promote positive behavioral health, and how to distinguish typical challenging behaviors of childhood and adolescents from behaviors that reflect a more serious concern. They should be familiar with child behavioral health and developmental disorders and behaviors or symptoms that differ from those experienced by adults, including autism, sensory processing disorders, developmental delays, separation anxiety, and Attention Deficit Hyperactivity Disorder. See Table 1 for examples of common behavioral health concerns among children and adolescents and how they might be presented during a crisis call.
- Call center staff should have **skills to navigate family systems** during crisis call, including how to diminish conflict and increase safety, engage additional support people, and determine whether speaking with the child or adolescent in crisis will be useful for information gathering and de-escalation. These skills would include how to best engage families as co-supporters and experts about their child, when possible, and addressing any parent/guardian concerns about child safety, including family concerns about being reported to protective services or law enforcement if they seek help.
- Call centers should have **developmentally attuned guidance for de-escalating children and adolescents** and their family members, as needed. This may include how to support family and school personnel in managing conflict and behavior dysregulation, and how to separate, support, and/or distract a child experiencing a crisis.
- All calls should be delivered in a **culturally responsive manner**, with call center staff receiving ongoing training on racism and bias, and the unique strengths and needs of Black, Indigenous and People of Color (BIPOC) youth and families, and how those intersect with behavioral health crises. Interpretation services should be made available to the extent possible (see Pinals, Edwards, 2020)⁷⁵.

- Call center staff should have training in **adolescent reactivity to peer rejection or romantic breakups**, both predictors of suicidality and risk behavior.
- Given the high risk for suicide, bullying, substance use and other behavioral health concerns among **LGBTQ+ children and adolescents**, call center staff need to be versed in supports responsive to this population.
- Call center staff need to be **familiar with school-specific concerns** such as chronic absenteeism or school refusal, aggression and bullying (including cyberbullying) in schools, and emotional and behavior dysregulation that disrupts the school environment, and how these may best be managed in the school setting.
- Call center staff should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Developmental Differences Manifest Differently in Youth

Approximately 75% of behavioral health conditions begin before adulthood. Crisis responders need to be aware of how youth may describe symptoms compared to adults. For example, young children rarely describe being “anxious” or “depressed,” but may instead complain of physical ailments, often week after week, as they may only notice that they feel badly rather than understand why. Youth with depression are often more likely to report feeling angry or irritable than to report feeling depressed or sad, and may stop doing previously enjoyable activities (e.g., riding a bike, playing a sport, etc.) when they become depressed.

In addition, some behavioral health symptoms more commonly occur in youth, and result in crises, such that crisis responders require specific child behavioral health training to be prepared to recognize underlying conditions that may result in a behavioral health crisis. Table 1 describes how parents/guardians may describe a current crisis to a 9-8-8 phone responder.

Table 1: Behavioral health Symptoms Presenting as a Crisis in Youth

Behavioral health Category	How This May Present as a Crisis Call to a 9-8-8 Phone Responder “My Child:”
Autism	<p>“doesn’t speak or look at me or seem to want to engage.”</p> <p>“won’t listen or respond to me.”</p> <p>“freaks out if we don’t do our usual schedule or change our plans”</p> <p>“doesn’t play or show any interest in other children.”</p> <p>“freaks out over normal noises.”</p> <p>“does weird stuff with toys instead of playing with them.”</p> <p>“just wants to swing or rock for hours and won’t stop.”</p>
Anxiety	<p>“won’t go outside, worries about everything.”</p> <p>“won’t be apart from me, wants to know where I am.”</p> <p>“describes having bad dreams every night and comes to my room.”</p>
Attention Deficit Hyperactivity	<p>“doesn’t think before doing dangerous, foolish things.”</p> <p>“refuses to listen to me and do what I ask.”</p>

	"runs into the street or jumps off high places."
Communication Disorders	"is making stuttering sounds." "got into another fight with a peer today because of misunderstanding."
Conduct	"is stealing/shoplifting/vandalizing, assaulting others." "is lying and I can't take it anymore." "is staying out late, disobeying my rules." "is hiding guns/knives/bullets in room." "hurt our family pet/set a fire for no reason."
Disruptive Mood Dysregulation	"is having horrible meltdowns over nothing every other day." "is in a bad mood all the time and can't calm down for hours."
Elimination Disorders	"is peeing all over the place; keeps wetting the bed after told not to." "is leaving poop under the couch; won't clean self after pooping."
Feeding and Eating Disorders	"will only eat a few things." "eats weird stuff—like dirt or hair" "refuses to eat because they'll get too fat." "will eat but then do things so they'll throw up."
Intellectual Disability	"isn't doing or keeping up with schoolwork." "isn't doing what other kids their age."
Learning Disorder	"hates school and refuses to do math/reading/writing assignments."
Movement Disorder	"is making weird movements with arms/legs/mouth/head." "is suddenly now blinking all the time/making weird noises uncontrollably."
Obsessive-Compulsive Disorders	"does this long ritual before they will leave home and freaks out if interrupted." "has pulled all their hair out over the weekend." "has hoarded all kinds of food into a closet, and it's all rotting now."
Somatic Disorder	"keeps saying they have a stomach/headache, refuses to walk." "is very sick, eyes rolling back in their head, and no one believes me."
Traumatic Disorder	"won't stay with a sibling alone at night in a room." "keeps avoiding my relative, who they used to like." "has bad dreams often and will scream or come to my room."

Mobile Crisis Team Services (*Someone to Respond*)

To respond to crises as they occur, mobile crisis teams that offer community-based interventions must be available to support individuals in crisis wherever they are, including home, school, or any other community location. Two-person teams are preferred, with diversion from emergency department or the justice system preferred. Minimally, mobile crisis team services must include a licensed and/or credentialed clinician who can respond wherever and whenever a crisis occurs. This can include home, stores, schools, offices, streets, and even juvenile courts outside of a locked facility in some states. The team will conduct warm hand-offs to facility-based care as needed and coordinate transportation if the situation warrants location transition. Best practices call for peer support (i.e., those with direct experience with the behavioral health system and who are trained to support individuals in crisis) as part of the mobile crisis team to decrease engagement of law enforcement. As above, mobile crisis teams should partner with the regional crisis call center to utilize GPS-enabled technology.

To meet the needs of children and families in crisis, mobile crisis team services should consider the following:

- **Expand technology options for crisis response teams, including the use of telehealth.** Children and adolescents may prefer to engage in crisis support via videoconferencing, as they may feel that these mechanisms are more familiar or less stigmatizing. In addition, telehealth may allow for broader access and improved response time and efficiency.
- For all crises pertaining to child and adolescent concerns, mobile crisis team members should be staffed by individuals with **specialized training** (as outlined above for call responders) including training in:
 - child and adolescent development and behavioral health and illness, including manifestations of child traumatic stress (e.g., difficulties at school, withdrawal);
 - skills to navigate family systems, including how to diminish conflict and increase safety, engage additional support people, and how to best engage child and family in a developmentally appropriate manner to gather information and de-escalate crisis;
 - the escalation cycle across the developmental spectrum, and developmentally attuned de-escalation skills, including approaches like collaborative problem solving and specific strategies (e.g., validate feelings but not actions; see Box 2 for specific child-specific de-escalation strategies from The Crisis Prevention Institute, <https://www.crisisprevention.com/>).
 - culturally responsive crisis management, including skills in supporting the unique strengths and needs of BIPOC and LGBTQ+ youth and families;
 - assessing for child abuse, neglect and family violence and supporting families if a report to child protective services is warranted;
 - assessing parent readiness and ability to implement recommendations and interventions, with consideration for parental behavioral health, cognitive ability, social supports and stressors and economic resources.
- Mobile crisis team members responding to child and adolescent crises should be **familiar with school-specific concerns and school procedures to support students with emotional and behavioral needs**. Team members should be versed in the special education process, including how families can access and advocate for special education programming (e.g., 504 Plans and Individualized Education Programs).
- Mobile crisis team members should understand the array of **child and adolescent supports and service delivery options**, including pediatric primary care, school supports and services, local child and adolescent behavioral health providers, and other community supports. These may include mentorship opportunities, extracurricular activities, faith-based supports, and service, and community service.

Box 2. 18 De-escalation Strategies for Children and Adolescents

1. Don't yell to be heard over a screaming child
2. Avoid making demands
3. Validate their feelings, not actions
4. Don't try to reason
5. Be aware of your body language
6. Respect personal space
7. Get on child's level
8. Use a distraction
9. Acknowledge child's right for refusal
10. Reflective listening
11. Silence
12. Be non-judgmental
13. Answer questions and ignore verbal aggression
14. Movement break
15. Avoid the word "no"
16. Decrease stimulation
17. Deep breathing exercises
18. Calming visuals

Crisis Receiving and Stabilization Services (*A Place to Go*)

During a crisis, it is essential that individuals have a place to go that will accept, support and stabilize them regardless of age or clinical condition. Crisis receiving and stabilization services act as a “no wrong door” mechanism for those in crisis to receive immediate behavioral health support and offer our de-facto crisis responders (i.e., law enforcement, emergency departments) a more appropriate alternative to address crisis. Minimally, crisis receiving and stabilization services accept all referrals (including walk-in and first responder drop-offs), do not require medical clearance prior to admission (but offer medical support, as needed), design services to address mental health and substance use needs, offer 24/7/265 multidisciplinary staffing capable of meeting all levels of crisis and screening for suicide and violence risk, when clinically indicated. Best practices dictate functioning for a 24 hour or less facility with a dedicated first responder drop-off area, incorporation of intensive support beds (including those within the real-time bed registry system), and coordinate connection to ongoing care.

To meet the needs of children and families in crisis, crisis receiving and stabilization services should consider the following:

- Children and adolescents should have a **separate area from adults** to be received and supported during crisis. It can be distressing and frightening to young people to witness adults in crisis, increasing the likelihood that the child's crisis will escalate rather than diminish. The climate of receiving and stabilization needs to be calming, positive, welcoming and compassionate.
- **Receiving spaces should be developmentally attuned**, with places to play and move safely, especially for younger children. For adolescents, who may be particularly concerned about the stigma of seeking help, spaces that allow privacy are optimal. The environment should

be calming aesthetically and include art and signage that is appealing and friendly to youth, and not overstimulating.

- **Telehealth should be available for care provision and engagement of supportive others.** Children and adolescents in crisis may prefer to see providers via videoconferencing, also expanding the capacity for access to limited child behavioral health specialists. Telehealth technologies can be used to integrate other support important in the care process, including school personnel, family members, peers, or primary care providers.
- For all crises pertaining to child and adolescent concerns, crisis receiving and stabilization services should be staffed by individuals with **specialized training** in child and adolescent development and behavioral health (as outlined above for call responders and mobile crisis teams).
- **Medical staff must have training in child and adolescent health** to ensure developmentally appropriate, high-quality medical care, as needed. If pediatric or child psychiatric providers cannot be available on-site, telehealth may be utilized as a mechanism to ensure 24/7/265 pediatrician and child psychiatry consultation.
- Crisis receiving and stabilization services must have **spaces for family support and gathering**, both to immediately support the child in crisis and to provide a space for separation and parental/guardian support, as needed. Families should be offered comfortable places to stay with children, including places for rest for young children, access to snacks and developmentally attuned activities.

Three vignettes are provided in **Appendix A** that describe example circumstances with varied system responses during child and adolescent crisis situations. These represent a small sampling of the crisis situations that present during childhood and adolescence but are illustrative of the unique considerations that arise during each stage of crisis response, from call to stabilization.

Examples and Outcomes of Child and Adolescent Crisis Response Systems



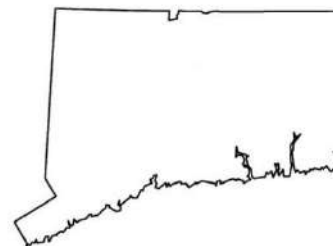
Arizona: Crisis Response Center (CRC)

In 2006, county bond funds supported the development of the Banner-University Medicine Crisis Response Center (CRC), serving adults and children in Pima County, Arizona. The CRC was initiated to provide support to those in need of urgent psychiatric care and to reduce the number of individuals with behavioral health needs in emergency departments or the criminal justice system. In addition to a 24/7 Behavioral Health Crisis Line that can dispatch GPS-tracked mobile crisis teams and manages an electronic bed placement board, the CRC offers a peer-operated warm-line staffed by trained peers who, as described on their website, “provide a friendly voice, support and

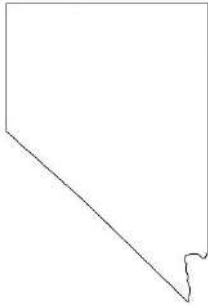
help to alleviate loneliness and isolation.”⁷⁶ They also offer a Tribal warm line, supported by the American Indian Support Service. The CRC serves approximately 12,000 adults and 2,200 children annually, with 45% brought directly by law enforcement via a secure gated sally-port and 10% are transported from emergency departments. Adults and children are served in distinct, separately licensed areas of the facility. The CRC is connected to a Level II trauma emergency room, a 66-bed Behavioral Health Pavilion, and the mental health court. Between 2015-2019, the CRC had an 8% increase in adult visits and a 24% increase in youth visits. Increasing numbers may reflect growing awareness of the service, including among law enforcement who now have a more sophisticated option than waiting hours in an emergency department, and may also reflect the limited options to prevent crises before they occur.

Connecticut: Mobile Crisis Intervention Services

Connecticut’s Mobile Crisis Intervention Services (formerly called EMPS) is available at no cost to all youth in the state under age 18. A single statewide call center, currently accessed by dialing 2-1-1, deploys providers to the crisis location. The providers are comprised of 160 trained behavioral health professionals from 14 different sites, allowing for on-site response within 45 minutes of when a child experiencing a behavioral health need or crisis. Mobile Crisis provides ongoing care to youth and families for up to 45 days to offer stabilization and linkages to ongoing behavioral health support.



Since data collection began in 2011, the number of Mobile Crisis response episodes of care increased by 54%, with 14,585 episodes in 2018 alone. For two consecutive years, schools have provided the greatest proportion of referrals to Mobile Crisis (44.3% in 2018). Schools often use Mobile Crisis as an alternative to transporting a child to the Emergency Department or contacting law enforcement. A recent study demonstrated that over a period of 18 months, youth using Mobile Crisis had 25% lower emergency department use than a comparable group⁷⁷. Most (88%) of parents or guardians report satisfaction with Mobile Crisis and 2018 data demonstrate significant decrease in problem severity and increase in functioning among youth who received Mobile Crisis⁷⁸. Evaluation of Mobile Crisis has demonstrated significant cost savings, with the average cost of an inpatient stay for Medicaid-enrolled children and youth being \$13,320, while the cost of Mobile Crisis was \$1,000, saving \$12,320 per youth⁷⁹.



Nevada: Children’s Mobile Crisis Response System Rural Team

In November 2016, the Rural Mobile Crisis Response (RMCRT) team of Nevada began taking calls. By September 2017, the RMCRT had served 243 youth and families across Rural Nevada; 86 percent of youth were successfully diverted from the hospital. Initially funded for three years through the State’s Division of Child and Family Services, the Department of Public and Behavioral Health Rural Clinics received a budget enhancement during the 2019 legislative session to grant continued funding through Fund for a Healthy Nevada (allocated from tobacco settlement monies to help with services that address the health and well-being of all Nevadans). Call volume has increased in recent years, and in 2017, the RMCRT reported a Hospital Diversion Rate of 86%. The rural team intends to expand coverage using telehealth and has already equipped many of its rural schools, hospitals and Juvenile Detention Centers with the telehealth program the RMCRT uses for interventions, allowing for more efficient crisis response.

Crisis Lessons and Innovations from COVID-19

COVID-19 has disrupted the delivery of behavioral health care across the globe. Data also points to an anticipated surge in behavioral health care needs related to the pandemic, including for children and adolescents who are suffering the burdens of family financial insecurity, caregiving load, and social isolation during a time of limited access to supports^{80 81}. Past pandemics, such as the Influenza of 1918, 2009 H1N1 flu, and the 2014 Ebola virus all were associated with increases in depression, anxiety, stigma, and shaming.⁸² Longitudinal negative impacts of other large-scale community crises (e.g., natural disasters) on children’s behavioral health and academic functioning have also been well documented^{83 84}. These tragic events, though, also led to significant transformations in behavioral health care.⁸⁵ There are many lessons and innovations from the global response to COVID-19 that can guide us as we reconstruct our children’s crisis system.

1. **COVID-19 has further illuminated disparate inequities in our health, education and economic systems and the resulting toll on youth behavioral health.** COVID-19 has disproportionately impacted non-White racial and ethnic groups^{86 87 88}. Social determinants of health, including systemic racism, poverty, and inequitable access and quality of healthcare and education, have historically prevented BIPOC individuals from having equal economic, physical and behavioral health. Children suffer the same disparities, which during and following crises are compounded by their limited ability to independently mobilize resources and supports to buffer the negative impacts⁸⁹. COVID-19 is expected to worsen the inequities in health outcomes for those living in poverty and in resource-poor rural communities across the United States⁹⁰. The disparate increases in unemployment and economic burden from COVID-19 in poor regions and in communities of color alone will be detrimental to children’s mental health. Golberstein and colleagues found a striking 35% to 50% increase in “clinically meaningful childhood mental-health problems” during a 5-percent-age-point increase in national unemployment during the Great Recession (2007 to 2009)⁹¹. Given unemployment rates of over 11% in August 2020 compared to less than 4% in January 2020, and that the increase is in the context of a health crisis and school closures, the mental health impact on children is likely to be even more severe than past trends, particularly in communities that are harder hit. In addition to greater density of family and community members inflicted with COVID-19 in communities of color, resulting in greater behavioral health consequences, youth of color are much less likely to have access to behavioral health support and at greater odds of receiving poor quality behavioral health care⁹².

Children living in rural areas are also more likely to have more negative COVID-19-related health outcomes and limited accessibility, availability and acceptability of behavioral health services⁹⁰
⁹³.

The profound inequities highlighted during COVID-19 have implications for how we build crisis response systems for children. Namely, children's behavioral health crises must be viewed within the context of the child's family and neighborhood/community and influenced by social and environmental factors. As such, these factors must be both assessed and addressed during crisis response, rather than simply focusing on the individual child or attributing crisis behaviors to individual psychopathology that can be treated at the child level⁹⁴. In addition to assessing for and addressing social determinants of health during crisis response with children and families, our systems must act as "health strategists," addressing the social determinants that contribute to the development of behavioral health crises in the first place⁹⁵. Recognizing the anticipated long-lasting impacts of COVID-19 on marginalized communities, Shah and colleagues (2020) called for our public health departments to think beyond individual interventions and to foster cross-system partnerships, with public health departments in the lead, to develop broad social supports (e.g., financial assistance, microloan programs) to assist those most vulnerable⁹⁰. So too must our children's behavioral health systems consider the broader interventions that may prevent and address crises by integrating supports for accessible and culturally responsive healthcare, food, housing and educational support.

2. **EDs are not suited for youth mental health or substance use crises, and broad community awareness campaigns and education can route children and families to more appropriate avenues for support** . Many families with children experiencing significant psychological deterioration in the context of COVID fear increased exposure risk by going to the ED. This has further highlighted the need for creating more appropriate places for children in crisis to go and has resulted in public awareness efforts to triage families to other community-based settings, including telehealth options. This type of re-routing of families from the default of the ED as the first point of entry during a crisis can be facilitated by the establishment of the 9-8-8 crisis line. However, the 9-8-8 system alone will not be sufficient to alter families' patterns of service utilization. Awareness campaigns can direct youth and families to trusted internet and social media sites as escalating events and crises do arise, providing de-escalation and help-seeking information and encouraging more appropriate pathways to support and care. During COVID-19, the Centers for Disease Control, the World Health Organization, and other health organizations regularly provide updates and guidance across multiple social media platforms, and these platforms similarly reciprocate by routing those seeking new, more specific information to the CDC and WHO sites,⁹⁶ and this similarly should be envisioned and configured with appropriate behavioral health crises sites. In addition, public health information to address behavioral health crises (e.g, the 9-8-8 number, noticing if others are struggling, de-escalation techniques) can be added to existing user platforms, including through banners, pop-ups, and other such tools to directly message users about preferred approaches for managing behavioral health difficulties. This may include chatbots for basic psychological first aid and geotargeted sites for crisis services based on one's location.⁹⁷
3. **The rise in risk coupled by a decrease in reporting of child abuse and neglect during COVID-19 highlighted the need for accessible mechanisms for youth and families to directly access crisis support**. Many children during COVID-19 are at increased risk of abuse, neglect and exposure to family violence.⁹⁸ Calls to protective services have decreased during stay-at-home orders, likely

due to schools being closed and traditional monitoring systems not being intact⁹⁹. By providing children and families with an accessible way to get help when they are in distress (e.g., by educating them about 9-8-8 and supports that are youth- and family-centered), exposure to adverse childhood experiences may be reduced or prevented. Further, youth and families will benefit from behavioral health literacy efforts that educate them about how to obtain and sustain positive mental health, recognize and seek help for mental health problems, and identify and support others experiencing mental distress. Recognizing the tremendous burden on families during COVID and the increased risk of child abuse and neglect, many organizations have mobilized to provide education and support to families to reduce risk. For example, the Child Mind Institute (<https://childmind.org/coping-during-covid-19-resources-for-parents/>), a national nonprofit, offers online learning, outreach, and resource support to families including tips for parent self-care, strategies for remote learning and discipline, skills for responding to children's mental health needs. Even prior to COVID-19, behavioral health literacy efforts for children and adolescents were increasingly implemented via school curricula, with several states (e.g., Florida, New York, Virginia) recently mandating the inclusion of mental health literacy in schools. For example, New York schools are required to integrate four key mental health literacy components into students' education¹⁰⁰: 1) Understanding how to obtain and maintain good mental health; 2) Decreasing stigma related to mental health; 3) Enhancing help-seeking efficacy (knowing when, where, and how to obtain good health with skills to promote self-care); and 4) Understanding mental disorders (*i.e.*, anxiety and depression) and treatments.

- 4. Telehealth services are needed, feasible, and often preferred by youth and families.** The paradigm shift in children's behavioral health crisis systems calls for significant expansion of telehealth technology. During COVID-19, behavioral health systems witnessed a dramatic increase in the utilization of telehealth to support the behavioral health needs of children and families. This occurred with federal, state and local infrastructure support, policy adjustments to ease use, and technical assistance and training to providers and consumers^{101 102}. A transformation of our children's crisis system toward robust telehealth capacity will require continued infrastructure improvements (e.g., enhanced broadband systems, up-to-date telehealth delivery equipment, internet connectivity services for providers and consumers); policy expansion (e.g., reimbursement parity for telehealth, expanded access of Medicaid and Children's Health Insurance telehealth programs); and ongoing guidance and support to providers and families to increase adoption and facility of telehealth services^{80 103}. Policy must move toward parity such that state parity laws guarantee comparable payment for telehealth at the same rate as in-person services (*i.e.*, reimbursement parity). Prior to COVID-19, only five states had implemented telehealth parity laws, and while 21 states expanded telehealth services during COVID-19, only 13 required parity. We must continue to evolve in this area and consider how to best integrate telehealth at all levels of the crisis system. As demonstrated during rapid adoption of telemental health during COVID-19, funding must be dedicated to both clinician and user training and to improving the infrastructure (e.g., hardware, software, internet access) necessary for successful telemental health practices¹⁰³.

During COVID-19 and beyond, child and adolescent mental health services traditionally provided in-person, including crisis services, may be shifted to telehealth, allowing youth and families to access support while minimizing health risks and other burdens of in-person care. As illustrated in Box 3, telehealth has already improved crisis response efficiency and outcomes for children and youth¹⁰⁴. It is important to recognize that rapid shifts to telehealth may inadvertently increase health disparities, as people with less income may not have consistent access to the internet or devices. Increasing access to the internet, ensuring that resources are accessible to individuals with disabilities, and providing free or low-cost devices may help to address this problem. Further, given that so many children and families access behavioral health services through schools, it will be essential for school-based behavioral health providers to become facile with and be supported to use telehealth services

Box 3. To address the absence of child and adolescent behavioral health specialists in EDs, the Children’s Hospital of Colorado used telepsychiatry to link the specialists at its central academic medical center to pediatric EDs and urgent care centers in the Denver area. The goal was to improve care and decrease patient transfers to the main campus. Children and youth who received the telehealth consultations, when compared with those receiving usual care, had ED lengths of stay that were 2.8 hours shorter, patient charges for care that were more than 40% lower, and higher satisfaction with services among ED providers and the patients’ caregivers.

- 5. COVID-19 has illuminated the need for flexibility and innovation to provide effective care amidst different public health parameters.** Across all tiers of support, from universal mental health promotion to treatment for mental illness, behavioral health supports have been adapted to meeting the changing landscape of mental health needs resulting from the pandemic and its sequelae and to conform to the necessary adjustments in service delivery. The innovations in behavioral healthcare during COVID-19 point to the importance of a nimble system during community crises, and to the importance of crisis systems being similarly equipped to adjust as needed to changing public health parameters. For example, at the universal (Tier 1) level, addressing prolonged loneliness experienced during COVID-19, a risk factor for multiple behavioral health conditions, requires that not only everyone retain some contact virtually with others (e.g., school, peer activity networks), but also that teachers, coaches, mentors, and other supportive adults directly reach out to young people weekly, as employers are now being encouraged to do with each worker.¹⁰⁵ Video and voice interactions will be needed, particularly for children often too young to shift to a more written or texting type intervention. At the selective intervention (Tier 2) level, the lack of direct contact and access will require modifications in screening and responding to early signs of distress. Nontraditional groups (e.g., parenting groups, teachers/school staff, community organization members) may be provided familiarity with a simplified version of psychological first aid and specific questions or approaches to check in with children, which historically may have been done with a more standardized program designed for more highly trained clinicians (but now insufficient or inaccessible) At the intensive intervention (Tier 3) level, different counseling models will be better suited to evolving public health circumstances; for example, written counseling has been described as effective to address needs for those who may not have access to telehealth equipment or resources¹⁰⁶. Novel approaches mindful of new public health constraints (e.g., changes in shaking hands/greetings, going to an office) should be monitored for applicability to crisis management as well.

6. Finally, even with brick and mortar schools closed, **schools remain a hub for a full continuum of behavioral health supports for students and their families.** Of children in the United States who receive any behavioral health care, over half receive care at school, and this is even greater for youth of color or living in poverty.¹⁰⁷ During COVID-19, schools mobilized to continue supporting students' nutritional, educational and behavioral health needs. While rates of community behavioral health access dipped during COVID-19, school support personnel and school-based mental health clinicians continued to provide needed behavioral health support, often via telemental health. Our children's behavioral health system should leverage schools as a place to support social emotional health, and to practice early identification and intervention, including crisis response. Parallels from Hurricane Katrina to COVID-19 also illuminate the need to ensure that beyond the supports for students and families, our behavioral health and education systems must attend to the ongoing needs of educators and other school staff as they work to support students' behavioral health.¹⁰⁸ Guidance from the Centers for Medicare and Medicaid Services and SAMHSA offers states ideas and examples for how state Medicaid programs can increase and improve school mental health service delivery and several states and local communities have leveraged school-community partnerships to improve children's behavioral health systems.^{109 41}

Conclusion

The stage is set to reimagine the child and youth crisis prevention and response system given the limitations of the existing system, burgeoning innovations in youth mental health, and lessons learned amidst the current global pandemic and increased attention to longstanding social injustices. As community behavioral health crisis policies and practices are established, the unique needs of children and families must be considered across the developmental spectrum and across communities and cultures, always addressing issues of equity and racism. The vision must include promotion, prevention, early identification and intervention available through natural supports like schools, primary care, and other community partners (e.g., afterschool programming, faith organizations) and through expanded technologies, including telehealth. The opportunity to shift the paradigm for how we build and implement children's crisis response systems is within our reach and will require thoughtful leadership and advocacy, significant policy and financing support, and active engagement of youth and families to shape the supports they will receive.

Appendix A: Vignettes

The roles of the (a) Call Responder, (b) Mobile Crisis Team, and (c) Receiving and Stabilization Services are described below, and then applied to each vignette:

Call Responder: (1) **clarify safety**: is this new/unusual (possible poison ingestion), or abuse/trauma reaction; (2) **identify impacts** across multiple spheres of life: does the child do this everywhere, or only at home, around certain people (3) **seek to understand this unique family and youth’s perspectives and their goals** to manage this event; and (4) **offer parent support/appropriate de-escalation strategies** (see Box 2); clarify if parent receptive to speaking with a behavioral health provider, if telehealth visit acceptable.

Mobile Crisis Team: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, both (a conflict between them), and/or other (e.g., school staff, peers); (2) **observe/speak** with the child to clarify potential behavioral health conditions that best explain behaviors; (3) **seek to understand this unique family and youth’s perspectives and their goals** to manage this event; and (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance, further evaluation (medical or behavioral health))

Receiving and Stabilization Services: (1) **seek to understand this unique family and youth’s perspectives and their goals** to manage this event; (2) Clarify if **ongoing parent/child/family support services** are needed (e.g., speech therapy for social pragmatics, autism program at school); and (3) **identify where these services might best be provided** (considering feasibility and accessibility for family).

Angel is a 4yo, whose parent calls 9-8-8 reporting “my child refused to eat dinner tonight and started screaming uncontrollably. My child isn’t like other kids and I’m scared; doesn’t talk to anyone, just sits in a corner, no facial expression, and freaks out if touched or asked to eat anything other than uncooked macaroni. I think something is really wrong and I don’t know what to do.”

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by distinguishing whether this circumstance is a new-onset, sudden deterioration (suggestive of poison intoxication, traumatic events, or an underlying medical condition) vs. an ongoing, worsening pattern (suggestive of autism spectrum or chronic trauma). The **CR** might further (2) **clarify impacts**, such as if these behaviors occur everywhere, all the time, with peers, family, and at preschool (suggestive of autism spectrum or general developmental or social skill delays) vs. only in certain settings and times, such as when visiting particular relatives (suggestive of trauma). The **CR** may (3) **seek to understand the parent’s reasons and goals** for calling now, which might be that the child is being treated differently than other children, that relatives have expressed concerns, or that the parent may be doing something to contribute to these behaviors; inquiry about the child may reveal whether the child is distressed by any of these behaviors, or instead preferring to be apart from others to do preferred activities. The **CR** may (4) **provide some immediate de-escalation** to this event by reviewing the history of these behaviors (“these are not new, but are now more concerning, so it seems you want someone more familiar with this to partner with as you decide your next steps”) and inquiring whether the family would like to speak with someone immediately about the behaviors Angel is displaying, including offering videoconferencing as an option for communication.

In Angel's crisis, the **Mobile Crisis Team (MCT)** uses telehealth technology to connect via videoconference (which the family preferred over an in-person visit) to (1) **elicit descriptions** from the parent about the evolution of these behaviors, who in the family seems most distressed or impacted by them; (2) **observe/speak** with the child to clarify potential behavioral health conditions (e.g., trauma, autism spectrum, anxiety and selective mutism) that best explain this child's unique constellation of behaviors; (3) **understand this unique family's perspectives and their goals** (parents might ask "Is this because we did something wrong?" "We don't know who can evaluate these symptoms to help us figure out what to do at home," or "Does Angel need a special school?" "What should we do right now about Angel only eating macaroni?") and (4) **clarify interventions needed now** to improve/resolve this crisis (e.g., parent support and guidance about trying some different types of food, engaging around activities/play to see if that increases interaction and communication, and partnering around the process to obtain further evaluation, medical or behavioral health, including potential fears (parents might ask "Will I get turned in to Child Protective Services or will Angel be taken away if we talk with someone?") or perceived obstacles ("I don't know what to do, or if I can do it; I don't have insurance to do any further evaluations, and they'll just blame me for all this...like they did before")). In this case, the **MCT** used videoconferencing to engage a pediatric specialist who could discuss some of the family's concerns and better assess Angel's behaviors. Angel and her family were routed by the **MCT** to a community-based assessment and intervention program with a pediatrician to clarify the diagnosis, to partner with the school to provide evaluation for additional needs (such as speech, occupational therapy, etc.) and to create a plan to be delivered through the preschool to address behaviors.

If Angel's behaviors continued to escalate or the family requested respite and immediate in-person support, the **MCT** may have referred them to **Crisis Receiving and Stabilization Services (CRSS)**. In this case, **CRSS** providers, including specialists in child development, might (1) **seek to understand this unique family and youth's perspectives and their goals** (parents might describe fears that Angel will escalate to doing harm to self or others, or that others in the family are frustrated and likely to lash out aggressively toward Angel, such that safety becomes an issue; e.g., "My other children, and I, are freaking out—we're afraid Angel may try to hurt herself while we're sleeping"); (2) clarify if **ongoing parent/child/family support services** are needed (e.g., family education and respite, parent peer support, child diagnosis and intervention), and (3) **identify where these services might best be provided** (e.g., other family members to stay with if the family is currently overwhelmed or concerns of traumatic conditions are present, local family support chapter for autism, pediatrician specializing in autism and developmental disorders).

Lin is a 7yo, whose parent texts 9-8-8, distraught that the child would not get out of the car to go into the school since the beginning of this school year; usually the child will scream and cry when approaching the school; when brought to the school other times, the child will describe physical symptoms so that the parent will be called and come get the child; today the child was cursing and biting at the teacher who was trying to walk the child into the school; the school threatened to report the child as habitually truant if the parent cannot get the child to come and stay at school.

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by addressing whether Lin is actually trying to harm others (e.g., the teacher(s)), describes plans or obtains "weapons" to harm anyone, has specific people at home, at school, or elsewhere that frighten Lin such that Lin seeks the protection of family and to avoid a perhaps past traumatic situation (suggestive of posttraumatic stress), or if there are consistent physical symptoms that may suggest an underlying, perhaps new, medical condition, or if Lin has consistently each year avoided separating from family to attend school or other seemingly safe, desirable places (suggestive of separation anxiety), The **CR** might further (2) **identify impacts** across

multiple spheres of life, such as how often these events occur, whether parents are able to transition Lin to school most days or to separate to be with others, and which people (e.g., parents, caregivers, certain school staff) are most engaged in this situation, and how long these episodes involve these other people, and how Lin is progressing academically and socially at school. The **CR** may (3) **seek to understand the parent's reasons and goals** for calling now, such as threats that the police or child services may be called if Lin does not transition into school, that the parent doesn't know what else to do and thus seeks help and support, the family fears school reporting may result in all children being removed and thus want Lin out of the home now, etc. The **CR** might (4) **offer parent support/appropriate de-escalation strategies** by helping the family preview separations to go to school, provide distracting options for Lin such as listening to music while driving to school, etc.), and to offer consultation or teleconferencing with a **Mobile Crisis Team (MCT)** to help devise alternative strategies (e.g., helping Lin transition to familiar others (staff and possibly peers) when Lin arrives at school to make these transitions less stressful) as well support the family as they address their fears about school reporting them.

In Lin's crisis, the **MCT** might initially have a phone call to demonstrate support for parent and address fears of reporting to the police/child services, and then as trust is created engage in a videoconference to (1) **elicit descriptions** from the parent about what Lin seems to "gain" by these episodes (e.g., get to go back home to be with a parent, avoid some person or activity disliked at school), how these episodes impact the parent(s) (Parent may say "yes, I have to stay home now to care for Lin, which isn't so bad since I hated my job anyway," or "I've had many problems with the school staff there---they have reported me multiple times with multiple of my children over the years, so this is just another way they try to get us to move."): (2) **observe/speak** with the child to discern if this sounds new and acute to suggest a traumatic origin, or if this seems more like ongoing separation anxiety (even if a repetition of what has occurred at the beginning of new school years), or some other behavioral circumstance (Lin might say "I need to be home with my Mother as she's sick" ("or needs my help taking care of my Grampa," etc.): (3) **understand this unique family's perspectives and their goals** (parents), which might include parental fears of being turned in, the police arriving and scaring other family members, fears of betrayal and distrust given past experiences with the school, and parental aspirations to get the school to be more understanding and partnered with the parents around these events or alternatively to compel the school to place Lin in a different school); and (4) **clarify interventions now needed** to improve/resolve this crisis, such as collaboration with the school to understand the school's experiences or concerns so that a different, more collaborative plan between home and school can be initiated to ease transitions, school options for gradually getting Lin to transition fully (all day) into school (which might include some interval of virtual school so that Lin becomes more comfortable with new teachers and peers)..

If Lin continues to be threatening to others at school or at home, or the parents fear that others in the family may get angry or aggressive toward Lin, then **Crisis Receiving and Stabilization Services (CRSS)** may be needed to (1) **better understand this unique family and youth's perspectives and their goals** to manage Lin's behaviors and eliminate aggression during school transitions, which might include family interviewing and then supportive or focused counseling (e.g., parent previewing, calm management of Lin's escalations, problem-solving techniques and practice with family to prepare for transitions, and anxiety reduction techniques for Lin) at the CRSS site; (2) clarify if **ongoing parent/child/family support services** are needed (e.g., school-based behavioral health services to target the source of transition behaviors via skill development and/or trauma treatment); and (3) **identify where these services might best be provided** (e.g., feasible practices for the family to do differently, the possibility of implementing promptly a school program with preferred school staff or peers to improve the magnetism of school for

Lin and to simultaneously make home more “boring,” so that Lin is more motivated to transition to school).

Devon is a 14yo, whose parent contacts 9-8-8 after finding a bag of “weed” in Devon’s room and confronting Devon; Devon became livid, asked why the parent was “in my stuff,” and ran out the door, breaking a lamp on the way out, saying “I don’t want to live like this anymore.”

In this vignette, the **Call Responder (CR)** might (1) **clarify safety** by asking family if this is a new/unusual explosive event, or recurrent (“has Devon had other episodes or signs of substance use, has Devon made threats, tried to harm self/others before” and directly address Devon’s comment by exploring “what did “I don’t want to live like this anymore” seem to suggest today?” to parents, or others present or who may have heard similar comments from Devon before, and which may have included descriptions of self-harm plans/acts, or preparations to gather weapons, write suicide notes, etc.). The **CR** might (2) **identify impacts** across multiple spheres of life: the CR might inquire about whether Devon explodes or “takes off” everywhere, or only today at home? and how Devon’s functioning with school, peers, and parents has changed in recent months). The **CR** may (3) **seek to understand the parent’s reasons and goals** for calling now, such as parental fears that Devon’s substance abuse is now problematic, fears that others involved with substances may come to their home, and fears that any discussion of this with others may lead to police searching their home. The **CR** may (4) **offer parent support/appropriate de-escalation strategies**, such as ensuring that Devon is now in a safe place with trusted others, and plans by parents for addressing this situation (parents may say “we want him to return but he has to get rid of the weed and not bring it into our home again,” or “we want Devon to go away now for treatment---this has been going on for too long—he cannot come back right now”), and clarify if parents are receptive to speaking with a behavioral health provider, including by teleconference, to identify next steps to locate/find Devon, and determine appropriate next steps.

In Devon’s crisis, the **Mobile Crisis Team (MCT)** might speak with family to: (1) **elicit description** from the parent—is this mostly a problem for the child, the parent, or both (a conflict between them), The **MCT** might then text or phone Devon to (2) **observe/speak** with Devon to clarify potential behavioral health conditions that best explain the episode at home (from depression to substance use (“I don’t want to live like this anymore” could refer to some ongoing situation or stressor, from bullying to gender or sexual identity concerns, to ongoing substance or legal problems, etc.). From both family/others and Devon, the **MCT** may be able to (3) **understand this unique family’s perspectives and their goals**, which might include parental fears of Devon harming/stealing from parents, police involvement and fear of arrests, family fears of Devon being unable to control substance use and significant deteriorations observed, as well as Devon’s fears of being misunderstood, overreactions to rare marijuana use that has not been associated with deteriorations in functioning, etc. Based on information from both family and Devon, the **MCT** would speak with parents and/or Devon to (4) **clarify intervention now needed** to improve/resolve this crisis (e.g., parent guidance to reach and deescalate conflict with Devon, steps to address Devon’s substance use vs. Devon’s underlying distress recently leading to substance use).

If this crisis results in Devon or parents unable to work out this situation so that he can return home safely, then **Crisis Receiving and Stabilization Services (CRSS)** may be required to: (1) **better understand this unique family and youth’s perspectives and their goals**, which might include discussing options with parents and Devon together to navigate an acceptable resolution, identifying underlying fears family members have regarding Devon, as well as stressors that may be influencing Devon’s recent behaviors, and both the family and Devon’s perceptions of law enforcement as well as social support

agencies in partnering with families like them; (2) **clarify if ongoing parent/child/family support services are needed** (e.g., crisis team members clarify whether Devon will be able to safely return home by the next day or whether other options for Devon may need to be explored now, are Devon and family able to work with a provider to agree to terms of returning, is the home environment likely to work or does it remain too volatile between child and parent such that immediate return may put Devon or family members at jeopardy for harm, etc.); and (3) **identify where these services might best be provided** (e.g., does Devon require further evaluation to clarify underlying substance use disorders/withdrawal/intoxication symptoms, specialized referral for other issues, substance abuse treatment, depression, etc.).

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Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.

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Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.

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The Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (referred to from here as "*National Guidelines*"), outlines the necessary services and best practices to deliver an effective crisis continuum. A comprehensive crisis service array includes three essential types of services: 1) centralized crisis lines that assess a caller's needs and dispatch support, 2) mobile crisis teams dispatched as needed in the community, and 3) crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime".¹ Data from the National Association of State Mental Health Program Directors Research Institute (NRI) indicate that nearly 98 percent of state mental health authorities (SMHAs) offer at least one of the crisis services recommended in the *National Guidelines*.² Of those, 82 percent of SMHAs offer 24-hour crisis hotline services, 86 percent of SMHAs offer mobile crisis response, and 90 percent offer crisis stabilization beds (either less-than 24 hours, or more-than 24 hours).³

While it is promising that the vast majority of states offer some level of crisis care to its citizens, it is unknown how widely available these services are, especially in rural and frontier areas, and whether they adhere to the best practices as prescribed in the *National Guidelines*. Ensuring all components are available to "anyone, anywhere, anytime" is an ambitious goal, and is especially challenging in rural and frontier areas where a lack of awareness, workforce shortages, distance to travel and transportation issues, cultural differences and the stigma associated with behavioral health, sustainability challenges, and availability of broadband internet services may present additional barriers to the delivery of comprehensive behavioral health crisis services in all locations.

According to the 2010 U.S. Census, 20 percent of the U.S. population, or approximately 60 million people, reside in rural and frontier areas of the United States, and their need for crisis services is comparable, or perhaps even greater, when compared to the need identified in urban areas.⁴ Data from SAMHSA's 2018 National Survey on Drug Use and Health (NSDUH) show that 18.9 percent of adults aged 18 and older living in completely rural areas experienced a mental illness in the past year, compared to 18.6 percent of adults in urban areas.⁵ 2018 NSDUH data also show that 2.5 percent of adults living in completely rural areas experienced a co-occurring substance use disorder and any mental illness in the past year, compared to 3.7 percent of adults in large metro areas.⁶ Although rates of mental illness and substance use are comparable between rural and urban areas, the rates of serious mental illness (SMI) are higher in rural areas, with 5.8 percent of adults experiencing an SMI in the past year, compared to 4.1 percent of adults aged 18 and older in urban areas.⁷ Additionally, while suicide rates among adults have risen since 2007 across the U.S., according to data from the Centers for Disease Control (CDC), the rate of suicide among individuals in rural counties increased at a rate 6.1 times faster than the rate in urban counties between 2007 and 2015.⁸ Studies also show that youth in rural areas have nearly twice the risk for suicide than do their urban counterparts.⁹ The divergence between suicide rates in rural and urban areas may be partially attributable to the prevalence of firearms in rural states, which accounted for half of all suicides during the same period. Additionally, the availability of behavioral health services when in crises in rural and frontier areas is significantly limited when compared to urban areas. Multiple studies have shown a chronic shortage of mental health professionals in rural areas, and a tendency for providers to practice in more urban areas. These two factors underscore the need for a robust array of behavioral health crisis services in rural and frontier areas.¹⁰

The purpose of this paper is to understand the challenges associated with the delivery of comprehensive behavioral health crisis services in rural areas, and recognize the strategies and opportunities pursued by state authorities and local providers to enhance access and the availability of these important services in rural and frontier areas of the U.S. In addition, the opportunities and challenges presented by the COVID-19 pandemic are incorporated throughout.

A review of the literature was conducted to identify the most pressing challenges facing states and localities, as well as strategies used in the delivery of behavioral health crisis services in rural and frontier areas of the U.S. To ensure that only meaningful and relevant information is included, the author limited her research to include peer-reviewed journal articles and U.S. governmental reports published between 2010 and 2020. However, given the rapid advancements in technology, and the ever-changing needs and priorities associated with the COVID-19 pandemic, some news articles are referenced as well. To understand firsthand how these challenges affect the delivery of crisis services in rural areas and the strategies employed to overcome these challenges, the author and colleagues from the National Association of State Mental Health Program Directors Research Institute (NRI) and RI International conducted a series of seven structured telephone interviews with state, local, and non-governmental representatives from five states: Alaska, Colorado, Nebraska, New Mexico, South Carolina, and Tennessee (multiple entities from Alaska and Nebraska were interviewed for this paper). For the purposes of this report, the author relies on the U.S. Census Bureau's definition of rural, which is an area encompassing all population, housing, and territory with a population outside of an urban area with fewer than 2,500 individuals. The U.S. Census defines Frontier as an area with a population density of fewer than two people per square mile.¹¹

This paper is divided into seven sections. The first five sections discuss the challenges and opportunities related to particular barriers to crisis service delivery in rural areas, including workforce, distance to travel and transportation, sustainability, and the use of technology and broadband access. These sections are followed by a section discussing additional effects the COVID-19 pandemic is having on the delivery of behavioral health crisis services in rural and frontier communities, and the implications each of these challenges and opportunities have for policy makers.

Behavioral Health Crisis Workforce in Rural Areas

As of September 2018, the Health Resources and Services Administration (HRSA) designated 2,672 Mental Health Professional Shortage Areas in rural areas.¹² The primary factor HRSA uses to designate Mental Health Professional Shortage Areas is “the number of health professionals relative to the population with consideration of high need,” with a minimum of one provider to 30,000 residents (or 20,000 if there are higher than usual needs in a given community).¹³ Data from the 2014 American Community Survey show that just 1.6 percent of the nation's psychiatrists practice in rural areas, which is on average nearly 47,000 residents per each rural psychiatrist.¹⁴ Data from the American Medical Association show that nearly 60 percent of all counties in the U.S. do not have a single psychiatrist.¹⁵ Compounding the issue is that many of the counties without a psychiatrist are clustered together, making it even more difficult for individuals to access psychiatric care quickly in case of an emergency.¹⁶ Workforce shortages and retention issues were identified as a significant barrier to providing quality crisis care in each of the seven phone interviews conducted for this report. Several states, including Alaska and Colorado, are implementing or considering unique methods to reduce limitations to the

delivery of behavioral health crisis services brought on by behavioral health workforce shortages in rural and frontier areas. Highlights of these unique methods are provided below.

Alaska

In the late 1960s, the Alaska Native Tribal Health Consortium (ANTHC) initiated the Community Health Aide Program to respond to the tuberculosis epidemic and the rise in infant mortality rates in tribal villages across the state. This program trained citizens with no experience in health care to provide basic health services and respond to the needs of individuals in rural and tribal areas across the state. The program was so successful that it was used as a model to implement the Behavioral Health Aide Program in 2008, which is a multi-level provider model that trains citizens on how to provide therapeutic services, respond to behavioral health crises, and support the general mental health and wellbeing of individuals in rural and tribal communities.¹⁷ Support for the program was garnered through a number of newspaper articles and publications that recognized the significant mental health and substance use issues in the community, and noted that the state and local villages did not have adequate resources to respond to the need. (Owens, Chipp, personal communication, July 1, 2020).

Behavioral Health Aides (BHAs) are employed by their regional tribal health organizations; citizens interested in becoming a BHA need to be 18 years of age or older, and have earned a high school diploma or equivalent. There are four levels of BHA certification, including BHA-I, II, III, and Behavioral Health Practitioners. Potential BHAs often receive training from the ANTHC, who operates the only BHA Training Center in Alaska and works closely with the Community Health Aide Program Certification Board. Most training offered through the BHA Training Center are typically facilitated using a blend of distance-delivered technology; making the transition of courses that are usually held in-person relatively seamless in response to COVID-19. Once certified, BHAs are qualified to provide and bill for various Medicaid services based on their level of certification, including SBIRT (Screening, Brief Intervention and Referral to treatment); tobacco cessation; and individual, group, and family psychotherapy. All BHAs are supervised by licensed clinicians who are able to assist BHAs in connecting individuals in crisis to higher levels of care, as needed (Owens, Chipp, personal communication, July 1, 2020).

BHAs are often the first to identify when someone is experiencing a crisis, and are the first to respond to traumatic events in the communities they serve. Alaska has found the BHA program to be effective at utilizing available human resources in communities that may otherwise not have an adequate supply, or any supply, of licensed behavioral health providers. BHAs serve multiple roles on the recommended crisis continuum, including answering emergency call lines and responding to crises in the community (similar to a traditional mobile crisis response team). These efforts help with the implementation of crisis services in rural and tribal areas. BHAs are notified of crises in the community in multiple ways, including a general awareness of crisis events in the community, monitoring patients and clients who have been identified as having serious mental illness, referrals that come through the general behavioral health department, collaboration with external behavioral health providers regarding aftercare needs for their clients who are returning home, or through referrals from Community Health Aides. To further highlight the essential role BHAs have in the continuum of care, Alaska's recently approved 1115 waiver clearly identifies BHAs as qualified provider types to deliver necessary services, including crisis response (Owens, Chipp, personal communication, July 1, 2020).

BHAs serve in multiple roles within the context of their position; this, coupled with the roles associated with being a member of a small community, can lead to high rates of burnout. During our interview with the ANTHC, it was noted that it is not unusual for BHAs to receive a “knock on the door at 2:00 am because they are known and trusted advisors in the community” (Owens, Chipp, personal communication, July 1, 2020). The multiple roles, the often indistinguishable boundaries between personal relationships and professional responsibilities, and the need to be constantly on-call to their communities can be confusing, exhausting, and lead to burnout, which ultimately leads to a high rate of turnover among BHAs. To reduce burnout and mitigate turnover, one of the largest tribal organizations in the state holds weekly teleconference calls specifically for BHAs to provide emotional support. During these calls, BHAs share stories to connect with and support one another, share traditional stories that connect to the types of cases they are serving and focus on their own wellbeing and mental health. (Owens, Chipp, personal communication, July 1, 2020).

The BHA program is financed through compact funding from the Indian Health Service (IHS), although the funding is limited. To increase resources to support the program, the ANTHC follows a fee schedule for courses delivered through the ANTHC BHA Training Center for aspiring BHAs, and has applied for several grants to fill the gaps (Owens, Chipp, personal communication, July 1, 2020).

In July of this year, the IHS announced the expansion of the Community Health Aide Program, including the BHA program, to tribes in the contiguous U.S.¹⁸ This effort will increase the ability of tribal communities that typically reside in rural and frontier areas to deliver physical health, behavioral health, and specifically behavioral health crisis services to individuals in their own communities. In addition to being available to tribes in the contiguous U.S., the Behavioral Health Aide Program makes available for a fee technical assistance to other communities interested in implementing a similar model.

Colorado

Currently Colorado requires there be at least one mobile crisis response team in each of the seven behavioral health regions of the state, and the teams need to be able to respond to a crisis within two hours of a crisis call. Each region has met the minimum obligation for number of teams; however, there are multiple mobile crisis response teams in the concentrated urban areas of the state, and only one crisis stabilization unit walk-in center and a few mobile crisis response team serving the entire Western Slope of the state, making it difficult for mobile crisis teams to adhere to the two-hour response guideline.

To improve crisis response times, Colorado is considering a model similar to, but less sophisticated than, the BHA Program in Alaska. The state has heard from communities in rural areas that there are concerned citizens who want to help respond to crisis situations, but they just do not know the most appropriate way to help. Rather than training citizens to be certified BHAs, the state is exploring training bachelor’s-level providers or peers to carry a tablet to an individual in crisis that would be used to connect the individual to a skilled or licensed professional via telehealth services. Unfortunately, the COVID-19 pandemic has delayed any progress in these programs, and future budgetary decisions may determine whether these programs will be able to be established.

Distance to Travel and Transportation to Crisis Services

Distance to travel, limited or no public transportation, and a lack of infrastructure are significant barriers to individuals in need of crisis services. These factors also limit an individual's ability to access other behavioral health services and community supports that minimize the need for crisis services in the future. These barriers often result in long waits for mobile crisis teams to respond, reliance on first responders to transport individuals to care, and a reluctance to call for help in the first place. Also, when individuals have to travel far to receive appropriate levels of care, they are often removed from their communities, and forced to navigate their crisis alone, without the support of their families and friends.

As recommended in the *National Guidelines*, states can adjust their mobile crisis team response times to accommodate for geographic distances in rural and frontier areas. In line with this recommendation, all of the states interviewed for this report indicated that they have relaxed their response-time requirements for mobile crisis teams when answering calls in rural and frontier areas. However, this does not change the need for an individual in crisis to receive a timely response.

Many smaller communities rely on their local law enforcement officers and other first responders to transport individuals experiencing a crisis to care. In all 50 states and the District of Columbia, police are authorized to initiate a psychiatric hold for an individual who appears to pose a risk to themselves or others.¹⁹ However, this legal authority often creates an over-reliance on law enforcement to respond to crises, especially in rural and frontier areas where behavioral health workforce resources are limited. The *National Guidelines* recommend not involving police unless alternate behavioral health first responders are unavailable, "or the nature of the crisis indicates that emergency medical response (EMS) or police are most appropriate".²⁰

An example provided by one state during the interviews for this report is that the state has an Emergency Protective Custody Statute that mandates officers bear the responsibility for deciding if someone meets the criteria for immediate harm to self or others. In these instances, officers may have to transport an individual more than two hours one way to make sure they are admitted into treatment. Because of legal issues and risks of harm to the officer and individual, the individual being transported must be restrained and transported in the back of the locked police car. This approach can create stressful situations for an individual in crisis that can exacerbate their symptoms, and serve to drain the resources of small law enforcement agencies in rural communities.

An electronic behavioral health bed registry that can be accessed online is helpful to individuals and law enforcement in rural areas when they need to access higher levels of care. A bed registry can be used to identify an appropriate nearby available inpatient psychiatric hospital bed. This will avoid a situation where a person might be turned away after traveling a long distance when a bed is not available at a crisis stabilization unit. Through its Technology Transfer Initiative (TTI) project, SAMHSA is currently funding 23 states to establish or enhance crisis bed registries to reduce this barrier.

Alaska, Colorado, and South Carolina shared their experiences about the impact transportation barriers have on their delivery of crisis services, as well as some of their unique approaches to overcome these barriers to effectively deliver crisis services to individuals in rural and frontier areas.

Alaska

An extreme example demonstrating the effect transportation barriers have on the accessibility of behavioral health crisis services is the lack of available transport for individuals experiencing a psychiatric emergency in remote areas of Alaska. Many of Alaska's villages rely on ferries, airplanes, and seaplanes paid for by the SMHA to transport individuals experiencing a behavioral health crisis to a designated evaluation team. Alaska's SMHA funds an on-call staff, available 24 hours a day, seven days a week to secure transports with contracted providers who are specially trained in transporting individuals in crisis. In addition, the SMHA funds all costs of transporting individuals to Designated Evaluation and Treatment (DET) hospitals. Transportation delays are also caused due to inclement weather and the challenges of getting in or out of Alaskan villages. Due to COVID-19 and the challenges associated with commercial airlines availability, the SMHA has funded an increasing number of private charters to bring individuals in crisis into a DET as soon as possible.

Prior to the COVID-19 pandemic, the SMHA relied on two airlines, Alaska Air and RavnAir, to transport individuals in rural, frontier, and remote areas to receive appropriate care (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Since March 2020, Alaska Airlines has significantly reduced flights, and has begun laying off employees in August 2020. The state's other airline, RavnAir has also been significantly affected by the current pandemic. RavnAir experienced a 90 percent decline in bookings and revenue resulting from the COVID-19 pandemic, which forced RavnAir into bankruptcy in April 2020, limiting the available transport options for individuals experiencing a mental health crisis, and exacerbating the inequities in access to mental health services during the pandemic.²¹ Alaska's Medicaid plan does not reimburse for expenses related to transport for a psychiatric emergency (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). The SMHA staff noted that even when two airlines were available to transport individuals experiencing a psychiatric emergency, it would often take several days to arrange for air transport from the remote villages. This is in stark contrast to when someone needs transport for a physical health emergency funded by Medicaid, when air transport would be arranged within hours. This barrier may lead to individuals who are deemed a risk to themselves or others being boarded in less-than-appropriate settings, including local jails because other treatment options (e.g., crisis stabilization units) are unavailable, until they can safely be transported to an appropriate level of crisis care.

Colorado

To reduce the reliance on law enforcement to transport individuals to crisis stabilization or other inpatient facilities, Colorado proposed legislation to pilot a program to train and certify members of the community in rural areas to become secure transport drivers. The proposed program would be sponsored through a partnership between the state's Medicaid authority and the public utilities commission. The program would train drivers in de-escalation techniques, and would use funds to secure and enhance a fleet of vehicles to make them safe for drivers to transport individuals in crisis. Unfortunately, funding for this pilot program in two rural areas of the state has been cut due to budget cuts resulting from COVID-19; however, one program has been allowed to continue in southeast Colorado after a provider and the Administrative Service Organization reallocated budgets to allow it to continue.

South Carolina

South Carolina offers mobile crisis response teams in all 46 of its counties, where master's-trained clinicians are available to respond to crises 24 hours a day, seven days a week. In Charleston County, a highly populated and large county, the mobile crisis response team only received, on average, five calls per month from local law enforcement and EMS. After discussions between the county and the EMS teams, it was revealed that EMS did not reach out to the mobile crisis response teams because it often took too long for the mobile crisis teams to respond. It was easier and faster for EMS to transport the individual in crisis to an emergency room, which is usually not the most appropriate setting, unless the individual in crisis was also experiencing a medical emergency. A partnership between the state and the EMS program in Charleston County was formed. Now when EMS is called to respond to a psychiatric emergency, they first evaluate whether the crisis is medical or psychiatric in nature. If medical, the ambulance will transport the individual to the appropriate level of care; if psychiatric, the EMS crew calls their supervisor to respond in an SUV. Once the supervisor responds, the ambulance is sent back out into service, and the supervisor connects the individual in crisis through the VIDYO telehealth app on their tablet to the mobile crisis response team. The mobile crisis response team is then able to evaluate and triage the crisis virtually, and can make recommendations on next steps. Service is immediate and allows for more appropriate use of EMS time and resources, and reduces the number of referrals to emergency departments in the county. It reduces the need for mobile crisis teams to travel long distances to reach a crisis, and allows individuals in crisis to receive services quickly. Since this program has been implemented, the county has experienced an increase in calls from EMS to mobile crisis from five to nearly 85 per month, and the county has seen a 58 percent decrease in ED use for individuals in psychiatric emergencies. (Bank, Blalock, personal communication, July 7, 2020).

Cultural Differences and Stigma Associated with Behavioral Health

According to a study out of Wake Forest University, the most commonly reported barrier to treatment among individuals in rural areas is the personal belief that "I should not need help".²² Additionally, it is easier to seek help anonymously in large urban areas. According to Dennis Mohatt, the Vice President of the Behavioral Health Program and Director of the Western Interstate Commission for Higher Education (WICHE), "your neighbors don't have a clue in a city if you're going to get some help. But everybody [in a small town] will know if your pickup truck is parked outside of the mental health provider's office." Nebraska's Region 3, as well as Alaska's BHA program echoed this sentiment.

In the community served by Region 3, which consists of 22 primarily rural counties, there is a mindset among the farming and ranching communities that "you get back on the horse," and that whatever is bothering you will pass and is not something to take seriously (Reynolds, personal communication, June 17, 2020). This lack of awareness of mental health issues, as well as the stigma associated with serious mental health conditions, including depression, is reinforced by the primary care physicians serving in the area who often do not evaluate for or diagnose symptoms of depression. Within the community there is a disconnect between the physical and mental health symptoms of the body that leads to a lack of mental health diagnoses and referrals to appropriate treatment. When these symptoms are overlooked for too long, in the worst cases they can lead to higher rates of suicide. Compounding the stigma in these communities, suicides are often not reported by the medical examiner as a cause of death on death certificates. Rather, death certificates indicate cause of death as a car accident or accidental overdose so as to not bring embarrassment to the family of the deceased (Reynolds, personal communication, June 17, 2020).

To combat this stigma, representatives from the Region often present at conferences for young ranchers. During these presentations, Region 3 staff share information about behavioral health and wellbeing, and promote the availability of behavioral health and crisis services in the area.

Additionally, the recommendations for centralized crisis hotlines made in the *National Guidelines* may also be more difficult to implement in rural areas due to beliefs in rural communities that people in the city would have no way to relate their problems. A study by the Pew Research Center found that “many urban and rural residents feel misunderstood and looked down on by Americans living in other types of communities [and that] people in other types of communities don’t understand the problems people face in their communities”.²³ This affects the use of the centralized crisis hotline in Colorado by individuals in rural and frontier areas.

During the phone interview with Colorado’s Office of Behavioral Health, it was noted that there is reluctance among both individuals in need of care and law enforcement officers in smaller communities to call into an anonymous state crisis hotline number. The reluctance is fueled by a sense of resentment that someone “in the big city would actually know about my life and my problems? Why do they think they can fix this?” This leads to more after-hour emergency calls to local community providers, which are often already overburdened, when the Colorado Crisis Services Hotline could just as easily direct the caller to appropriate care and dispatch appropriate crisis services (Lee, personal communication, July 1, 2020).

Higher utilization of the centralized hotline can relieve the pressure of rural providers who are already overburdened with other responsibilities. During the interview with the ANTHC, a former provider in a remote village shared his story about being the only clinician available to answer crisis calls in the community during a six-month period. During this period, he had to be constantly available and in reach of his phone, even while trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials. A centralized call center that is promoted and utilized across the state could help absorb some of these misdials, and alleviate some of the pressure on rural providers.

To encourage the use of the statewide hotline, New Mexico waived the state’s unfunded requirement for local providers to operate their own emergency call capability. The only thing required of the providers is a memorandum of understanding with the statewide call center (Lindstrom, Wynn, personal communication, June 9, 2020).

Sustainability

Crisis services in rural and frontier areas face sustainability challenges in order to provide quality crisis care to “anyone, anywhere, anytime,” when the population size and demand for services may not fully support the overhead and staffing requirements of the programs, especially for crisis receiving and stabilization facilities.

Many states fund their crisis services with state general revenue funds, especially for those services provided in rural and frontier areas of the state. Prior to its implementation of the Medicaid Section 1115 waiver, all of Alaska’s crisis services were paid for through state general revenue funds and funds from the Indian Health Service for services provided to tribal villages (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Even with the

new Medicaid Section 1115 waiver for crisis services, the state will continue to rely on general revenue funds for building infrastructure and supplementing costs of care that cannot be covered by Medicaid (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020).

Tennessee approaches this challenge by implementing a “firehouse model” to fund services provided by mobile crisis teams and crisis stabilization units. In this approach, crisis services are paid for on a per-member, per-month basis, based on the number of members in a particular catchment area at the time rates are established, not based on the number of people receiving services. Thus far, it has allowed for the sustainability of crisis services in rural areas of the state.

The changes implemented by the Centers for Medicare and Medicaid services in response to the COVID-19 pandemic have been incredibly helpful to states in providing crisis services to individuals in rural and frontier areas. A lack of broadband access in these areas limits an individual’s ability to connect remotely to telehealth services, creating a greater demand for telephonic interventions, which are typically not reimbursed by Medicaid. However, as of March 1, 2020, under the CARES Act in response to COVID-19, CMS has waived the requirements for video technology and now allows the use of audio-only equipment to furnish a variety of services described under 42 CFR § 410.78(a)(3).²⁴ In addition to the flexibility for telephonic interventions, CMS has also relaxed some rules related to the qualifications an individual needs to be reimbursed for telehealth services. Prior to the emergency declaration, only certain providers were able to bill Medicaid for the provision of telehealth services. During the emergency declaration, all providers eligible to bill Medicaid for their professional services may now also bill for the telehealth services they provide.²⁵

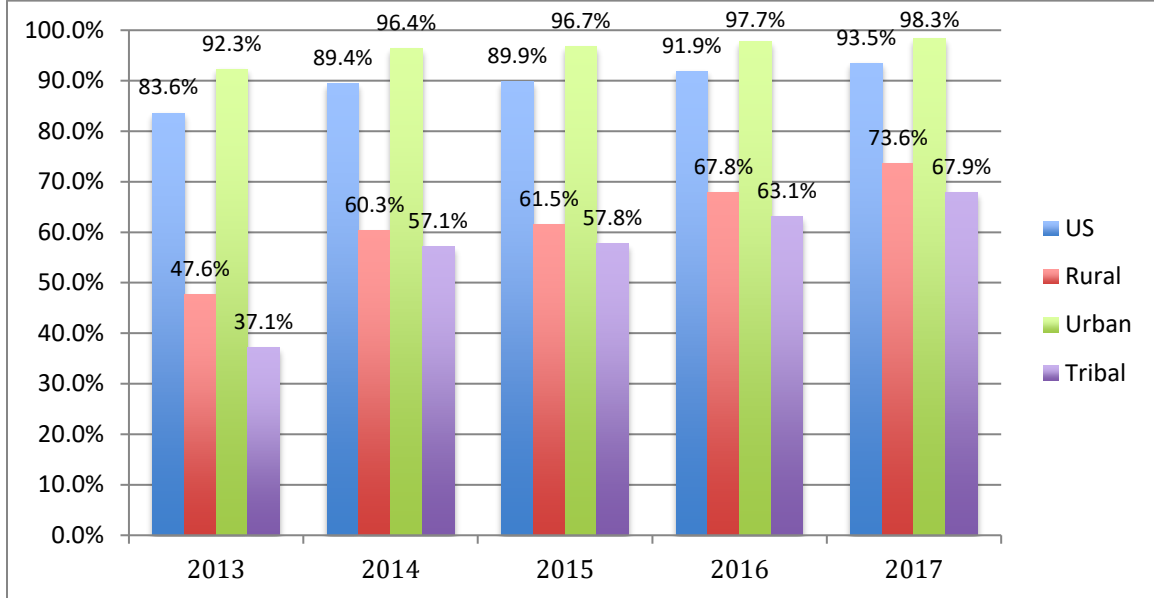
These flexibilities allow states to better serve individuals in rural and frontier areas, and increase access to crisis services for these populations. Each state interviewed for this report expressed appreciation for these changes, and advocated they be made permanent, beyond the public health crisis.

Use of Technology and Broadband Access

As described in the sections above, technology offers exciting opportunities to deliver sustainable crisis services to individuals in rural and frontier areas of the U.S. However, the infrastructure to support these methods is often lacking in less densely populated areas of the country. Inconsistent broadband connectivity in rural and frontier areas was identified as an area of need during each of the seven phone interviews conducted for this report.

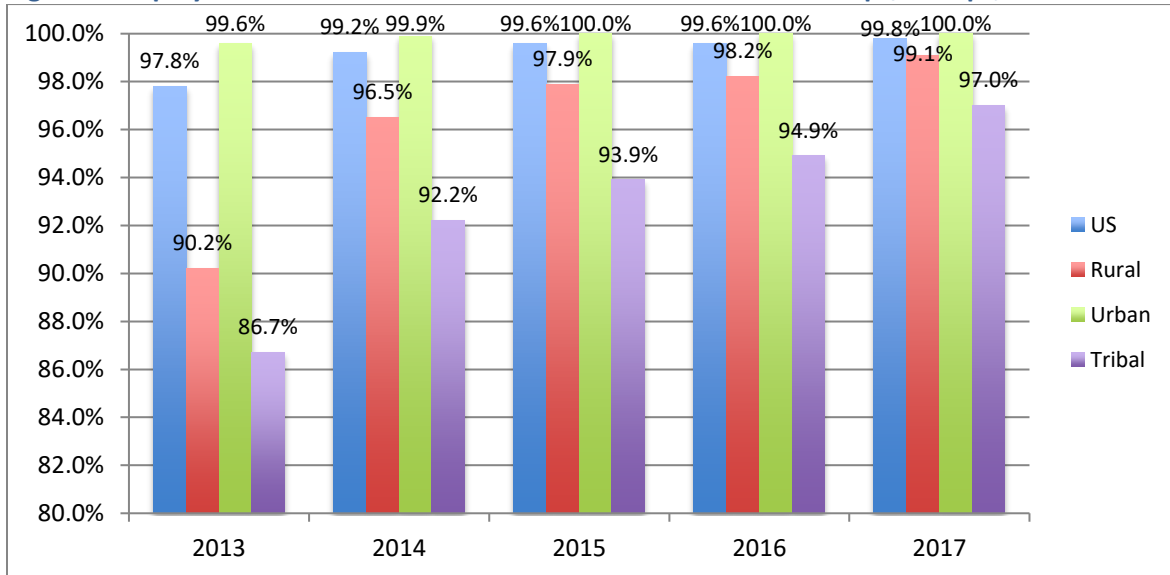
According to the Federal Communications Commission (FCC), the minimum fixed-broadband requirement is 25 Mbps download speed and 3 Mbps upload speed.²⁶ Data from the FCC show that this minimum level of broadband access has significantly expanded across all areas of the U.S., including rural and tribal areas, since 2013, although access in rural and tribal areas still lags behind urban connectivity. See Figure 1.²⁷

Figure 1: Percentage of Population with Fixed Broadband Services of 25 Mbps/3 Mbps, 2013-2017



In addition to calculating rates of fixed broadband availability across the U.S., the FCC also monitors the availability of cellular technology. The minimum performance benchmark for mobile services is 4G LTE, within minimum speeds of 5 Mbps download, and 1 Mbps upload.²⁸ This level of mobile access is more widely available across all areas of the U.S., including rural and tribal areas, than fixed broadband services. See Figure 2.²⁹

Figure 2: Deployment of Mobile 4G LTE with Minimum Service of 5 Mbps/1 Mbps, 2013-2017



While broadband connectivity, both fixed and mobile, is improving, and appears to be available throughout both rural and urban areas of the U.S., the experiences of individuals living in these areas may not align with the information available from the FCC. According to a 2018

Bloomberg report, the FCC’s connectivity map (available onlineⁱ), which maps the availability of broadband access by address, is inaccurate because it relies on Census blocks to calculate connectivity at a given address. Within Census blocks, which tend to cover small areas in urban communities and large tracts of land in rural areas, the availability of broadband can vary quite a bit. According to the report, “just because your closest neighbors have broadband doesn’t guarantee you’ll have any”.³⁰ While the FCC purports that 21.3 million Americans lack access to broadband connectivity, research from BroadbandNow estimates that the number of Americans without broadband access is closer to 42 million, when taking into account the disparities within Census blocks.³¹ The FCC data also do not consider limitations accessing broadband services due to the associated costs, and inability of some individuals to afford these services.

Not only does a lack of reliable broadband access limit the availability of telehealth services in rural and frontier areas, it also affects the perception of safety of mobile crisis response teams in rural and frontier areas. As discussed above, there are not enough mobile crisis teams to serve the entire Western Slope in the State of Colorado. This geographic area has mountainous terrain and can experience significant weather events, especially in the winter. Mobile crisis response teams are often reluctant to travel in these conditions, especially at night, when connectivity may be unavailable or inconsistent. To reassure members of the mobile crisis teams that they should be able to reach help, should it be needed, the Office of Behavioral Health is sharing a map of broadband and cellular coverage with the mobile crisis teams. Additionally, mobile crisis teams across the state are exploring the idea of setting up mobile crisis “pop-up shops” in grocery stores and libraries in communities with better broadband coverage. The mobile crisis teams market to individuals that they can meet them closer in the community than an individual would have to travel to reach a crisis stabilization unit, while utilizing available broadband services. While this is not a perfect solution because the mobile crisis teams are not meeting individuals where the crisis is occurring, it is a compromise to help maximize the safety and wellbeing of the community, and sense of security of the mobile crisis teams.

Staff from South Carolina’s SMHA pointed out that COVID-19 is highlighting the need for expanded broadband connectivity across all areas of the state, and SMHAs across the U.S. can partner with other agencies, including departments of education, to lobby their legislatures for expanded broadband connectivity.

Other Effects of COVID-19 on Crisis Services in Rural & Frontier Areas

The COVID-19 pandemic has restricted state budgets to pursue innovative programs, such as the transportation program and citizen response program in Colorado. It has also reduced the availability of transportation services in Alaska through decreased availability of air transport, compounded by the bankruptcy filing by RavnAir. In addition to these limitations, COVID-19 has also forced the closure or delayed opening of critical crisis services in rural and frontier areas of the U.S.

South Carolina’s SMHA indicated that while mobile crisis response services did not cease during the pandemic, the state did have to temporarily close one crisis stabilization unit because the building is small and the space is not conducive to social distancing. Given utilization rates of

ⁱ The FCC’s Connectivity Map is available online at <https://broadbandmap.fcc.gov/#/>

other crisis stabilization units in the state, it is likely that demand for this unit would have increased during the pandemic; the crisis stabilization unit in Charleston experienced three times as many walk-ins between May and June than it had in previous years. Prior to COVID-19, South Carolina planned to expand its crisis stabilization services in four additional counties; however, the pandemic has delayed these efforts, and future progress is unknown due to budgetary restraints. Hospitals in the four counties where the crisis stabilization unit program was set to expand are funding partners of the initiative; however, given the financial hardships hospitals are facing as a result of the pandemic, they may no longer be able to financially support this initiative.

In Alaska, BHAs have realized an increase in demand for services since the COVID-19 pandemic began, because reportedly, baseline symptoms of anxiety among community members has increased, particularly in smaller communities that may not have centralized water and sanitation, and for those who have multi-generational families living in one home. When COVID-19 began to spread across the U.S., many villages completely closed their borders to the rest of the state, allowing no transportation in or out, with the exception of cargo deliveries. Borders were closed, in part, due to historic trauma caused by the 1925 diphtheria outbreak and tuberculosis epidemic that decimated the populations of small villages (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020). This isolation not only raises the collective feelings of anxiety of the community, but also limits the ability to access necessary care, unless robust telehealth services are available.

In addition, the COVID-19 pandemic has served to further exacerbate health disparities between rural and urban areas, which can heighten anxieties further in the face of a pandemic. Rural communities are disproportionately affected by an array of serious health issues, including heart disease, cancer, and stroke, which put individuals at higher risks of significant health consequences brought on by COVID-19, and can further strain limited resources in rural hospitals and health facilities.³²

Implications for Policy Makers

Although the majority of states offer at least one of the recommended crisis services prescribed in the *National Guidelines*, it would be prudent for SMHAs to review where these services are available, and whether or not they meet the best practices guidelines recommended for their implementation. Based on the interviews for this report, although many states offer statewide crisis hotlines, they may not be used effectively in all areas of the state, especially rural areas, and most states do not use GPS technology to efficiently identify geographic location and dispatch the nearest support. Most states also provide mobile crisis response teams and crisis receiving and stabilization facilities; however, in many states these services are concentrated in urban areas, resulting in extended travel and wait times for individuals in need in rural and frontier areas of the states. States should also consider implementing an electronic bed registry system, if one is not already available, to facilitate access to available psychiatric inpatient and other treatment beds that provide appropriate levels of care closest to an individual's home. An evaluation of a state's crisis system could identify areas where additional services are needed and improvements can be made. The need for expanded promotion of these services was also identified. A review of service utilization could help SMHAs identify areas to more effectively promote their behavioral health crisis services.

The COVID-19 pandemic has highlighted the inequities between the delivery of crisis services in rural and frontier areas and urban areas of the U.S., and the related budget cuts faced by states are forcing the postponement or elimination of innovative programs designed by states to better serve individuals in rural and frontier areas. However, the pandemic has also served to underscore the need for broadband to access telehealth services and has identified opportunities for sustainable telehealth expansion. Behavioral health policy makers have an opportunity to unite with other stakeholder groups (including education and physical health) to advocate for expanded broadband coverage in rural areas. Following the current emergency health crisis, states should work with CMS to make permanent some of the flexibilities afforded to providers in the delivery of telehealth services during the pandemic.

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Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies

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Title: Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies

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Abstract

How a community responds to Behavioral Health (BH) emergencies is both a public health issue and social justice issue. Individuals in BH crisis often receive inadequate care in emergency departments (EDs), boarding for hours or days waiting for treatment. These individuals account for a quarter of police shootings and over 2 million jail bookings per year. Explicit and implicit bias magnify these problems for people of color. Growing bipartisan support for reform provides an unprecedented opportunity for meaningful change, but solutions to this complex issue will require comprehensive systemic approaches. As communities grapple with BH emergencies, the question isn't *whether* law enforcement (LE) should respond to BH emergencies, but rather *when, how, and with what support*. This policy paper reviews best practices for law enforcement (LE) crisis response, outlines the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement and ED utilization, and provides strategies for collaboration and alignment towards common goals. Finally, policy considerations regarding legal statutes, financing, data management, and stakeholder engagement are presented in order to assist communities interested in taking steps to build these needed solutions.

Defining the Issue

Healthcare and criminal justice systems are facing increasing challenges from the growing numbers of individuals experiencing behavioral health (BH) crises (defined here as a crisis related to mental illness or a substance use disorder).^{1,2} Unfortunately, there are few options available for a person in crisis. Law enforcement (LE) agencies, emergency departments (EDs), jails, and prisons have become the safety nets, yet they are not equipped to provide the care that these individuals desperately need.

Unlike medical emergencies, BH emergencies often result in a LE response. BH emergencies constitute between five to fifteen percent of all calls to 9-1-1 systems.³ Adverse and sometimes tragic outcomes are all too frequent. It is estimated that a quarter of police-involved shooting deaths are linked to mental illness, half of which occur in the person's own home.⁴ Over 2 million people with serious mental illness are booked into jail each year, often for non-violent "nuisance" or "quality of life" crimes such as loitering or vagrancy. Not surprisingly, the prevalence of mental illness and substance use disorders in jails and prisons are three to four times that of the general population.^{5,6} Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment.^{7,8,9} Upon release, with Medicaid benefits interrupted and a criminal record, they are more likely to be unemployed, homeless, and rearrested.^{10,11,12,13} Then the cycle continues.

Explicit and implicit bias magnify these problems for people of color. African Americans are 2.6 times more likely to be killed by police than non-Hispanic Whites; when combined with mental illness, this difference is nearly ten-fold.¹⁴ For those struggling with substance use disorders, disparate sentencing penalties (e.g., harsher sentences for crack vs. powder cocaine) result in excessive imprisonment of Black Americans.¹⁵ These long-standing inequities have been underscored by the continued high-profile killings of unarmed people of color by LE. Reducing racial inequities in crisis response and in access to BH care must be a central focus of any reform efforts.

The status quo negatively impacts LE as well. State civil commitment laws often prevent more appropriate responses to persons in crisis by requiring LE officers to conduct involuntary mental health transports. The lack of easily accessible treatment makes these transports time consuming and frustrating for officers.¹⁶ A recent survey of LE agencies in the U.S. estimated the nationwide cost of transporting people with severe mental illness is \$918 million annually. Law enforcement leaders also expressed dismay at the inhumanity of criminalization as a result of their role and concerns that the time spent on this function may restrict their ability to uphold public safety.¹⁷ Police violence takes a toll on the officers too, with high rates of trauma and more suicides per year than line-of-duty deaths.¹⁸

As social movements for racial equality gain prominence, calls for fundamental policing reforms have gained traction and become more politically viable. This presents an unprecedented opportunity to rethink current approaches to people in BH crisis. While some call for "defunding" of the police in lieu of clinician first-responders, this will not eliminate the need for LE completely. Some BH emergencies may not become apparent until after officers are on scene for another issue. Other situations may pose an unacceptable amount of safety risk to civilian clinicians. Solutions will require broad systemic approaches with collaboration between LE and the healthcare system to create the optimum response for different types of cases, some of which may involve an LE response, a clinician response, or a co-response with shared responsibility.

For any response to be successful, the responders—whether LE or clinicians—require a functioning BH crisis system that can quickly accept individuals in crisis and provide the care they need. The solution is not simply to build more inpatient psychiatric beds any more than building more dialysis centers is the solution for gaps in diabetes care. Rather, communities must commit to investing in a coordinated system of care in which people get the help they need as early as possible, in the safest and least-restrictive setting as possible. This is underscored in The National Association of State Mental

Health Program Directors' (NASMHPD) recent report entitled, *"Beyond Beds: The Vital Role of a Continuum of Psychiatric Care."*^{19, 20} Other initiatives such as *Crisis Now* describe systemic approaches to community-based crisis services that are often less costly than more restrictive alternatives.²¹

This policy paper is intended as a guide for those who seek better ways to respond to individuals experiencing a BH crisis, beginning with the moment a request for help is made and ending with the successful transition to an appropriate level of care. We describe best practices for LE crisis response and outline the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement, ED utilization, and hospital admission. We discuss the importance of addressing this complex issue from a systems approach rather than relying on standalone programs for an easy fix. Finally, we present policy considerations to assist communities to take concrete steps towards building an advanced crisis response system.

Law Enforcement Responses

The LE response to BH crisis has been under increasing scrutiny by the courts for several decades. In particular, the 9th Circuit Court of Appeals 2011 ruling in *Glenn vs. Washington* was a critical decision in the movement to improve outcomes for individuals experiencing behavioral emergencies. In this case, which involved the death of a young man in crisis holding a knife, the Court upheld an earlier ruling (*Deorle v Rutherford, 2001*)²² stating that "we have made it clear that the desire to quickly resolve a potentially dangerous situation is not the type of governmental interest...that justifies the use of force that may cause serious injury." Furthermore, they underscored that the use of less forceful tactics is expected when responding to calls involving a person in emotional distress who is causing a disturbance or resisting arrest. Instead, LE officers should be expected to proceed slowly and figure out how to de-escalate the situation. This decision became the basis for many LE agencies to implement or expand Crisis Intervention Team (CIT) programs.

CIT and Training

The CIT model is the most widely known approach to providing LE with the tools needed to recognize individuals experiencing a BH crisis, deescalate them, and divert them to treatment instead of jail. CIT began in the late 1980s in Memphis, Tennessee, in response to a police shooting involving a person with mental illness. The centerpiece of CIT is a 40-hour training that involves scenario-based exercises and participation of community stakeholders including BH clinicians, treatment agencies, people with lived experience of mental illness, families, and advocacy groups.

CIT training is associated with higher likelihood of referral to treatment and lower likelihood of arrest, and CIT trained officers are more likely to use verbal redirection as the highest intensity level of force in the field.²³ CIT training is most effective when undertaken voluntarily by experienced officers. Compared to officers mandated to receive CIT training, voluntarily trained officers demonstrate better self-efficacy, de-escalation skills, and referral decisions. Even when physical force was documented, voluntarily trained CIT officers were more likely to refer to treatment services and less likely to make an arrest.²⁴ It is estimated that 3,000 jurisdictions across 47 states have implemented CIT programs.²⁵

The National Council for Behavioral Health and CIT International recommend that 100% of a department's uniformed patrol officers receive a required 8-hour Mental Health First Aid for Public Safety training while 20-25% voluntarily receive the 40-hour CIT training. 9-1-1 personnel should also receive training to help them recognize calls with a mental health nexus so that they can dispatch CIT trained officers when needed. This approach ensures both a basic level of competency among all officers and 24/7 availability of a specialized CIT response.

While CIT is often thought of as a police training program, its creators continue to underscore that training is only one part of a more comprehensive community approach.²⁶ Once officers are trained

to identify a person in crisis and divert them to treatment, their first question is often “divert to what?” For this reason, the full CIT model recommends a crisis system that is ready to receive individuals from LE with quick and easy access and 24/7 availability. In practice, services are often not available and patients instead board in EDs waiting for inpatient beds. Oftentimes the officer must wait with them, sometimes for hours, making jail the path of least resistance for busy officers juggling multiple calls for service.

Beyond CIT: Dedicated Specialty Teams

Some LE agencies have created BH specialty teams composed of dedicated—not designated—personnel. This is a crucial distinction in LE. CIT trained officers are often *designated* to handle BH calls in addition to their regular duties, whereas *dedicated* teams focus exclusively on BH concerns. Team members may respond to mental health calls like regular CIT officers, but their specialization provides time and flexibility to problem-solve complex cases and collaborate with mental health partners on system improvement efforts. Examples include substance use teams that connect people to treatment in lieu of arrest, mental health case management teams that follow up with individuals after a crisis, investigative teams that seek to connect individuals to treatment before they reach the point of crisis, and homeless outreach teams. This level of resource commitment indicated leadership buy-in, and many of the agencies recognized as Police-Mental Health Collaboration Learning Sites (described below) have some form of dedicated team, in addition to CIT training, as part of their comprehensive approach to BH.

BH Crisis Response

Currently there are no national standards for crisis services like that of Emergency Medical Services (EMS) systems. However, several emerging frameworks have started to define crisis services and how they should interact with LE:

The Sequential Intercept Model describes the typical pathway through criminal justice system for a person with BH needs and identifies opportunities for the healthcare system to intervene.²⁷ Intercept 0 (community-based crisis services) and Intercept 1 (9-1-1 and first responders) describe opportunities for crisis and LE to collaborate to prevent LE contact or arrest.²⁸

Crisis Now: Transforming Services is Within Our Reach, is a 2016 report that lays out essential services for a crisis continuum of care: call centers, mobile crisis teams, and stabilization centers.²⁹

National Guidelines for Crisis Care: A Best Practice Toolkit was released in 2020 by the Substance Use and Mental Health Services Administration (SAMHSA) as an update to Crisis Now.³⁰

21st Century Behavioral Health Crisis Care is a report by the Group for the Advancement of Psychiatry, in collaboration with the National Council for Behavioral Health, scheduled to be released in 2021 that describes the services, competencies, and governance needed to create a coordinated crisis system with measurable outcomes.³¹

Crisis Call Centers and “Care Traffic Control”

Crisis call centers are often the first entry point to crisis services and, in some instances, can take the place of 9-1-1 calls that might otherwise have resulted in police dispatch. Crisis lines offer support to people in crisis 24 hours a day, 7 days a week via a range of modalities such as suicide hotlines, warm lines, and text functions. The National Suicide Prevention Lifeline (NSPL), launched in 2005, is a network of more than 170 crisis call centers located in communities across the U.S. that are supported by

SAMHSA and local funding. The Veterans Administration Crisis Line (VCL) is linked to the NSPL, has since its inception in 2007 responded to more than 3.9 million calls, 467,000 online chats, and 123,000 texts.³² In some communities crisis calls are accessed through nonemergency and information lines such as 2-1-1 and 3-1-1 or other local crisis lines. Studies of NSPL call centers have found that callers have significantly decreased suicidality during the course of the call,³³ a third are successfully connected with mental health referrals,³⁴ and less than a quarter result in LE or EMS being sent without the caller's collaboration.³⁵ As awareness of the utility of crisis lines increases, there has been growing momentum to create a nationwide, easy to remember three-digit number for NPSL and other crisis lines. The Federal Communications Commission (FCC) recently approved a new 9-8-8 number for implementation in July 2022.³⁶

In addition to crisis counseling, crisis call centers are well situated to serve as a centralized hub for relaying information and coordinating the appropriate response. Such "care traffic control" functions include dispatching the nearest mobile crisis team, making outpatient appointments, and finding placement in crisis facilities or inpatient units. Some systems even have clinicians embedded in 9-1-1 communications centers so that BH calls can be diverted to the crisis line in lieu of a police response. Local and regional mental health system leaders must engage with relevant emergency management agencies to develop clear protocols and clinical criteria for when to dispatch a clinical team, LE, or both. Such policies and procedures can also help reduce the potential for implicit bias to affect decision-making.

Mobile Crisis Teams

Mobile crisis teams (MCTs) play a critical role in providing access to care for people in crisis. The first MCTs are believed to have been established as early as the 1930s in Amsterdam.³⁷ As of June 2020, at least 34 states in the U.S. have MCTs, although few operate statewide.³⁸ MCTs are typically composed of one or two providers including masters-level clinicians and psychiatric technicians³⁹ and frequently interact with EMS, LE, and CIT-trained officers.^{40, 41} MCTs meet the patient where they are—at home, in the ED, on the street—obviating the need to transport them to a more restrictive environment.^{42, 43, 44} MCTs should have clear clinical criteria for when to request assistance from LE. Standardized protocols reduce the potential for implicit bias to affect clinical decision-making that may unnecessarily expose people of color to higher rates of LE involvement.

Some localities have established centralized dispatch for MCTs, often within crisis call centers. To improve response times, MCTs may be stationed throughout larger geographical areas (e.g., in police departments or outpatient clinics). Rural areas in particular benefit from dispersed models that are centrally coordinated. A more advanced approach is illustrated by the crisis line in Tucson, Arizona, which uses mobile phone software with GPS technology. Dispatchers can see each MCTs' location and status, allowing them to identify teams that are nearby or close to finishing up an encounter, similar to popular app-based ride hailing companies. The app also facilitates transmission of clinical information from the crisis line dispatcher to the MCT to assist with continuity of care.

Co-Responder Teams

In co-responder models, a BH clinician co-responds to crisis calls with LE. This model is popular in the United Kingdom and Canada (where it is sometimes called "street triage") and was pioneered in the U.S. by the Los Angeles Police Department in the early 1990s. There is wide variability in how co-responder programs are operationalized.⁴⁵ Models include teams that ride and respond together, teams that arrive separately, and teams where only the officer responds to the scene with clinician support via phone or video. Some programs have plainclothes officers in unmarked cars, while others are uniformed. There is no consensus on which model is most effective, and programs should be adapted to the local context. For example, an officer and clinician riding together may work well in a dense urban

area with a high volume of mental health calls, while a more sparsely populated area may be better served by one of the other models. EMS co-response models have also been implemented. Developed in 1989 in Eugene, Oregon, the CAHOOTS (Crisis Assistance Helping Out On The Streets) program pairs a clinician with EMS to respond to crisis calls.⁴⁶ The RIGHT (Rapid Integrated Group Healthcare Team) Care model, operating in Dallas, Texas, deploys a three-member team of a clinician, LE officer, and paramedic.⁴⁷

While community members report they prefer the co-responder model to a police-only response, studies of other outcomes have been mixed.⁴⁸ A review of police and mental health co-responder programs concluded that these programs decreased arrests and the amount of time officers spent handling mental health calls, but there was limited evidence on other impacts.⁴⁹ Furthermore, many programs are limited in scope in terms of hours of operation or geographical area served. In particular, programs experience difficulty when there is a lack of community mental health resources. While co-responder models have recently received much attention, they are not a panacea but rather one component of a larger crisis response system.

Specialized Crisis Facilities

Crisis facilities vary widely in scope and capability. Some are designed for low acuity patients who primarily need peer support and a safe place to spend the night, while others treat the highest acuity patients presenting as danger to self or others, acute agitation, and substance intoxication. When coupled with the lack of standardized nomenclature, this variation can create confusion for community stakeholders and policymakers unless expectations are clearly articulated and understood.

From its inception, the CIT model outlined requirements for a “receiving center” where officers can bring individuals for treatment.⁵⁰ These include 24/7 availability, faster drop-off times than jail, and a policy of never turning officers away. Ideally, the center should be able to accept any patient regardless of behavioral acuity, including those who may be suicidal, violent, or intoxicated. Such a “no wrong door” policy ensures that highest acuity patients receive care in a specialized setting designed to meet their needs.

Receiving centers are known by a variety of names— crisis stabilization units, 23-hour observation units, psychiatric emergency services units, emPATH (emergency Psychiatric Assessment, Treatment & Healing) units—and may be free-standing or adjacent to a hospital or ED. Many also receive patients via LE, MCTs, transfers from EDs, and walk-ins.⁵¹ Crisis facilities provide a safe and therapeutic environment for assessment and stabilization, with interdisciplinary treatment teams that include psychiatric providers, social services staff, nurses, BH technicians, or peer supports. With rapid assessment, early intervention, and proactive discharge planning, most patients are able to return to community-based care. Studies show these units are associated with reduced rates of hospitalization, boarding of psychiatric patients in EDs and arrests.^{52, 53, 54}

Living Rooms, detoxification centers, and sobering centers provide 24/7 alternatives for less acute needs and often accept police drop-offs for patients who meet their admission criteria. They are typically unlocked and serve patients who are voluntary, non-violent, and motivated for help.⁵⁵ Living Rooms offer a home-like environment with couches and artwork and are staffed predominantly by peer specialists, with limited coverage by a psychiatrist or other provider. They are especially helpful if psychosocial stressors are the main precipitants of the crisis. Detoxification centers provide medically supervised detoxification services, while sobering centers employ primarily psychosocial and peer support.

Crisis clinics or mental health urgent care centers offer same-day or walk-in access for outpatient assessment, crisis counseling, medication management, and coordination of care, including enrollment in benefits. These clinics can be part of a crisis center, ED, outpatient specialty mental health

clinic, or standalone, and provide bridge services until the person is connected to appropriate outpatient care.

Crisis residential, crisis respite, and peer respite facilities offer longer term (days to weeks) residential care. They are often used as step-down from inpatient care. Some programs may accept low acuity patients from LE.

Post-Crisis Care

Post-crisis wraparound services are increasingly recognized as essential to ensure that patients are successfully linked to long-term treatment and avoid reutilization of crisis and other acute services.^{56, 57, 58} These services can be provided by BH programs (e.g., peer navigators), LE-based case management, or a combination of both. In addition, community paramedicine approaches deploy paramedics to check on frequent 9-1-1 callers, some of whom have BH needs.⁵⁹ In each model, the goal is for crisis services to connect people to treatment and address the social determinants of health (e.g., housing, transportation, food) with the goal of preventing future encounters with LE.

Advanced Systems

Crisis Services vs. Crisis Systems

While each of the various programs described thus far is likely to improve outcomes in isolation, the impact is multiplied when an array of programs and services work together as a coordinated system to achieve common goals. This approach is illustrated in Figure 1, which is based on the crisis system in Tucson, Arizona. In this model system, healthcare and LE stakeholders agree on a common goal of preventing avoidable jail, ED, and hospital use by providing care in the least restrictive setting that can safely meet the needs of an individual experiencing a BH crisis. Because less restrictive settings tend to be less costly, clinical and financial goals are aligned. In Arizona, a Regional Behavioral Health Authority (RBHA) contracts with multiple BH agencies to create an array of services organized along a continuum of intensity, restrictiveness, and cost. At all points along the continuum, which in this case includes co-location of crisis call center staff within 9-1-1, co-responder teams, and crisis facilities, easily accessible handoffs by LE facilitates connection to treatment instead of arrest. To further incentivize coordination, some contracts confer a “preferred customer” status to LE, so that, for example, response time targets for MCTs are faster for calls that involve LE.

Governance and accountability are key to ensuring that crisis services operate as an organized and coordinated system. In the Arizona model, the RBHA serves this function via its role as the single payer and regulator for the crisis system. Other systems may be governed by counties, cities, or formalized stakeholder groups. Regardless of the convener, advanced crisis systems should have governance and accountability structures that align the various services towards common goals, foster collaboration between a broad array of community stakeholders (e.g., LE, health systems, schools, etc.), operate with a “no wrong door” approach where components collaborate to deliver services without restrictive entry or exclusion criteria, and use data to measure outcomes, make decisions, and improve performance.

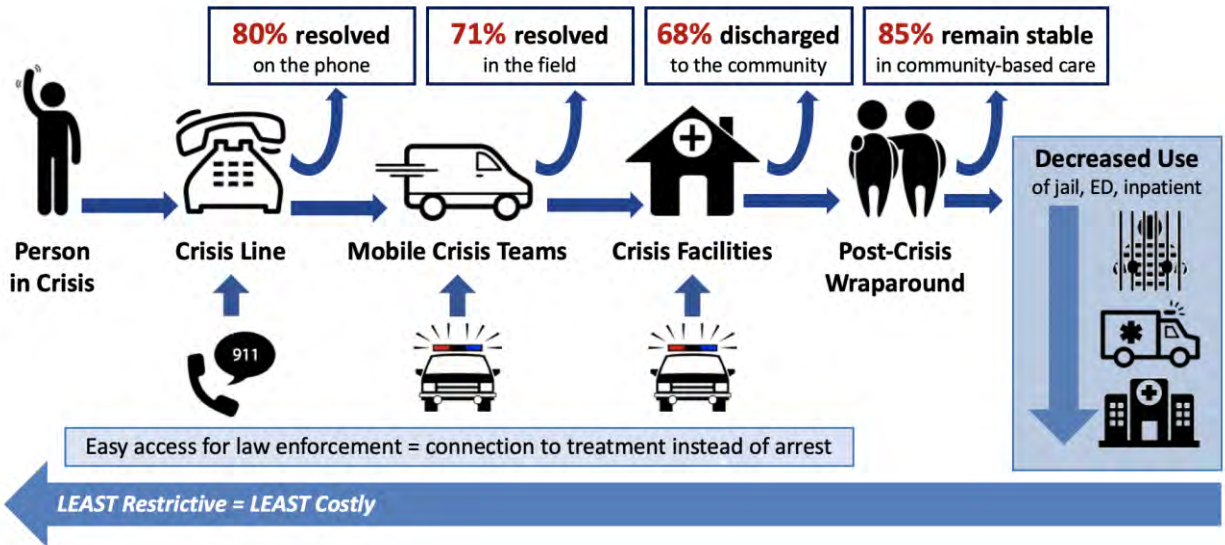


Figure 1. Alignment of crisis services towards a common goal. In a high functioning system, the individual services in the continuum work together to achieve a common goal, in this case, stabilization in the least restrictive (which is also the least costly) level of care. Data is provided by Arizona Complete Health and applies to the southern Arizona geographical service area for FY2019. Crisis line resolved calls is the percentage of calls resolved without dispatching CMT, LE, or EMS. MCT resolved cases is the percentage of face-to-face encounters resolved without the need for transport to a higher level of care. Crisis facilities community disposition is the percentage of discharges to levels of care other than hospital, ED, or jail. Continued stabilization is the percentage of individuals with an MCT or crisis facility encounter who did not have a subsequent ED visit or hospitalization within 45 days.

“One Mind” Law Enforcement Organizations

Social movements such as Black Lives Matter have motivated communities to examine the role of LE in supporting the safety and welfare of their citizens, and there is growing momentum for policing reforms such as community-oriented policing and procedural justice that seek to improve trust and legitimacy between LE and the communities they serve. The treatment of a community’s most vulnerable members plays an important role in building that trust, and thus improved responses to BH crisis are critical to reform efforts.

Like crisis systems, public safety agencies benefit from a broad organizational approach that goes beyond the implementation of a single program or training. The International Association of Chiefs of Police (IACP) created its “One Mind” campaign to encourage this type of systems thinking, challenging LE leaders to begin by committing to three core elements: partnership with community mental health agencies, model policies to guide interactions with individuals experiencing a BH crisis, and training programs built on Mental Health First Aid and CIT.⁶⁰

Figure 2 illustrates how these elements fit together to create a systematic approach across the Tucson Police Department. Leadership provides the foundation by creating the culture and operational procedures needed to support safe and compassionate interactions with people in crisis. Mental Health First Aid training provides a basic level of competency to all officers, while those with the aptitude and interest are encouraged and incentivized to pursue more advanced CIT training. Specialized teams receive further training such as Motivational Interviewing and Trauma-Informed Care and work to develop partnerships with BH agencies and other community partners As they continue to gain

knowledge and experience, these specialized teams also serve as subject matter experts to the rest of the organization.

A growing number of LE agencies have developed similarly sophisticated strategies for addressing BH emergencies. The U.S. Department of Justice Bureau of Justice Assistance has identified ten such agencies departments as model programs called Police-Mental Health Collaboration Learning Sites. These agencies serve a wide range of jurisdictions in terms of population size and geographical distribution. Most employ a number of the programs described in this paper, tailored to work for their individual communities. What makes these departments exceptional is that these programs fit within comprehensive, agency-wide approaches in partnership with BH and other social service agencies. Details about each program can be found on the Learning Sites website,⁶¹ and funding is available for site visits and other technical assistance. In addition, the Council of State Governments, which supports the Learning Sites program, has created an online *Police-Mental Health Collaboration Toolkit* to help LE executives to develop or advance approaches to addressing BH crisis.⁶²

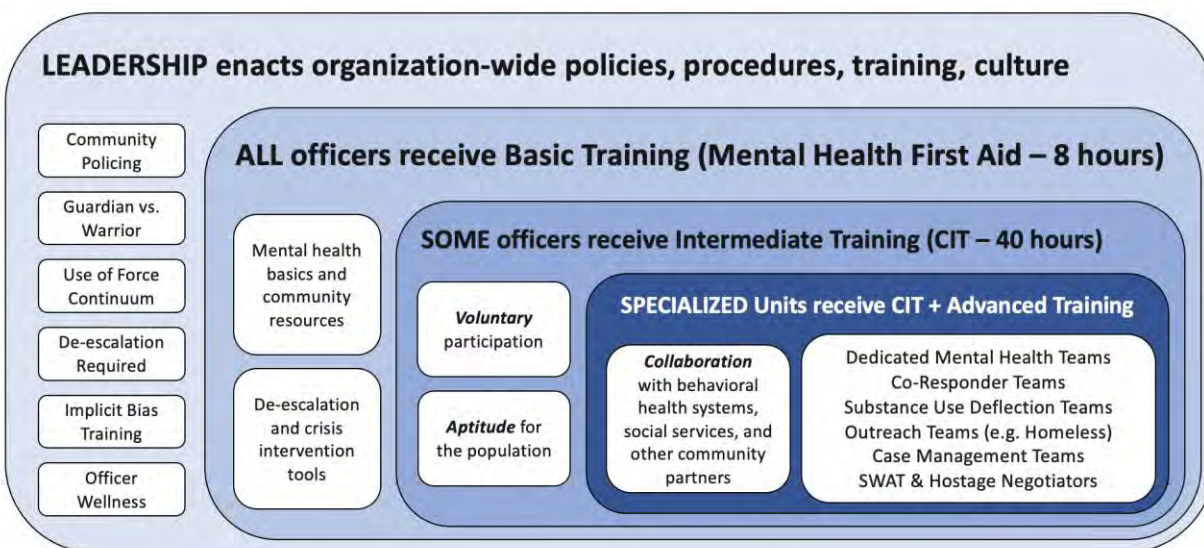


Figure 2: Organizational approach to serving community members with BH needs.

Cost Savings Across Systems

Numerous studies have demonstrated that crisis services reduce spending on ED visits and inpatient hospitalizations. For example, in one study, a mobile crisis intervention decreased spending on inpatient admissions by 79%,⁶³ and in another, the addition of a clinician co-responder reduced costs by 23% compared to regular policing due to fewer inpatient admissions.⁶⁴ A claims analysis of crisis stabilization services estimated a \$2.16 return on investment due to savings in inpatient, outpatient, and ED utilization.⁶⁵ The Health Care Financial Management Association estimates that eliminating unnecessary ED use for BH emergencies in the U.S. could save as much as \$4.6 billion annually.⁶⁶

Better crisis response benefit LE and the justice system as well. CIT training in the Denver Police Department resulted in follow-up care for more than 44% of individuals rather than arrest and incarcerations, saving the state more than \$3 million in jail expenses.⁶⁷ By changing the response to suicidal patients “barricaded” in their homes, the Tucson Police Department reduced the number of SWAT deployments from 14 per year to 2, at a cost savings of \$15,000 each.⁶⁸

The true power of a collaborative approach is illustrated by studies of savings across healthcare and justice systems. Maricopa County, Arizona, has a robust crisis system composed of call centers, mobile teams, and crisis stabilization centers. In 2016, the system served approximately 22,000

individuals and generating savings of \$260 million in hospital spending, \$37 million in ED spending, 45 years of ED psychiatric boarding hours, and 37 full-time equivalents (FTEs) of police officer time and salary.⁶⁹

IV. Policy Implications

To create high-functioning systems, a range of policies across multiple stakeholders must be put in place.

Civil Commitment and Mental Health Transports

While many people in crisis voluntarily seek care, there remains a subset who lack the capacity to make rational decisions. In these situations, state civil commitment statutes define the role of LE in detaining and transporting individuals involuntarily for psychiatric evaluation.⁷⁰ In some states, only LE—not clinicians or family—can initiate the process to petition the court for emergency psychiatric evaluation. Even if civilians can initiate petitions, some states require that the individual’s risk of harm to self or other be “imminent.” Waiting for the situation to decompensate to the point of present dangerousness creates the conditions for a volatile and risky encounter with LE. Furthermore, existing laws often dictate that involuntary transports to crisis or other treatment facilities must be performed by LE. However, a recent survey of LE agencies estimated that 65% of transports did not pose a risk of harm to others and could be completed by another entity.⁷¹ Many of these laws were written decades ago and should be updated to include earlier interventions and alternative crisis responses rather than relying so heavily on LE. LE should provide transport only when no other means is available to protect the safety of the individual or those providing the transport. The use of handcuffs or physical restraints should be a last resort and limited to those persons who have been identified as risks to themselves or others without the use of restraints.

Regulations and Accreditation Standards

Because most crisis services are funded and regulated at the state or local level, there is wide regional variation in terms of program definitions, licensure, accessibility, and quality. National standards are needed in order to ensure consistent quality across crisis services and systems. The upcoming *21st Century BH Crisis Care* report, created in response to the federal Interdepartmental Serious Mental Illness Coordinating Committee’s call for national standards, will be the first attempt at defining measurable standards for a comprehensive crisis system, inclusive of service continuum, governance/finance, and clinical quality.⁷² In the meantime, accreditation exists and should be incentivized for some individual crisis programs via organizations such as the American Academy of Suicidology, CARF International, and the Joint Commission.

Standardized practice across the nearly 18,000 LE agencies has been even more challenging. While best practice standards have been proposed through initiatives such as President Obama’s 21st Century Policing Task Force⁷³ and IACP’s One Mind Campaign, participation is voluntary. Too often, reform and accountability are only realized after a Department of Justice consent decree is enacted. However, there is growing support for policing reform legislation that include accreditation standards and incentives for LE agencies to adopt more progressive practices.

Financing

With organized governance and financing structures, communities can braid funding streams from federal, state, and local sources to create robust crisis systems that provide both good care and

responsible stewardship of public funds. Medicaid in particular is a critical component of crisis financing, and thus Medicaid expansion is one straightforward strategy for states to enhance crisis funding. All states use Medicaid to finance some degree of crisis services (e.g., reimbursement for billing code “H2011 – Crisis Intervention Service”), but those with managed Medicaid have increased flexibility to fund a wider variety of crisis services via 1115, 1915(b), or 1915(c) waivers. Managed care organizations provide a structure to combine multiple funding streams such as state and local funds earmarked for crisis or indigent care, SAMHSA Mental Health and Substance Abuse Block Grants (MHBG and SABG), and other federal grants such as Projects for Assistance in Transition from Homelessness (PATH) grants and Cross Area Service Program (CASP) grants. Such arrangements maximize efficiency and accessibility by pooling resources to create a common safety-net crisis infrastructure that can serve anyone in need, regardless of payer.⁷⁴ Emerging financing models such as value based payments provide additional mechanisms for Medicaid programs to invest in crisis and other social services, and future federal budgets may include a crisis “set aside” in the MHBG.^{75, 76}

In contrast, Medicare and most private health plans provide little or no coverage for crisis services. When privately insured individuals receive crisis care, the cost is either uncompensated or borne by public safety-net funds. These payers must be held accountable to provide parity coverage for BH emergency care. The Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) demonstration program provides parity Medicare reimbursement for EMS to transport to “alternative” destinations other than the ED, including crisis facilities.⁷⁷ Models like this are a step in the right direction

In communities with robust crisis systems, co-responder and other support personnel can be allocated to collaborate with and assist LE officers without additional cost to LE agencies. There are also federal grants such as the COPS (Community Oriented Policing Services) and Byrne Memorial Justice Assistance Grants that LE may use to create BH programs.

Policy makers, state officials, and payers may express concerns about the costs associated with funding a crisis system. The cost savings described above must be presented in a compelling narrative to convince decision-makers that the costs of *not* doing so is neither good business sense nor good for community health and safety.

Data Sharing and Quality Improvement

Individual-level data sharing can help LE agencies and BH providers coordinate care for individuals involved in both systems. For example, knowing that someone is receiving BH services can help LE officers choose the most appropriate intervention when coming into contact with that individual. Conversely, LE officers often have information about past interactions and psychosocial factors that can aid clinicians in their assessment. When developing data sharing protocols, it is important to reach consensus regarding relevant state and federal laws and to include input from stakeholders with lived experience. The Health Insurance Portability and Accountability Act (HIPPA) is often seen as a barrier but does allow data sharing in emergencies. Data can also be shared via Business Associate Agreements (BAA) or by obtaining consent from the patient.

Data is a powerful tool for quality improvement across the entire system,⁷⁸ and performance data will also be increasingly tied to financing as alternative payment models evolve. Data can also be used to improve health equity by deliberately looking at disparities in outcomes among underserved populations. However, very few quality measurement standards exist for BH crisis services. Some standard measures are in use by crisis call centers⁷⁹ and a measure set for crisis facilities has been proposed.⁸⁰ Reporting through SAMHSA’s Uniform Reporting System, which is already required of states receiving MHBG funds, may be expanded to include crisis metrics if the MHBG crisis services set aside is approved in upcoming federal budgets.⁸¹

For now, communities will continue to be compelled to define metrics that reflect their values. Aligning metrics across multiple system components can guide the system towards common goals. For example, in Figure 1, the various system components—call center, mobile teams, crisis facilities—report the percentage of patients stabilized without the need for a higher level of care. Each of these measures is one facet of the overarching goal of crisis stabilization in the least restrictive setting possible, and can be organized into a dashboard that monitors performance relative to that goal. System partners can then use real-time outcomes to identify targets for improvement and organize improvement initiatives.

For communities just beginning to organize, data collection can be a good first step. Data helps to engage stakeholders and build the business case for investing in crisis services. Furthermore, data sharing with the public and key community stakeholders can garner trust and legitimacy for LE agencies attempting to improve their approach to BH emergencies.

Stakeholder Engagement and Collaboration

Strong partnerships are critical to generating the enthusiasm to design, fund, and implement crisis systems and ensure they function effectively on an ongoing basis. Potential stakeholders include state and local governmental agencies, payers, LE agencies, emergency management agencies responsible for 9-1-1 dispatch, BH providers, social service agencies, and consumer advocacy groups representing people with lived experience of a BH crisis. Strategic inclusion of elected officials or other influential community leaders can be an effective way to garner support.

How to begin largely depends on the dynamics of each local community. Momentum may come from a variety of stakeholders, including counties seeking to reduce their jail population, EDs overcrowded with psychiatric patients, LE agencies strained by mental health transports, or community leaders galvanized by a tragic outcome involving a person in BH crisis. Collaborative groups can be built upon existing organizational infrastructure (e.g., a county task force) or created *de novo* as an independent group. Most localities already have at least some component of a crisis system in place, and system mapping exercises such as Sequential Intercept Mapping serve as a process to both ensure understanding of the existing context and engage additional stakeholders. Successful collaborations are iterative and longitudinal and may begin with small, simple improvements that require no additional resources (e.g., setting up a process for LE and BH agencies to communicate with one another in certain situations). By building on the success of these “easy wins,” partners can progress to more sophisticated solutions. Eventually, the collaborative is no longer building a crisis system but rather monitoring and improving the system they built.

Disparities, Inequity, and Explicit Bias

Solutions will need to take into account the many complexities at play and explicitly address any forces that perpetuate stigma, health inequities, and racism, including how they impact crisis response decisions, service structures, and service delivery. Whenever possible, minorities, people of color, and individuals with lived experience should be involved in system planning to provide their perspectives on what it means to be a truly recovery-oriented, trauma-informed, and culturally responsive system.

V. Conclusion

As communities grapple with BH emergencies, the question isn't *whether* LE should respond to BH emergencies, but rather *when, how, and with what support*. Both LE agencies and healthcare systems must adopt systems approaches to serving individuals in crisis that strive towards a common goal of connecting people to care in the least restrictive setting, minimizing LE involvement when possible, while ensuring the safety of the individual in crisis, care providers, and the public. Stakeholders will need to collaborate closely to ensure adequate planning, financing, accountability, data collection,

and oversight. Successful solutions have the potential to improve health outcomes for individuals in crisis, improve public safety by lessening demand on police, and reduce costs across the healthcare and criminal justice systems. With growing bipartisan support for meaningful change in these complex systems, every effort should be made to seize the moment and improve the accessibility, quality, and equity of BH crisis care in our communities.

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