

# FROM CRISIS TO CARE

Building from 988 and Beyond for Better Mental Health Outcomes

**NASMHPD**

September 2022

A Series of 10 Technical Assistance Briefs

## Foreword

The 2022 compendium, *From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes*, is comprised of ten technical assistance papers that reflect contributions of many stakeholders and public mental health leaders that informed the content contained within each paper. The work results from a longstanding and rich collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Association of State Mental Health Program Directors (NASMHPD). SAMHSA is the federal agency charged with reducing the impact of substance use and mental illness on America's communities. Its work has helped shape funding and policy and supported innovation and growth in programs and services to help drive positive outcomes for people living with these conditions. SAMHSA partners with stakeholders at all levels to further its mission. NASMHPD is the organization that brings together state mental health leadership from around the country, many of whom also have responsibility for substance use services, to share and promote ideas to help improve the lives of individuals with serious mental illnesses and youth with serious emotional disorders across each U.S. jurisdiction.

July 16, 2022, marked a turning point for crisis services with the transition to 988 as an easy-to-remember, three-digit national suicide and crisis line. Even with that transition, there is much more work on the horizon. In meeting the needs of people of all ages experiencing behavioral health crises, there is recognition that there remains work to be done to prevent crises and to make quality crisis services and follow-up care available when and where it is needed. With workforce challenges everywhere in this latest phase of the COVID-19 pandemic, rising suicide rates, emergency department boarding, and the opioid crisis continuing, the need for crisis services and a comprehensive continuum of behavioral health care is critical. With that in mind, the 2022 Compendium of *From Crisis to Care* aims to provide topical guidance on several areas of services to help the field and individuals move out of crisis mode of and into care and treatment with systems available to meet the population needs. Written on behalf of SAMHSA and executed by NASMHPD, the *From Crisis to Care* compendium provides 10 authoritative papers on these and other critical and current topics to help leaders in behavioral health policy move the needle to improve systems of care.

Topics presented in this series are culled from issues that arise for mental health system leaders and each paper is designed to provide highlights and recommendations for states to consider. The papers can provide guidance within the state behavioral health authority leadership teams to help drive policy and practice, promote funding to meet the ongoing needs in system infrastructure, assist in developing the necessary mental health workforce, and promote learning about the behavioral health system for legislators. We are proud of the work done and eager to share the information contained herein. As the single federal authority focused on the impacts of mental illness and substance use disorders, helping facilitate access to care and appropriate responses to crisis is a key direction for the nation. We thank Brian Hepburn, Executive Director of NASMHPD and his team, as well as the numerous contributors to this year's paper series.

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## 2022 Compendium Editors

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### Acknowledgements

We are at a moment of great strides, watching the 988 suicide and crisis line transition as a great catalyst for change. In this light, recognizing the efforts of behavioral health leaders around the country in the face of so many challenges, the work of producing ten technical assistance papers embedded in this compendium has been incredibly rewarding. The many contributors with whom we have spoken to help move the needle in behavioral health care for better outcomes has been endlessly inspiring. The theme for this year's papers, *From Crisis to Care*, is exactly what the field needs now and helps us realize the vision of moving "beyond beds" as a single solution to complex system needs. As we live with COVID-19 in a more chronic way and continue to reel from workforce shortages and increasing demand for mental health supports, it is clear the system must continue to build crisis supports while enhancing the entire care continuum. With that in mind, these ten papers provide resources that acknowledge accomplishments around the country and help shape the work ahead. We would especially like to thank SAMHSA for its support of these papers from conceptualization to public release. We at NASMHPD also want to thank the individual authors of each paper, as well as Debra A. Pinals, M.D. for her work editing and authoring several of the papers, Elizabeth Sinclair Hancq, MPH for her thoughtful editorial and research assistant's input, Nili Ezekiel of NASMHPD for shepherding the work as "air traffic control," David Miller and others at NASMHPD for all their efforts, along with Rhea Jones for her rigorous review for 508 compliance to make these bodies of work accessible to all. We are excited to have the field see these papers and to hear from stakeholders through the country to drive improvements and ongoing efforts further establishing an infrastructure of quality and accessible crisis services and systems of care in the years ahead.

Brian Hepburn MD  
CEO NASMHPD

### Disclaimer

The information presented and views expressed in the individual papers of the compendium papers are solely those of authors and do not necessarily reflect the views or opinions of the editors.

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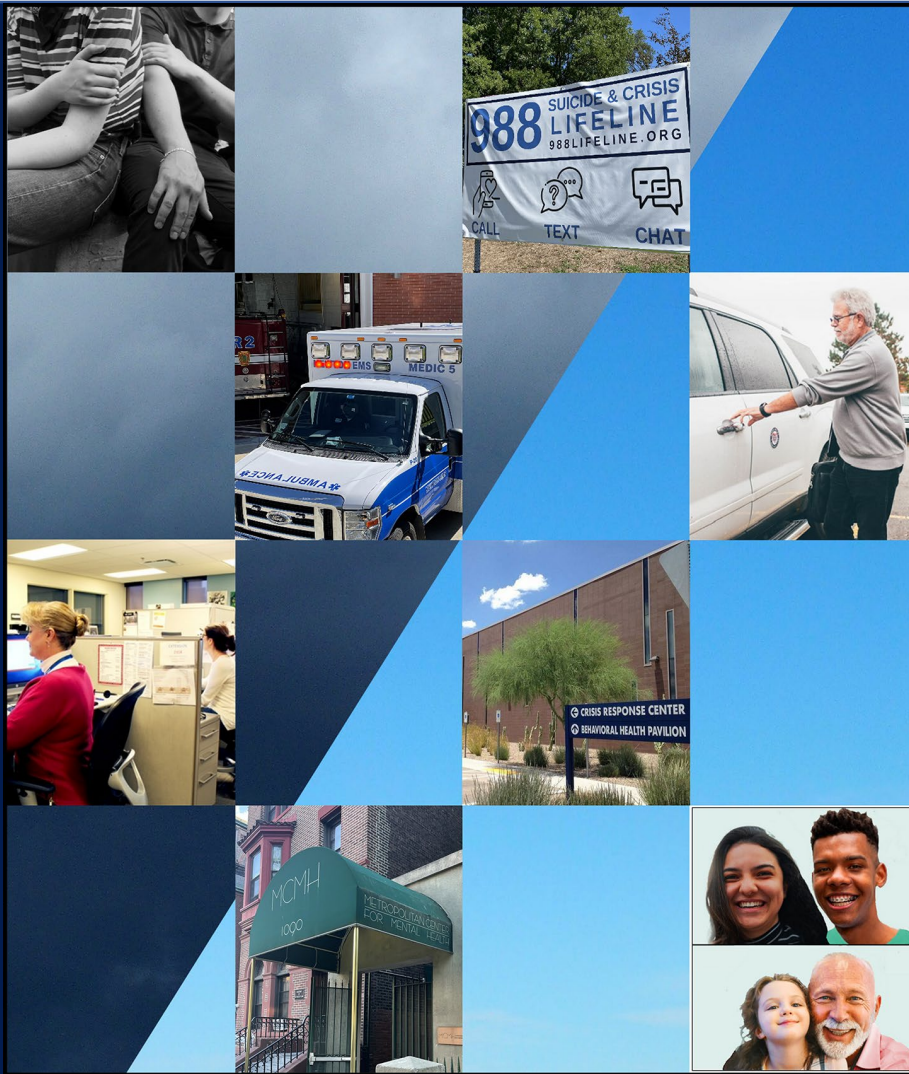
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# FROM CRISIS TO CARE

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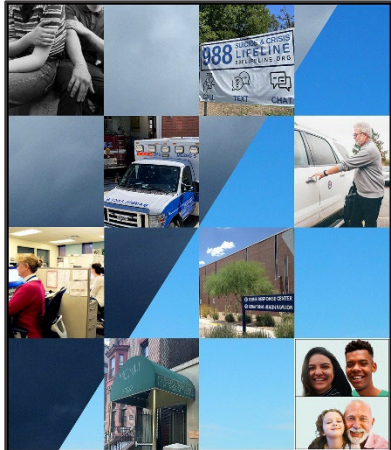
**NASMHPD**

September 2022

Key elements to help individuals and systems move from crisis to care

Paper No. 1 in the *From Crisis to Care* Series

# From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes



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***First in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs  
Focused on Building from 988 and Beyond for Better Mental Health Outcomes***



**National Association of State Mental Health Program Directors**

[www.nasmhpd.org/content/tac-assessment-papers](http://www.nasmhpd.org/content/tac-assessment-papers)

**September 2022**

## **Disclaimer**

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## **Acknowledgements**

Setting the stage to help state policymakers move their systems and the people they serve from crisis to care has special meaning these recent years given the unprecedented stressors we have all faced in the context of the COVID-19 pandemic. Despite these difficult times, incredible efforts have realized major gains with the initiation of 988 and more. For that, on a personal level I am grateful to those who lead this country's reform efforts who have informed the content of this paper, whether working in government, provider agencies, community mental health, advocacy, research, professional capacities, direct care, payor systems, or as peers and family members with lived experience. Through their work, the lives of people with behavioral health challenges can be lived better and longer, and as a result we all stand to gain. To that end, my colleagues in the Michigan Department of Health and Human Services and representatives from each of those sectors are part of that collective whole that help inform this work, and I offer my thanks and appreciation. I am also grateful to Brian Hepburn, M.D. for his kind and steady stewardship for positive change, along with Meghan Haupt, and the work of the entire NASMHPD team who continue to push for better practices and more resources to those individuals challenged by behavioral health needs. This year, Nili Ezekiel, took on the role shepherding these papers to completion on behalf of NASMHPD, and we could not have finished this series without her "air traffic control" skills, further refined while the papers were already in flight...She took on the job with grace, a smile and an assertive "how can I help?" attitude despite the press of deadlines. Kudos to you, Nili for a job well done! Also I want to give a humble nod to my ever-patient family, who offer help when they see me writing at many odd hours, and support me in ways that transcend words...And finally, I am also and ever especially grateful to Elizabeth Sinclair Hancq, MPH, who continues to provide a steady and able hand researching facts and figures and in constructing these papers to make them better than I could ever do alone.

## **Recommended Citation**

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## **Abstract:**

Alarming rates of suicide, opioid overdoses, arrest and incarceration, homelessness, waits in emergency departments to access psychiatric hospitalizations, along with heightened social strains are now intersecting with a depleted workforce amidst the waxing and waning COVID-19 pandemic waves. In this context, policymakers have recognized the need to look beyond psychiatric inpatient beds as a single solution for youth and adults in need of psychiatric care. The discourse among mental health leaders is now centered around immediate access during crises, while moving individuals, including those with serious mental illnesses, substance use disorders, intellectual and developmental disabilities and other conditions, from crisis response to ongoing and interconnected care. The July 2022 transition of 988 as a three-digit number for behavioral health emergencies is among the new bold strategies for improving crisis response. It has already catalyzed significant changes for state behavioral health systems, including creating new partnerships with 911 and other stakeholders. The Certified Behavioral Health Clinic (CCBHC) model for comprehensive services and improved fiscal infrastructure for community mental health systems is expanding with increased funding at the federal level. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been leading the nation on standards and expectations on all these fronts. Yet, to yield an accessible, interconnected, effective, and just behavioral health crisis services continuum that ultimately achieves better mental health outcomes, strategic priorities will be critical. This paper provides an overview of seven key elements to move individuals and systems from *Crisis to Care* that are needed now.

## **Highlights:**

- The transition to 988 offers opportunity to grow crisis response services along a continuum. This transition should be leveraged to ensure careful attention to the full continuum of psychiatric care.
- There are exciting opportunities to better develop a network of effective community services that will be responsive to the needs of people at risk of behavioral health crises.
- Attention to timely access to services and needed funding will be important to move to a crisis-to-care continuum.
- A strong behavioral health workforce is the necessary ingredient for strengthening the system.

## **Recommendations:**

- 1) Leaders should make every effort to examine existing strategies to strengthen the behavioral health workforce for recruitment, retention and nurturance.
- 2) Home and community-based services that foster the implementation of emerging evidence-based practices for out-of-hospital care to support individuals with complex behavioral health needs should be a national priority.
- 3) Leaders should make every effort to foster timely access to care.
- 4) Policymakers and behavioral health leaders should make every effort to enhance engagement and other strategies to maximize retention in treatment.
- 5) Leadership should facilitate access to the rapid advances in technology that came about through the COVID-19 pandemic while also carefully reviewing various applications of technology to maximize its most robust and effective use while minimizing ineffective use.

- 6) State behavioral health leaders should continue to foster partnerships and coordination with traditional and non-traditional partners and consider where funding and workforce can be braided and catalyzed for more meaningful access and outcomes.
- 7) Policymakers should promote sustainable and adaptable practices and identifying funding that can meet the growing demand for care across the behavioral health system.



July 16, 2022 was a historic date in the United States. On this date, “9-8-8” as an easy to remember, three-digit dial was established for the National Suicide Prevention Lifeline. And 988 goes further than the original Lifeline and has evolved into a broader “crisis line.” To get to this point, many things had to happen, not the least of which was the July 2021 approval by the FCC for 988.<sup>1</sup> With a global pandemic and years of rising suicide rates, the time was ripe to catalyze this shift. With this transition to 988, State Behavioral Health Authorities (SBHAs) and other policymakers continue to work hard to build out the mental healthcare system beyond 988 to further establish a robust psychiatric continuum of care, recognizing that crisis care must link to services that provide more than crisis resolution, while the full continuum must continue to support individuals to avert crises in the first place. This paper reviews seven key elements needed to move the behavioral health system forward, *From Crisis to Care*, both for the people served, and for the system itself. Given the increasing demand for mental health services, counterbalanced with depleted staff and the sense of global fatigue from all that has been endured with the COVID-19 pandemic, only through this ongoing pursuit of a strengthened and expanded array of community services will there be improved mental health outcomes.

## Taking a Step Backwards to Help Look Forward

Taking a step backwards to help look ahead, in 2017, the National Association of State Mental Health Program Directors (NASMHPD), on behalf of the Substance Abuse and Mental Health Services Administration, commissioned a review of what seemed to be growing demand for psychiatric beds, leading to the publication of *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*. All too often public discourse centered on building more beds—often state hospital beds—as a single solution for needed mental healthcare. Some of this push was in response to numerous system challenges. Emergency department boarding of psychiatric patients, for example, has been a growing phenomenon that many were and are recognizing as highly problematic.<sup>2,3</sup> At the same time, arrest and incarceration of persons with serious mental illness has for many years been a constant point in need of problem-solving. Waits for individuals found incompetent to stand trial became a source of strain on systems and even pointed litigation at SBHAs revolving around individuals waiting in jails for psychiatric beds.<sup>4</sup> For youth, states were facing calls for reform to shift services to more in-home supports by creating a network of community-based systems of support and infusing new models of care for youth with serious emotional disturbances, all while youth boarding in emergency departments awaiting psychiatric admission was increasing. Since the COVID-19 pandemic, the cry to address youth behavioral health has only gotten stronger and louder.<sup>5</sup> Today, the message in *Beyond Beds* continues to resonate. It remains clear: “the rush to ‘more beds’ needs to be tempered with illumination and clarity about patient need, the kinds of beds best suited to meet those needs...[and that]...only a complete continuum of psychiatric care can reduce the human and economic costs associated with mental illness.”<sup>6</sup> In alignment with that call for a continuum, the American Psychiatric Association recently produced its own analysis, offering a model for assessing psychiatric bed need in a given community.<sup>7</sup>

### 2017 *Beyond Beds* Key Recommendations

- The vital continuum
- Terminology
- Criminal and juvenile justice diversion
- Emergency treatment practices
- Psychiatric beds
- Data-driven solutions
- Linkages
- Technology
- Workforce
- Partnerships

After the *Beyond Beds* messaging took hold, subsequent NASMHPD papers spoke of setting bolder goals for better outcomes, and even looking beyond the borders at international practices to enlighten progress.<sup>8,9</sup> In more recent years, the confluence of many different voices and advocates looking across the continuum of care has made a laser focus on crisis services as the gateway to care. In that context, in February 2020 SAMHSA, issued its *National Guidelines for Behavioral Health Crisis Care: Best Practices Toolkit*.<sup>10</sup> Just as this was released, the world was hit with an unbelievable challenge—the global COVID-19 pandemic. Suddenly SBHAs were working on disaster preparedness at new levels—not only ensuring that individuals in public behavioral health services had access to proper COVID-19 protections (including personalized protective equipment, viral testing, contact tracing and ultimately vaccination access), but also that emotional supports to the general population were available.

In August 2020, the Centers for Disease Control (CDC) released results of a survey from late June of that year showing that 40% of U.S. adults reported struggling with mental health or substance use, including 11% who had reported seriously considering suicide.<sup>11</sup> The Disaster Behavioral Health hotline saw an 891% increase in calls in the early months of the COVID-19 pandemic.<sup>12</sup> In response to this growing demand, Crisis Counseling Assistance and Training Program (CCP) grants were issued throughout the United States as a partnership between SAMHSA and the Federal Emergency Management Agency (FEMA).<sup>13</sup> Many states took advantage of these federal opportunities and launched campaigns under the CCP programs to foster mental well-being even beyond the pandemic. In Michigan, for example, the Stay Well initiative ([Michigan.gov/staywell](https://michigan.gov/staywell)) continues to produce an array of resources from a call-line to online group supports and videos that remains active to help provide free supports to all who may be struggling emotionally in the context of the pandemic.<sup>14</sup> Utah built a crisis intervention chat line through SafeUT (<https://safeut.org/>),<sup>15</sup> and Maine built out the StrengthenMe (<https://strengthenme.com/>) approach to provide free stress management and resiliency resources for anyone in Maine experiencing stress related to the COVID-19 pandemic.<sup>16</sup>

The COVID-19 pandemic provided further clarity that crisis services needed to be more firmly established everywhere. To that end, NASMHPD, on behalf of SAMHSA, again commissioned bodies of work with collections of papers along the crisis services themes, issuing in 2020, *Crisis Services: Meeting Needs, Saving Lives*,<sup>17</sup> and in 2021, *Ready to Respond: Mental Health Beyond Crisis and COVID-19*.<sup>18</sup>

Though the vision of a crisis services continuum has centered around the rollout of 988, to keep moving forward, it is also important to recognize that a crisis response that only deals with the issues of the moment will not have the same promising impact as one that “moves the individual *“From Crisis to Care,”* and does so through a coordinated and interconnected system that can support the individual over time. Such a system must prioritize helping individuals from diverse backgrounds with any number of challenges, including mental illness, serious emotional disturbances, substance use disorders, intellectual and developmental disabilities, or other conditions or circumstances. This system should help those individuals achieve their maximum potential beyond the crisis, in their home environments and outside of institutions, while offering supports, as well as places and spaces that foster recovery and return to community settings or relief that can be brought into the home. At the same time, such a system must coordinate across multiple sectors, integrating 911, 988 and an entire array of resources.

Putting the pieces together of a true and robust continuum of psychiatric care from the lens of the crisis system is a key theme of this paper, *From Crisis to Care*, and is supported by a number of individual papers as part of a 2022 compendium to help policymakers and mental health advocates forge ahead with the latest information to continue to improve upon the mental health services delivery system. Themes for those papers have helped inform this one (see Text Box). This overarching “umbrella paper”

highlights seven **key elements** that are necessary to move the behavioral health system towards the vision of a sustained and robust continuum. These include:

1. A strong behavioral health workforce
2. Effective home and community-based services
3. Timely access to care
4. Engagement and strategies to foster retention in care
5. Strategies for routinizing and developing effective technology
6. Old, new, and improved partnerships
7. Sustainable and expandable services

Just as 911 is baked into the fabric of American society, 988 is the next frontier in mental health crisis response. There is no doubt that many lessons will be learned along the way in its growth and development. History will look back on this exciting era of change and opportunity as a remarkable time, and today's behavioral health leaders are shaping that history.

### ***From Crisis to Care: Papers in the 2022 Series***

1. *From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes*
2. *Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018*
3. *Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum*
4. *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth*
5. *Innovation and Determination: How Three States Are Achieving Comprehensive, Coordinated and Sustainable Behavioral Health Crisis Systems*
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8. *The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis*
9. *Responding to and Preventing Crises: CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum*
10. *Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders*

# The Key Elements:

## 1. *A Strong Behavioral Health Workforce*

In June 2022, the Bureau of Labor Statistics of the U.S. Department of Labor reported a slight gain in non-farm payroll employment, including professional and business services, leisure and hospitality, and health care as well as an overall unemployment rate of 3.6%.<sup>19</sup> And yet, worker shortages and supply chain disruptions in 2022 are among the top concerns among businesses with “millions more job openings than workers to fill them,” according to a CNBC report.<sup>20</sup> Ironically, the impact of children’s behavioral health on the adult workforce is also devastating, with one 2021 study from On Our Sleeves showing that 53% of working parents have missed work at least once per month to support their children who had mental health needs.<sup>21,22</sup> The American Hospital Association examined workforce challenges for the health care system, which is an industry that provides care and services to hundreds of millions of people annually and is a major consumer of supplies and community resources. In their strategic analyses published even before the full impact of the pandemic in 2020, they identified professional shortages, financial pressures, burnout among professionals and workplace violence as key areas of concern that needed addressing to help foster a robust and skilled workforce.<sup>23</sup>

The behavioral health workforce is facing too many of these concerning realities. Yet, demand and need for behavioral health treatment is only increasing. Critical trends in behavioral health needs in the context of rolling out 988 and related services include high suicide rates, relentless opioid and other fatal drug overdose rates and substance use, astounding levels of homelessness, arrests and incarceration among people with serious mental illness, co-occurring substance use disorders and other behavioral health conditions, and families in despair regarding their children with emotional health needs who wait long periods for appropriate services.<sup>24</sup> These realities are only more highlighted by data from Mental Health America showing that over half of those who need mental health services are not receiving them.<sup>25</sup> It is clear that what is needed—and yet in critical short supply—is a strong workforce, and one that can meet the needs of complex populations.

It may be that at no point in history has the behavioral health workforce been sufficient to meet the needs. In fact, as part of the 21<sup>st</sup> Century Cures Act that went into effect in 2016 at the end of the Obama Administration, the Health Resources & Services Administration (HRSA) was mandated to study the behavioral health workforce. In its report examining projections from 2017 to 2030, certain behavioral health providers (psychiatrists and addiction counselors) were projected to experience shortages by 2030 if there were no changes in behavioral health utilization.<sup>26</sup> Although the same report indicated that other behavioral health workers would be in adequate supply, current data are quite different. A recent report produced by Health Management Associates and the National Council for Mental Wellbeing spoke of the national crisis related to the behavioral health workforce.<sup>27</sup> In that report they surveyed 260 behavioral health organization members of the National Council for Wellbeing in the fall of 2021 and found that the demand for services has increased, waitlists for services are growing, and yet nearly all respondents (97%) reported they are having difficulties recruiting and retaining employees, with too few qualified applicants, non-competitive salaries, and high burnout after COVID-19 as among the top reasons. Other reports highlight the geographic maldistribution of America’s behavioral health workers.<sup>28</sup> With the trends across almost every sector of the labor market showing depleted resources, these workforce needs are creating critical levels for vulnerable populations who depend on people to support their needs, mitigate risks, address disabilities, and foster recovery. Moreover, given studies

showing that Black and Indigenous People of Color (BIPOC) report higher levels of behavioral health distress than white counterparts,<sup>29,30</sup> efforts are necessary to address the diversity of the behavioral health workforce in addition to general workforce needs.<sup>31</sup> Addressing the workforce from a diversity perspective will also require careful analyses and intentional approaches. As an example, states like Hawaii have specifically called out in their Workforce Innovation and Opportunity Act State Plan an effort to target services specifically for Native Hawaiians.<sup>32</sup>

The situation is so dire, that states have called for emergency provisions to protect certain behavioral healthcare systems, such as occurred when the Oregon State Hospital turned to the National Guard to assist with a staffing crisis in fall of 2021.<sup>33</sup> In order to tackle the behavioral health workforce needs, there must be an “all hands-on deck approach” and many leading scholars and policymakers have been working in partnership with local and national entities to help develop strategies. In a broad effort to

*Beyond Beds*

**Recommendation #9: Workforce**

Initiate assessments to identify, establish, and implement public policies and public-private partnerships that will reduce structural obstacles to people’s entering or staying in the mental health workforce, including peer support for adults and parent partners for youth and their families. These assessments should include but not be limited to educational and training opportunities, pay disparities, and workplace safety issues. The assessments should be conducted for the workforce across all positions.

improve the workforce, a Health Workforce Research Center was established with federal funding in 2015 and is housed at the University of Michigan’s School of Public Health. That work spawned a report looking at the need for data to help plan for the behavioral health workforce.<sup>34</sup> To improve trends and the health of people who are underserved, HRSA, with initial funding support in partnership with SAMHSA, moved further in this direction with the development of their Behavioral Health Workforce Education and Training (BHWET) program that provides opportunities for providers through education.<sup>35</sup> Training programs supported by BHWET for the first three years grew to almost 150 according to its recent report, supporting over 9,000 trainees, including pre-doctoral interns to master’s level practicum trainees and peer paraprofessionals, 40% of whom upon graduation indicated an intent to work in a rural or underserved area and 72% indicated an intent to work with children, adolescents and transitional-age youth.<sup>36</sup>

The U.S. Department of Health and Human Services produced a further report through the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 2021 that identified three models showing some promise for increased workforce efficiencies, including utilization of psychiatric mental health nurse practitioners, behavioral health mobile applications and development of crisis services.<sup>37</sup> Several states, like Nevada, Illinois, Indiana, Colorado, Wisconsin, Tennessee, Massachusetts, New Jersey, and Washington State were spotlighted for innovations in using American Rescue Plan Act (ARPA) dollars to enhance their direct care workforce in innovative ways.<sup>38</sup>

The National Governors Association highlighted the children’s mental health provider workforce shortage<sup>39</sup> considering reports from the CDC showing that one in five children may have a mental health issue, but only 20% of them receive care.<sup>40</sup> Individual states have also done their own analyses regarding workforce capacity and developed state level approaches to overcome staffing gaps. For example, the Ohio Council of Behavioral Health & Family Services Providers identified shortages in every one of eight disciplines in 2016, and projected even deeper shortages in six of them (except for certified nurse practitioners and social workers) by 2030.<sup>41</sup> On a local level, these projections created an advocacy pitch to seek immediate investments in the state budget to support workforce development and provide



funding to behavioral health organizations to offer recruitment and retention initiatives as well as support for supervision lines. In Oregon, the State’s Oregon Health Authority issued approximately \$132M to 152 provider organizations as grantees for awards to shore up workforce gaps.<sup>42</sup>

As noted, many recommendations have been set forth to date, and they can be divided along different organizing frames of reference, which for policymakers can make it somewhat overwhelming to consider what direction to go or where to begin. In one review, Beck and colleagues argue for establishing a consensus process as an immediate first step in arriving at solutions for the workforce development needs across the country.<sup>43</sup> They suggest that there be an examination of workforce *production, distribution, resilience* and *maximized potential*, with concomitant planning, evaluation, policy development and practice approaches that can be built around these four frames.

Though an exhaustive review of strategies to rebuild a workforce in behavioral health is beyond the scope of this paper, given the imperative needs right now, promising recommendations suggested by others are highlighted in the text box below. Many of these ideas harken back to the 2017 *Beyond Beds* recommendations calling for attention to the workforce and building non-traditional partners to help augment it. In 2022, those recommendations are just as important, and workforce rebuilding and rebooting will be a key element in moving *From Crisis to Care*, addressing the workforce crisis within the behavioral health system while shaping services so those in need can access care across a robust continuum.

### ***Recommendations related to workforce development from various contributors***

Recommendations from Beck, Manderscheid, and Buerhaus:<sup>44</sup>

1. Continue to foster the development of a minimum data set as a foundational step for standardizing collection of workforce data to inform workforce planning efforts.
2. Foster policy development that reduces barriers to address shortage issues.
3. Reduce burnout for workers.
4. Enhance training workers through initiatives that foster integrated care and access specialists.
5. Build in peer provider workforce development

Recommendations from ASPE:<sup>45</sup>

1. Expand partnerships and their capabilities within crisis services.
2. Address funding barriers.
3. Expand workforce with the use of peers.

Recommendations from the National Governors Association:<sup>46</sup>

1. Align curriculum between 2-year community colleges and 4-year colleges for seamless credit transfer to promote mental health-related degrees.
2. Offer creative incentives to participate in higher education, receive certification and attract workers.
3. Adapt apprenticeship models to support the social services and mental health workforce.

### Recommendations from the National Council on Mental Wellbeing and Health Management Associates:<sup>47</sup>

1. Leverage strategies that states have used for emergency preparedness and disaster response, which allows for funding expansion and relief through disaster declarations that could expand access to Crisis Counseling Assistance and Training Program Grants.
2. Increase funding and financial incentives to attract and retain the workforce, leveraging stimulus funds, legislative remedies for rural areas, and innovative financing models, while promoting partnerships, loan repayment, waiver of HRSA residency requirements for J-1 visa holders, and partnerships with the Department of Labor and Employment.
3. Optimize access to the available behavioral health workforce, through promotion of payment and regulatory adaptation and training and support for physical health providers to conduct routine behavioral health screenings, reducing administrative and regulatory burdens for behavioral health working in primary care, and supporting psychiatric consultation models, as well as shifting mid-level staff ability to perform functions previously reserved for other professionals and expand telehealth capabilities and policies, while developing paraprofessional staff such as non-specialists and peers.
4. Waive burdensome documentation and administrative activities, such as waiving elements of comprehensive psychosocial assessments, extend deadlines for treatment plans, eliminating separate treatment plan documentation and allow payment and regulations that foster brief encounters prior to full intake completion.
5. Maximize use of Medicaid graduate medical education (GME) for training the behavioral health workforce, by expanding Medicaid GME, which does not have the same limitations as Medicare GME, and could benefit from CMS guidance to enhance flexibility for states to structure and pursue policy goals.

### Recommendations identified in *Psychiatric Times*:<sup>48</sup>

1. Expand collaborative care models.
2. Expand the use of telehealth.
3. Prioritize recruitment, retention, mentoring, and hands-on training experiences.
4. Reduce stigma associated with psychiatry by partnering further with primary care.
5. Improve upon insurance reimbursement opportunities and willingness for mental health professionals to accept insurance.
6. Reduce regulatory barriers and opportunities.

### Recommendations by Beck, Spitz, Frogman, et al:<sup>49</sup>

1. Production (policies that examine population needs, recruitment and training strategies with a focus on diversity)
2. Distribution (specialty right-sizing, community worker shortages, need for primary care, broad investments that are not disproportionate to certain settings such as rural and acute care),
3. Resilience (safer working conditions, attending to the mental health of healthcare workers, decrease burnout),
4. Maximize potential (flexible regulations for billing, interstate mobility and licensure, cross discipline work)

Recommendations to address diversity in the workforce from the National Academy of State Health Policy:<sup>50</sup>

1. Engage BIPOC Communities.
2. Use Data to understand workforce needs.
3. Incorporate diversity, equity, and inclusion into state workforce planning.
4. Align efforts across state agencies.
5. Prioritize behavioral health in health care workforce recruitment and retention.
6. Create increasingly culturally inclusive workplaces to facilitate and nurture BIPOC professionals.
7. Leverage funding opportunities to invest in a diverse workforce.

## 2. Effective Home and Community-Based Services

A crisis is a temporary challenge, yet critical infrastructure for crisis care must encompass a community system that is effectively able to provide care for people who experience crises and also provides necessary supports to prevent crises from occurring altogether. Thus, as noted in *Beyond Beds*,<sup>51</sup> a robust and effective, tightly linked community-based service system is a foundational element of a complete continuum of psychiatric care. Across the United States, efforts to establish more robust community-based services are underway for both youth and adults. Take for example, the work being done in children’s crisis services, where an important ingredient for crisis response includes in-home stabilization.<sup>52</sup> In the years after the rollout of the Rosie D remedy, based on a lawsuit regarding Medicaid eligible children in Massachusetts, in-home stabilization and support of youth with complex behavioral health needs has only expanded further in the state.<sup>53</sup> Overall trends in youth crisis work include longer periods of in-home stabilization services after the crisis, as described in detail in *A Safe Place to Be: Crisis Stabilization Services for Children and Youth*.<sup>54</sup> This work with youth can set up important examples of what may be needed now for adults. Home and Community-based Services in the most generic sense are simply those that take place in home environments and in communities—rather than in institutions, jails or other non-integrated

settings. Regulatory and legal mandates have formalized the term “Home and Community-Based Services” or HCBS, and these laws and regulations are driving change in behavioral health system offerings. As policymakers build services beyond those directly attached to 988, it will be important to develop best practices along both the formal and informal meanings of HCBS. For this to occur, there are many lessons and considerations for development of that robust community-based continuum.

*Beyond Beds*

### Recommendation #1: The Vital Continuum

Prioritize and fund the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.

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### Lessons from the International Community Regarding Potential Home and Community-Based Supports

As described in “#CrisisTalk,” there are innovations to look at internationally related to home-based crisis response and stabilization.<sup>55</sup> For example, a study out of the Netherlands of individuals and family members with acute psychotic or manic symptoms found that their first interactions with a mobile crisis

team had challenges with communication and cooperation, the feeling of being stigmatized especially when police were needed, and a lack of reliance on personal crisis plans, demonstrating that there is more to learn about mobile responses.<sup>56</sup> At the same time, Intensive Home Treatment is a program based in the Netherlands where multidisciplinary teams, known as Crisis Resolution Teams, work in people's homes to help resolve psychiatric issues.<sup>57</sup> Thus, there is work that could be developed to address the gaps that people experience in home-based care.

Another study out of Switzerland is examining crisis resolution and home treatment (CRHT) teams that represent a community-based mental health service as an alternative to hospitalization to care for people with severe and acute mental disorders who might otherwise be considered for admission to hospitals.<sup>58</sup> Early results just published in 2022 showed that CRHT was comparable to standard hospitalization in terms of psychiatric symptom reduction and readmission rates, though had a longer first treatment period, even though the latter trend appeared to be shifting with experience in the model.<sup>59</sup> A study out of France revealed that home-based psychiatric mobile team services showed promising effects including responding to calls, home visits, coordination of meetings, clinical assessments of patients, and utilization of crisis resolution teams and Assertive Community Treatment (ACT) models.<sup>60</sup> What this suggests is that there will be increasing innovations and evidence likely to address the underlying conditions and challenges faced by individuals who present in crisis with increasing community-based and at-home care.

## **Evidence-Based Practices as Part of the Home and Community-Based Service Array**

Expanded access to community practices that are evidenced based is essential to meet the growing need, as well as is the development of new practices that maximize engagement and support for people in community settings. The role of Permanent Supported Housing (PSH) and employment services will continue to be key service components to support individuals who may utilize crisis services.<sup>61</sup>

Other essential models include ACT, a service delivery model that became known as the "hospital without walls," with multidisciplinary teams that provide care and support to individuals with histories of multiple psychiatric hospitalizations. Experienced policymakers and behavioral health leaders likely resonate with the important findings of a recent study that identified, after 45-years of working with the model, implementation challenges with ACT related to evolving psychosocial factors for clients, barriers to clinicians' developing competencies, and shifting mental health systems.<sup>62</sup> Although a gold-standard for a community-based service, it will be important to continue to understand how to promote its use most effectively. Programs and services that rely upon the model, such as Forensic Assertive Community Treatment (FACT) were designed to support individuals who have some of the same histories as ACT clients but allow for an additional focus on prevention of arrest and incarceration.<sup>63</sup>

Additional services that expand community supports include those that are targeted to address important transitions. Critical Time Intervention (CTI) has received much attention as an intervention designed to help individuals transition from institutions or homelessness to more permanent community-based services.<sup>64</sup> It was designed as a shorter-term transitional case management model with a phased approach that focuses on building connections in the community as staff work to develop and hand-off the client to more permanent supports. One study showed that CTI participants were less anxious and felt more supported across their transition to have a home.<sup>65</sup> CTI also improved engagement with community mental health teams compared to controls at six weeks (53% vs. 27% with control group), with continued engagement at six months in one study of 150 male prisoners with serious mental illness.<sup>66</sup> There is an entire infrastructure of training and support through the Center for

the Advancement of Critical Time Intervention to help in its implementation.<sup>67</sup> New Hampshire's Department of Health and Human Services launched in July 2022 a statewide initiative to offer CTI to help individuals transition out of psychiatric hospitalization as part of its 10-year mental health plan.<sup>68</sup> Models of transitional supports for individuals with co-occurring mental illness and substance use disorder such as MISSION and MISSION-Criminal Justice,<sup>69</sup> supporting individuals shift from homelessness or incarceration to more consistent community treatment, rely upon CTI, trauma-informed principles, and other evidence based practices to implement these transition goals.

First episode psychosis programs, funded in part by SAMHSA's block grant, are another type of program that should be explored by state leaders to address some of the populations who might be accessing crisis lines. It is estimated by the National Institute of Mental Health that about 100,000 adolescents and young adults in the U.S. experience a first episode of psychosis every year,<sup>70</sup> and these individuals can present with prodromal or full symptoms that left untreated all too often result in a downward spiral for the individual and their family. A model of coordinated specialty care (CSC) involving group or individual psychotherapy, family support and education, medications, supported employment/education and case management has been shown to be effective especially if it helps reduce the duration of untreated psychosis.<sup>71</sup>

Access to important and effective medications will also be key for home and community-based supports. Take for example, clozapine, which is the only psychotropic medication FDA-approved for treatment-resistant schizophrenia and reducing suicidality. Despite its evidence and effectiveness, it is utilized less in the United States than elsewhere in the world.<sup>72</sup> Today, there are many avenues to facilitating prescribing of this evidence-based life-saving medication. The internet-based SMIAdviser.org, funded by a grant from SAMHSA awarded to the American Psychiatric Association, provides technical assistance, frequently asked questions and consultation to promote the prescribing of this and other effective medications for people with serious mental illness.<sup>73</sup> Long-acting injectable medications (LAMs or LAIs) are also important options for persons living with chronic psychotic illnesses with further information about them also at SMIAdviser.org<sup>74</sup> Barriers to prescribing these medications must be better understood, as maintaining medication at therapeutic levels can be a key mechanism to avoiding crises in the first place.<sup>75</sup>

Access to effective services should also attend to racial and socioeconomic disparities. One illustrative example that should continue to set alarm bells regarding inequitable access to particular evidence-based practices is in access to specific medications for opioid use disorder. Increasing attention to this issue is needed to help ensure that disparities are addressed and eliminated.<sup>76</sup> Recent changes may help in this regard. For example, certain regulatory barriers to Buprenorphine to treat opioid use disorder have been lifted during the COVID-19 pandemic and continue to be lessened to expand access given the growing awareness that the opioid overdose death rates are still alarming.<sup>77,78</sup> Recently, SAMHSA identified that it would maintain its relaxation of regulations, allowing telephonic and video assessments to continue for Buprenorphine induction beyond the Public Health Emergency.<sup>79</sup> Policymakers will want to continue to pursue all avenues for these evidence-based treatments to be as readily available in an equitable fashion as possible across all populations.



As policymakers work to drive greater use of evidence-based practices, the notion of “warm handoffs” could use further examination. Policies and practices to help people move *From Crisis to Care* in their communities will also need to incorporate tighter linkages from one service to another. Since it is well known that transitions in care are fraught with negative outcomes, improving these warm handoffs will continue to be an important part of the community-based service system. In addition to hand-offs and transition points, continuity of care across settings can help further positive outcomes. For example, many advocates are arguing for health reform combined with justice reform with Medicaid services at the cornerstone of the debate for care coordination and community supervision.<sup>80</sup> This area of reentry from criminal legal settings is just one of many examples of where warm handoffs are all too often lacking and negative consequences common. The goal going forward would be to continue to build in supports that reduce these examples and improve outcomes.

### ***From Crisis to Care: Continuity and Linkages***

*Continuity of Care:* Seamless care and treatment that continues despite the setting one is in, where goals and approaches to treatment are not interrupted.

*Warm Hand Offs and Tight Linkages:* Promote continuity of care by assisting individuals move from one setting to another, preserving information about treatment interventions in place and recovery goals by helping to ensure that providers have the same information across transitions, and that individuals in care are supported to reduce barriers to continuity and help with minimizing stressors in working with new providers.

## **Legal and Regulatory Realities of Home and Community-Based Services**

Although the tenets of *From Crisis to Care* would suggest care must follow the crisis, it is important to recognize that the fabric of care in the community that predates crises may serve to minimize them in the first place. Policymakers must ensure that these services must, whether as part of the community system as a whole or part of the crisis system, keep constant vigilance to the need for full community integration of people with disabilities of all types. Defaulting to hospitals and out-of-home placements for someone in crisis could invoke questions about disability rights. The U.S. Supreme Court decision of *Olmstead v. L.C.*,<sup>81</sup> rested on the Americans with Disabilities Act, requiring that individuals with disabilities have a right to live in the least restrictive and most integrated setting. Since that landmark decision related to state hospital patients, state policymakers and communities have pursued numerous strategies for moving people with serious mental illness, intellectual and developmental disabilities from state hospitals and intermediate care facilities into community settings. The rights of people with substance use disorders have now also spawned attention.<sup>82</sup> In addition, responses to crises are discussed within the framework of least restrictive approaches, in part with this legal framework in mind.

Medicaid has also had a longstanding goal of maximizing the potential for beneficiaries to receive care through HCBS. These forces have created an impetus for the development of State Plan Amendments and Medicaid Waivers to create opportunities for federal reimbursement across a more complete continuum. In 2014, CMS promulgated a new rule set for HCBS waivers under what has been referred to as the “HCBS Final Rule.” CMS set March 17, 2023 as the transition period deadline for full state compliance with the HCBS Final Rule. The shifts in regulations come about as an effort to foster meaningful person-centered planning for beneficiaries and allow states to improve quality of services, including allowing waivers to be more easily administered, and allowing states to combine coverage for multiple target populations under one waiver.<sup>83</sup> At the same time, the Final Rule provides additional protections for individuals, including privacy, dignity, respect and freedom from coercion and restraint

and control of personal resources. The Final Rule also focuses on ensuring that services fully integrate persons served into their community as they choose, with opportunities and access to the community to facilitate relationships with others without disabilities beyond paid staff, and providing individual control over what to eat, who can visit, what services they receive.<sup>84</sup> Though the public health emergency may create exigencies, it is expected that even with staffing shortages, states will still be required to operate policies consistent with the regulations and maximize autonomy and community participation for beneficiaries.<sup>85</sup> At the same time, CMS may authorize corrective action plans (CAPs), which are to be submitted by December 1, 2022, in order to preserve federal reimbursement of HCBS in settings already in existence as of the transition period deadline, if more time is needed for those settings to establish practices that incorporate additional elements consistent with the evolving regulations.

Given current trends, there are increasing opportunities for more in-home and community-based care. The HCBS mandates will allow for waivers to continue that give states flexibility for a robust service delivery system. In a study examining HCBS waivers for services for older adults from 1997 to 2020, there has been overall expansion in the use of 1915(c) and 1115 waivers across the U.S., with a broader range of services offered, especially supports for self-direction and community transitions.<sup>86</sup> The authors point out that efforts to decrease reliance upon nursing homes was seen as even more critical during COVID-19 and will likely continue. Similarly for persons with serious mental illness and youth with SED, opportunities remain ripe for waiver consolidation and simplification at the state level, in order to offer service expansion and decrease reliance upon institutional placements.

Though the areas of promise are many, ongoing challenges for state leaders will include the need to ensure services are compliant with rules that eliminate restrictions and non-integration, which have been part of the community culture and will require systems shifts. It will also be important for these services to be approached with a cultural, diversity and equity lens to maximize their meaningfulness, effectiveness and equitable distribution. These are important steps forward for individuals being served, and strong leadership to pursue these goals will help continue the trajectory toward an improved community-based continuum that can provide the necessary infrastructure to manage and prevent crises.

### *3. Timely Access to Care*

What good is a promising practice if it is not available when it is needed? Today, there are too many examples of individuals waiting to access care. Waitlists for services pepper many areas of the behavioral health continuum. In 2020, the Kaiser Family Foundation identified state-level

waiting lists by target population for those accessing Medicaid HCBS waiver services, finding the total waiting lists included more than 665,000 individuals waiting for home and community-based services.<sup>87</sup> This is all the more reason that evolving flexibilities and expanded mental health service capacity for states will be so important. Another concerning example of waits involves “Emergency Department (ED) Boarding,” something that has been studied and described for many years,<sup>88</sup> where individuals determined to need psychiatric hospital level of care wait for days, weeks, and months in EDs “boarding” until a bed becomes available. Washington was sued for ED boarding, with the court ruling that psychiatric boarding was not a legitimate method to avoid overcrowding of evaluation and treatment facilities.<sup>89</sup> In another case decided for plaintiffs, New Hampshire was sued about their ED boarding problem in one case related to the right of individuals to contest their detention within three days of arrival,<sup>90,91</sup> and they are not alone in defending such cases. The crisis of boarding in EDs has continued to make national news, especially for youth who may be particularly impacted.<sup>92</sup>

Many if not most states are also experiencing delays in timely admissions of people into clinical programs and services from jails, particularly those individuals found incompetent to stand trial. A report by Wik, Hollen and Fisher in 2017 highlighted the growing numbers of forensic patients in state hospitals between 1999 and 2016, and how many states were facing unprecedented demands for forensic patients to be served for competency restoration.<sup>93</sup> The reasons for these waits are complex, involving system dynamics with the push and pull of levers from countless stakeholders who have different views of the needs of individuals and the systems that serve them.<sup>94</sup> Advocates have described the wave of litigation against many states related to this issue.<sup>95</sup> State leaders are working hard to shift this balance from all directions, such as Texas, which launched a campaign called, “Eliminate the Wait,” and created a related toolkit,<sup>96</sup> which has received positive attention. Every branch of government seems to have taken an interest in this issue, including court leaders who have pursued a national initiative to try to help problem-solve around these logjams.<sup>97</sup> Often these solutions circle back to providing ready access to services that are engaging and effective, to decrease the cycling in and out of care and crisis.

With these realities in mind, if a crisis occurs and an individual needs care, timely access to that effective care will be critical, and policymakers should examine their systems prioritizing not just effective care, but timely access to it. As described by Parks and colleagues,<sup>98</sup> one of the leading models to try to address more urgent access involves the CCBHC effort, which reflects a collaboration between SAMHSA and CMS for both demonstration and expansion sites and the develop of a more flexible funding model to deliver a comprehensive array of behavioral health services to communities and include a requirement for time standards for accessibility. A CCBHC must provide comprehensive mental health and substance use services that ensure timely access to care, provide services that include 24/7 crisis response and MAT for opioid and other substance use disorders.<sup>99</sup> In addition, CCBHCs are required to coordinate with both the criminal-legal stakeholders in their communities and education systems, which means that efforts at jail diversion and law enforcement partnerships, as well as school mental health partnerships, are part of their development. With the prospective payment system and rates set for the population to be serviced, the clinics are able to provide functions that are not revenue generating and might not otherwise be provided because budgets would be too inflexible and tight. Given that Congress has passed the Bipartisan Safe Communities Act<sup>100</sup> that expanded the opportunities for CCBHC expansion across all states and any territory, it is a categorical game-changer to community mental health across many regions in the United States.

Other forces also push for minimizing wait times for behavioral health services and these have included increasing attention to data, such as in Washington where the state made a large investment in a data infrastructure to try to move the needle on the waits for people in jail needing to access therapeutic settings.<sup>101</sup> As another example, behavioral health leaders are working with 911 and learning about Computer Aided Dispatch (CAD), Automatic Call Distribution (ACD) systems, and the roles of the Public Safety Answering Points (PSAPs) to build coordinated networks for rapid response to 911 and 988 calls regarding behavioral health crises. There is also work occurring to develop bed registries that go beyond just knowing where there are openings but are using technology to forward referral information and have receiving facilities work cooperatively to minimize waits for access to residential and inpatient psychiatric services.<sup>102,103</sup> In addition, in *Lending Hands*,<sup>104</sup> Pinals describes the evolving potential for initiating real treatment in a crisis context, which could have a significant impact on being stabilized at home, decreasing demand for some services. Creating more opportunities for in-home care, establishing clear data sets to understand who is waiting for what service and identifying barriers that are creating delays are some of the strategies to address a current imperative to maximize timely access to the most effective services.

## 4. Engagement Strategies to Foster Retention in Care

According to a report on engagement from the National Alliance on Mental Illness, 70% of people who drop out of mental health care do so after their first or

second visit.<sup>105</sup> One meta-analysis noted that although approximately 42% of persons with schizophrenia become non-adherent with prescribed medication, only 13% of patients dropped out of psychosocial treatment.<sup>106</sup> In the Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS) study, young persons aged 8-19 years-old with early onset illness found that aggressive behaviors reported by parents and being African American were associated with a greater likelihood of drop out, even though many had positive responses to medications.<sup>107</sup> The authors noted that these findings point to the need for building additional supports for particular populations, and given disparities across the healthcare system, additional supports undoubtedly need to tackle structural issues that may further disengagement across varying racial and ethnic populations. In a study of outpatient care attrition after psychiatric hospitalization of veterans, 88% of 202 patients had disengaged from care, with attrition associated with male gender, younger age, increased expectations of stigma, less short-term participation in group therapy and poorer medication adherence.<sup>108</sup> Those with fewer prior-year inpatient psychiatric days, more perceived support and less short-term attendance at psychiatric appointments left care earlier than those with more inpatient days.

On the substance use front, the data of dropouts and relapse is also robust. In a study out of Germany examining drop-out of people with Methamphetamine Use Disorder, people who dropped out of treatment after residential treatment services had higher craving scores,<sup>109</sup> while another study showed the association of dropouts with a co-occurring history of injection drug use, even though there had been improvement in psychiatric symptoms during treatment.<sup>110</sup> The cycling of individuals through the justice system, substance use system, mental health services, and houselessness are emblematic of the major challenges with retaining people in meaningful care who may be at various stages of readiness for engagement.

Despite the longstanding knowledge that a “therapeutic alliance” is an important component in psychiatric care, there is still much more to learn about fostering adherence and engagement to reduce attrition and the risk of cycling through complex and disconnected systems. Engagement approaches are a key component of a true care continuum, and lessons from biological and psychosocial research have much to teach. There have been many studies that have looked at engagement itself, especially with complex populations. For example, Angell and colleagues examined strategies to engage prisoners with mental illness upon release, looking at two models such as FACT and CTI (described above). In their qualitative studies they found that practitioner strategies that included tangible assistance as well as specific approaches to interactions and the work with third parties such as family and parole were utilized by program staff as strategies for engagement.<sup>111</sup> Another study of a model of Intensive Case Management for Addiction (ICMA), which combined ACT and CTI methodologies, showed recipients significantly decreased their use of emergency departments for care.<sup>112</sup>

Studies related to enhancing the healthcare experience suggest that respect for a patient’s dignity and humanity, as well as adequate working conditions and resources, facilitate the humanization of care more generally.<sup>113</sup> There have been many strategies that have been used to foster adherence and engagement throughout medicine and mental health care, and even in other venues such as specialty courts and probation services (see Text Box for examples).

Even with the best of strategies, there will be some individuals with serious mental illness who have difficulty adhering to treatment, challenged by their illness and at times their decision-making capacity. Laws exist to protect those individuals from harm due to impaired judgment and to help them in the event they present a risk of harm to themselves or others. For example, every jurisdiction has laws that allow for temporary holds for evaluation,<sup>114</sup> guardianship,<sup>115</sup> and civil commitment.<sup>116</sup> There are many strategies that can be utilized prior to seeking legal authority to override individual autonomy in delivering mental health services or services for those with complex conditions affecting their well-being, such as maximizing supported decision-making when possible.<sup>117</sup>

***Examples of strategies to help foster engagement and reduce attrition from services:***

- Follow-up care post-crisis
- Motivational interviewing techniques
- Considering individual attitudes about services in shaping the service delivery models
- Positive reinforcements for participation
- Provide reminders about appointments
- Assisting with skill building such as reliability training, communication with providers, and calendar management
- Facilitating access through transportation
- Assist participants with problem-solving around job responsibilities, childcare, family responsibilities, and pet care for the individual who may need to leave home for appointments or care
- General stress management training
- Offer incentives, welcome messages and positive respectful praise for returning for care

Still, these small subset of individuals with serious mental illness for whom retention in care is challenged may need additional approaches. Many jurisdictions are examining their civil commitment laws to make assisted outpatient treatment (AOT) for court-ordered community-based treatment available and more useful.<sup>118</sup> Although a review of these laws is beyond the scope of this paper, it is important to realize that the court order can be helpful for some people, but overuse and over-reliance on a court order as a single solution can be oversold, and will potentially cause unintended negative consequences and at the very least not yield as many desired successes if not applied appropriately. And engagement strategies will still be critical for all.

There are other tools along the “continuum” of strategies that are also potentially important and available in many jurisdictions. Take for example, Psychiatric Advance Directives,<sup>119</sup> which offer an opportunity for an individual to develop their own treatment plan with the understanding that their condition may render them incapable of making decisions in the future. Meaningful dialogue about one’s care well in advance of any crisis can offer opportunities for providers to hear of the individual’s concerns, answer questions about options, and set forth a plan to be able to more rapidly access care needed.



*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.

Notwithstanding legal authorities, it is important to realize that perceptions of coercion in treatment can be a component of whether an individual remains engaged in care. Even when court-ordered for treatment, a sense of being coerced may have more to do with whether an individual feels they have been treated fairly and given the appropriate information than it has to do with whether there is actually a court order or not.<sup>120</sup> Other aspects of feeling coerced may have to do with one's own background, such as was seen in a study of veterans engaged in a jail diversion program for individuals with co-occurring mental illness and substance use disorders, who reported fewer measures of perceived coercion, potentially related to backgrounds in their careers of following orders.<sup>121</sup> Researchers in the UK have been examining the impact of coercion on treatment refusal and

engagement for years, and initiated work called the CRIMSON (CRisis plan IMPact: Subjective and Objective coercion and eNgagement) protocol.<sup>122</sup> Though one study showed mixed results related to outcomes with the use of joint crisis plans (a statement of the service users' wishes for treatment developed with the clinical and an independent facilitator) on individuals under compulsory treatment per the Mental Health Act, the authors found this may have had more to do with how the plan was implemented.<sup>123</sup> The study's findings raise important questions about how best to train staff on fostering patient voice in development of plans. In another study examining two types of crisis plans—a clinician facilitated crisis plan and a patient advocate crisis plan—it was found that those facilitated by patient advocates had some advantages compared to those developed with clinicians.<sup>124</sup> Regardless, there is much more to learn on this front to help individuals who are struggling with adherence to understand their barriers and perceptions. Research is sorely needed to help improve strategies to maximize their ongoing participation in care.

Given the well-recognized disparities and structural inequities that impact individuals and families dealing with behavioral health challenges, engagement must also be done in the context of cultural humility.<sup>125</sup> Federal and local policymakers have been more intentionally building in diversity, equity, and inclusion infrastructure into their staffing and leadership for governance to pay closer attention to correct the inequities that exist. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care should be utilized as one frame of reference to see how one's system is fairing with regard to improving overall quality of services *From Crisis to Care*.<sup>126</sup> The SAMHSA crisis services guidelines make clear that crisis services must serve everyone, and Matthews and Edwards<sup>127</sup> describe the diversity of populations that crisis services must be equipped to help, and this is no less true for the care system and complete continuum attached to the crisis response.

The NAMI Engagement report highlights outdated policies and practices, including overcrowded hospitals, large caseloads, time constraints imposed by payers, lack of training and lack of coordination across systems as challenges and barriers to true engagement.<sup>128</sup> Moreover, they identify the responses of coercion, shackles, locked units, deficits-based as opposed to strengths-based approaches, challenges working across diverse cultures, lack of respect, and an inability to convey a sense of hope for recovery and goal attainment as creating mistrust and roadblocks. To overcome these obstacles, they recommend adopting 12 principles (see Text box) and described a “culture of engagement.” This premise is one that is key to the *Crisis to Care* continuum. Policymakers would do well to consider how

the creation of such a culture of engagement is fairing at every step and across systems and make every effort to foster and nurture a realization of this laudable goal.

### ***Summary of NAMI's 12 Principles for Advancing a Culture of Engagement<sup>129</sup>***

1. Make engagement a priority at every level of the mental health system
2. Communicate hope
3. Share information and decision-making
4. Treat people with respect and dignity
5. Use a strengths-based approach to assessment and services
6. Shape services around life goals and interests
7. Take risks and be adaptable to meet individuals where they are
8. Provide opportunities to include families and close supports
9. Recognize the role of community, culture, faith, sexual orientation and gender identity, age, language, and economic status in recovery
10. Provide robust, meaningful peer and family involvement in system design, clinical care and provider training
11. Add peer support services as an essential element of mental health care
12. Promote collaboration across systems and providers

## ***5. Strategies for Routinizing and Developing Effective Technology***

The use of technology in behavioral health care, such as electronic medical records, health information exchanges and virtual appointments is not new. Technology is clearly a mainstay of crisis services with the crisis hub, text lines and a call center infrastructure that routes callers behind the scenes through a network of technologically connected interfaces and GPS tracking capabilities. Moving *From Crisis to Care* is already easier and will

continue to be more rapid and accurate as bed and program registries and appointment apps help facilitate efficiency and connections for making referrals easier. The use of technology to examine big data across systems could identify areas in mental health services where growth and development are needed, as several countries have done where they can cull from large datasets to identify important trends and develop new programs and services.<sup>130</sup>

The necessity for additional technological advancement and availability in multiple ways became crystalized right at the outset of the COVID-19 pandemic. Suddenly, public behavioral health leaders were faced with the need to continue to provide seamless essential services, maximize communications across a workforce that was working from home, and train staff to work with new virtual platforms and standards with little notice. The federal government has assisted with the infrastructure and loosened regulations needed to make treatment through technological means workable during the public health emergency (PHE). In doing so, many have wondered which of the shifts would remain after the pandemic-related emergency period. To that end, SAMHSA recently announced authorization for audio-only assessments for opioid treatment programs to use telehealth evaluations for buprenorphine induction even when the PHE ends.<sup>131</sup>

With the adaptation to technology more in the mainstream, it will be important to continue to improve upon its delivery and ensure that increasingly better mental health outcomes are front and center. Promising findings from implementation of telemedicine for mental conditions, for example, include findings of positive feasibility and resultant improvement in symptoms and quality of life for a broad range of individuals in care through telehealth.<sup>132</sup> Findings related to the benefits of technology have only grown. For example, *Open Minds* reported on telehealth as an effective modality in reducing symptoms of obsessive compulsive disorder and other related symptoms and in helping consumers with I/DD.<sup>133,134</sup> To further its utilization and proper delivery, SAMHSA produced a resource guide on telehealth for the treatment of serious mental illness and substance use disorders, issued in 2021.<sup>135</sup> In that guide they focus on ways in which treatment of these serious conditions can be assisted through telehealth.

Mobile options such as text messaging for crisis support and strategies that help with progress monitoring provide a “new frontier” for mental health support and data collection according to the National Institute of Mental Health (NIMH).<sup>136</sup> Another area of growth is in the development of mental health apps. The NIMH website on this topic describes several types of apps, such as those for self-management, those that purport to improve thinking skills, those that help with more general skills training, illness management and supported care, symptom tracking and data collection.<sup>137</sup> They also note that clinicians and engineers are forging relationships (see partnerships section below), finding that technological interventions must be well-liked and engaging, and must rely upon the engineers’ skills for ease of use and the clinician’s skills for effective interventions.<sup>138</sup>

In 2017, an NIMH initiated National Advisory Mental Health Council Workgroup on Opportunities and Challenges of Developing Information Technologies on Behavioral and Social Science Research released a report that focused on technologies to advance assessments, research on and delivery of preventive and therapeutic interactions, and technologies to improve reach, efficiency and quality of mental health services.<sup>139</sup> In a 2022 NASMHPD paper by Phillippi and Thomas, several types of technological advances in behavioral health are reviewed, including efforts to expand self-directed care options.<sup>140</sup> Virtual

reality (VR) is being explored to expand tools for people with behavioral health needs across the globe.<sup>141</sup> Artificial Intelligence (AI) is yet another area of growing interest in the mental health space. For example, The Trevor Project, a suicide prevention and crisis intervention organization for LGBTQ young persons, launched a partnership with Google.org to develop an AI-based Crisis Contract Simulator, a unique counselor training tool powered by AI. By simulating digital conversations with LGBTQ youths in crisis, counselors are trained to deliver services by experiencing a realistic conversation.<sup>142</sup> Other areas of growth include the use of AI to help improve the mental health of the workforce more generally.<sup>143</sup> At the same time, experts are predicting that a large proportion of the workforce could be shifted to computerized labor through the developments in AI, which creates anxiety about job loss and can further impact worker mental health.<sup>144</sup>

*Beyond Beds*

**Recommendation #8: Technology**

Create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing, and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.

Although the promises for telehealth service delivery and expanded use of technology are broad and exciting, there are caveats to consider. Even with the potential for reaching anyone at any time day or night, there is the important need to look at how these technologies are regulated, whether there is appropriate privacy, and whether the services espoused as effective have the backing of research to support claims made by developers. There is also a need to examine the goodness of fit of the patient population for specific virtual services (e.g., certain older adults or children/families may benefit from some types of technology in behavioral health services but not others).<sup>145</sup> Ethical, clinical and legal challenges still arise in the telehealth space (some of them similar to in-person issues) and over time will continue to need to be addressed as new information becomes available.<sup>146</sup> Disparities in access to the internet and to technology devices and programs must also be addressed given the potential for inequities that have already been seen.<sup>147</sup> Rural communities for example may not have the same broadband access and thus less access to these growing supports. Even with these caveats, the role of technology will likely only grow going forward, and thus, policymakers would do well to advocate for advances that work and stay abreast of its growth as a key element in the *Crisis to Care* considerations.

## 6. Old, New, and Improved Partnerships

Although the idea of collaborations across systems is not new, the COVID-19 pandemic and some of the political unrest that catapulted the country to consider alternatives to police response to behavioral health emergencies has shown new avenues for partnerships that can be improved, and mechanisms to think more broadly about those partnerships. Examples of newly evolving partnerships are abundant.

Take for example, the more in-depth work between SBHAs and public health officials, both to reduce the impact of COVID-19 on the total population of people served in the behavioral health system, but also in working to uplift society’s mental well-being. CCP grants were issued throughout the United States to foster improved disaster behavioral health responses.<sup>148</sup> These forces leveraged new partnerships between state and local leaders.

With the 988 transition, states are pursuing laws to help implement and fund 988. To do that, leaders in behavioral health are establishing relationships with 911 and its related “Public Safety Answering Points” or PSAPs, to ensure coordination of crisis care for those who need it and continue to foster responses that do not default to police unless there is a critical need to do so. In NASMHPD’s 2022 *Lending Hands*, the issues of old, new and improved partnerships between behavioral health, law enforcement, and emergency medical services is explored with specific areas of potential growth for effective crisis response to get the various responders more coordinated and the right, least restrictive and most therapeutic response to people in need.<sup>149</sup> With the drive for 988 and Crisis Now to have answering hubs and call centers interconnected with networks, partnerships with engineers are a whole new area of focus.<sup>150</sup> Beyond

### ***New and Strengthened Partnerships Seen in Recent Years:***

- Public health and behavioral health staff
- Crisis responders including emergency medical services, behavioral health services, and law enforcement as well as behavioral health leaders working with 911 and PSAPs
- Engineers and technology experts and behavioral health
- Children’s behavioral health services, schools, child welfare and juvenile justice
- Persons with lived experience and policymakers
- IDD and behavioral health policymakers and providers
- Courts and behavioral health leaders

building new platforms and the connectivity behind the scenes, there are numerous examples of communities breaking new ground to build out legislation and programs as part of forging new and strengthening established partnerships.

State examples of these activities are everywhere. Take Knoxville, Tennessee, for example, where 988 is seen as a means of complementing a co-responder program that was established between police and behavioral health specialists.<sup>151</sup> Legislators in Massachusetts proposed “an Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation.”<sup>152</sup> In the District of Columbia, a coalition of hospitals and health centers explored the

*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.

needs of people in the District, and issued a white paper examining the crisis system’s challenges and opportunities to increase health and reduce harm by properly leveraging partnerships between behavioral health, law enforcement, and 911.<sup>153</sup> This close examination of the system informed growth in activities that leverage meaningful partnerships necessary for proper crisis services across diverse communities in the city. And on a broad scale, as described in NASMHPD’s 2022 paper on CCBHCs and other Urgent care models,<sup>154</sup> CCBHCs actively require agreements with various partners such as local law enforcement to enhance jail diversion.

Another area of expanded partnerships has evolved through the recognition of mental health needs for youth and for parents of young children.<sup>155</sup> For older youth, crossover collaboration between behavioral health, education and child welfare systems is also booming. More than 20 years ago Weist, Lowie, Flaherty and Pruitt wrote about the importance of augmenting roles played by mental health and public health systems in improving school-based mental health services while minimizing “turfism and negative attitudes.”<sup>156</sup> Today, these collaborations are much more established, yet with the tragic incidents involving school shootings and the mental health toll of the pandemic, there are more reasons than ever to foster and prioritize these collaborations with creative opportunities for their expansion.

NASMHPD and the National Association of State Directors of Developmental Disabilities Services (NASDDDS)<sup>157</sup> are working together on a number of initiatives to address complex populations. Together with The National Association for the Dually Diagnosed (NADD) and NASMHPD, NASDDDS is growing participation in its Capacity Building Institute for Individuals with I/DD and Mental Health Support Needs (CBI).<sup>158</sup> This center aims to help states better serve those individuals with dual diagnoses by facilitating and improving skill sets of participants. As HCBS waivers become more available to those with dual diagnoses and systems begin to build their capacity, these collaborations will continue to expand. Non-governmental partners with states have launched initiatives to help providers navigate some of the complex waters of these collaborations, such as one out of Alaska, the Alaska Healthcare Providers Toolkit, which emerged in 2015 as a joint project of University of Alaska Anchorage (UAA) Center for Human Development Leadership Education in Neurodevelopmental and related Disabilities (LEND) and the WITH Foundation.<sup>159</sup>

Partnerships across branches of government are also growing. The National Judicial Task Force to Examine State Courts’ Response to Mental Illness launched in March 2020 by the Conference of Justices and the Conference of State Court Administrators and facilitated by the National Center for State Courts is an important example of partnerships between judicial and executive branch representatives.<sup>160</sup> This initiative has produced reports and tackled issues related to criminal justice, civil and probate courts,



juvenile justice, child welfare and family, leadership and collaboration and education, with ongoing work being done in these domains. Reports will continue to be produced from this body of diverse leaders, and collaborative meetings with SAMHSA on a regional level have already begun to inspire work to implement many of the Task Force recommendations. On a local level, the Miami-Dade County's Eleventh Judicial Circuit of Florida has been diligently growing its Criminal Mental Health Project under the Direction of The Honorable Steve Leifman and in partnership with the local behavioral health system and with support from the legislature and getting national attention for its work.<sup>161</sup>

Partners with the advocacy community, persons with lived-experience and their families, tribal leaders, veterans' administration and services and faith-based organizations to name a few are underway throughout the community to help improve the lives of so many individuals who daily struggle with behavioral health conditions. The movement of building non-traditional partners across the country as recommended in *Beyond Beds* has been impressive.<sup>162</sup> Though examples abound, SMAdviser.org is one to not as a resource that has been built with voices from a broad range of stakeholders.<sup>163</sup> With federal attention on improving mental health as part of President Biden's Unity agenda, there will be growing work across federal agencies that examine how to implement the President's strategy.<sup>164</sup> This work marks an important time to build a stronger system from *Crisis to Care*, with partners both traditional and non-traditional ready to serve and stand up for improvements for better mental health outcomes.

## 7. Sustainable and Expandable Services

Funding of crisis services are critical to ensure that they are effective and available. The American Rescue Plan provided an additional \$1.5 billion in Mental Health Block Grant dollars to states to be spent over the next several years, which SAMHSA has encouraged states to use to

develop partnerships among critical stakeholders to the crisis services continuum.<sup>165</sup> Announcements of expanded funding in various areas, such as HHS announcing nearly \$35M to strengthen supports for children and young adults and suicide prevention are always welcome.<sup>166</sup> But what will behavioral health service needs look like over time? With the infusion of dollars related to the pandemic slated as temporary, there will need to be careful attention to long-term funding. Before the pandemic, it was anticipated that spending on mental health and substance use treatment would double between 2003 and 2014.<sup>167</sup> Yet, behavioral health has a long history of being inadequately funded. This cannot be an option, especially given recent data reported in the *Lancet* showing a critical increase in disability adjusted life years related to depression and anxiety for people in the workplace as a result of the impact of the COVID-19 pandemic. Findings like this support an urgency to strengthen mental health systems in most countries.<sup>168</sup> It is anticipated that the demand for mental health services will grow, and the 988-call line is due to be in high demand. To help shift people *From Crisis to Care*, the behavioral health care continuum will need to grow accordingly, or there will be more demand than supply resulting in greater waits for services.

In the President's strategy to address our national mental health crisis, many aspects of needed improvement are noted (See Text Box),<sup>169</sup> which speak to issues addressed throughout this paper. With this commitment at the highest level of government to include not just expansion of behavioral health services but focused attention on assisting individuals with substance use disorders and helping to integrate primary care and behavioral health, there will undoubtedly be funding strategies to support this work. Moreover, efforts to address parity and make it meaningful can only assist in ensuring access to proper care for people with behavioral health conditions. And, as part of the infrastructure, innovations like the Healthy People Initiative<sup>170</sup> that sets forth planning for the future and envisioning



what it would take to create healthy people by 2030, there is promise ahead that systems are growing in the same direction and advocates will have the tools needed to inspire funding to meet the goals set forth by the President.

### ***Summary of President Biden’s Strategy to Address Our National Mental Health Crisis***

#### ***1. Strengthen system capacity***

- a. Investing in programs to bring providers into behavioral health
- b. Pilot new approaches to train a diverse group of paraprofessionals
- c. Build a national certification program for peer specialists
- d. Promote the mental well-being of our frontline health workforce
- e. Launch the “988” crisis response line and strengthen community-based crisis response
- f. Expand the availability of evidence-based community mental health services
- g. Invest in research on new practice models

#### ***2. Connect Americans to Care***

- a. Expand and strengthen parity
- b. Integrate mental health and substance use treatment into primary care settings
- c. Improve veterans access to same-day mental health care
- d. Expand access to tele- and virtual mental health care options
- e. Expand access to mental health support in schools and colleges and universities
- f. Embed and co-locate mental health and substance use providers into community -based settings
- g. Increase behavioral health navigation resources

#### ***3. Support Americans by Creating Healthy Environments***

- a. Strengthen children’s privacy and ban targeted advertising for children online
- b. Institute stronger online protections for young people, including prioritizing safety by design standards and practices for online platforms, products, and services
- c. Stop discriminatory algorithmic decision-making that limits opportunities for young Americans
- d. Invest in research on social media’s mental harms
- e. Expand early childhood and school-based intervention services and supports
- f. Set students up for success
- g. Increase mental health resources for justice-involved populations
- h. Train social and human services professionals in basic mental health skills

## **Conclusions**

The transition to 988 has been described by Balfour as a “*carpe diem* moment” for behavioral health crisis services.<sup>171</sup> It is true that these are unprecedented times, and the political winds and societal needs are coalescing to shape a promising future for behavioral health services within the crisis care continuum. With this moment comes the imperative to continue to connect the dots in the psychiatric continuum of care, thinking beyond crisis to the accessible care that will be required both to avoid crises in the first place and to deliver timely care in the moment that it is most needed. This paper set forth seven key elements that are considered crucial to make this work successful. In building out services beyond 988 and *From Crisis to Care*, behavioral health leaders have shifted far from the days where the

single solution to the mental health system fragmentation was more state hospital beds. Now, levers of all sorts are pushing for a safety-net infrastructure that is well-funded, sustainable and expandable to meet the growing demands not just for people in the public behavioral health system, but for all individuals who serve them, their families, and the public as a whole.

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# TRENDS IN PSYCHIATRIC INPATIENT CAPACITY

## United States and Each State, 1970 to 2018

**NASMHPD**

September 2022

Paper No. 2 in the *From Crisis to Care* Series



# Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018

**Ted Lutterman**

National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

*Second in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs Focused on Building from 988 and Beyond for Better Mental Health Outcomes*



National Association of State Mental Health Program Directors

[www.nasmhpd.org/content/tac-assessment-papers](http://www.nasmhpd.org/content/tac-assessment-papers)

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## **Abstract:**

Although inpatient beds are only one part of a complete psychiatric care continuum, the availability of psychiatric beds for individuals in crisis is a continuing national issue. Individuals experiencing mental health crises who need intensive supervised treatment frequently are stuck (boarded) in emergency departments for hours or days awaiting an appropriate bed or do not receive timely, appropriate services, with many even being routed to the criminal system. Discussions about shortages of psychiatric beds often start with dialogue of the major decrease in state psychiatric hospital beds over time—a reduction of over 84% since the 1970s. However, these conversations often do not address the growth of psychiatric beds in settings outside of state psychiatric hospitals or the tremendous increase in a broad array of community-based mental health services and supports during that time. This report updates a 2017 NRI/NASMHPD paper<sup>1</sup> on trends in psychiatric bed capacity from 1970 to 2014 by adding information between 2014 through 2020\*. This report also addresses the very different use of state psychiatric hospitals in 2018 and 2020 compared with their use 50 years ago and discusses where some of the individuals who previously would have been served in state psychiatric hospitals are now receiving care today.

## **Highlights:**

- From 1970 to 2018, there has been an 84% reduction in state hospital beds, but most of those bed closures occurred decades ago during the 1970s and 1980s, with 65% of all state hospital beds that closed between 1970 and 2020<sup>2</sup> having closed during the first decade (1970 to 1980).
- In the most recent decade (2010 to 2018), despite many discussions about bed shortages and assumptions about the downsizing of beds, overall inpatient psychiatric beds in all types of organizations increased 17% between 2010 to 2018. State hospital beds decreased 18.5%, but private psychiatric hospital patients more than doubled, and general hospital psychiatric unit beds increased more than 25%.
- There was a major shift in use of psychiatric beds by age. Children in mental health inpatient or residential treatment beds decreased by 20% from 2010 to 2018. The number of adults in inpatient or residential treatment beds increased by 24% from 2010 to 2018.
- Historical comparisons of the number of mental health patients often focus only on state psychiatric hospital data and do not adequately account for how state hospitals have changed the populations they serve over time, serving for example, fewer older adults with dementias and intellectual disabilities and more people with criminal justice legal statuses.
- An increasing majority of State Mental Health Authorities (SMHAs) are reporting shortages of psychiatric beds, but the major policies to address these shortages are not focused on reopening state hospital beds but are instead focusing on community-based services and crisis services to divert clients from inpatient care.
- Medicaid's role in paying for mental health services, especially community-based services, has grown over time helping to support alternatives to inpatient and residential care, and Medicaid's Institution for Mental Disease (IMD) policy continues to restrict Medicaid's role in financing inpatient mental health services.

\* Although this paper includes data through 2020, the 2020 data are excluded from many analyses due to the unreliability of bed data reporting during the start of the COVID-19 pandemic.

## **Recommendations:**

1. Although this report uses the latest complete information available about mental health patients in 24-hour settings, it identifies several major areas where data are not available for 2018 or 2020, and where trend data are not available. Major gaps include the provision of mental health services to persons in jails and prisons, and mental health services in general hospital scatter beds. Future analyses of available mental health beds could benefit if estimates of beds in these additional settings become available.
2. The COVID-19 pandemic affected 2020 reporting and has led to the closure of some facilities amid persistent workforce shortages. Updating information now as systems emerge from the COVID-19 pandemic will be important.
3. One area of focus is a shortage of beds for children with complex health needs. Little information is available about the number and capacity of Medicaid Psychiatric Residential Treatment Facilities (PRTFs) and other settings being used for children, including information about the number of children being sent to out-of-state placements. SAMHSA and CMS data systems do not currently detail the number of PRTF beds available, or characteristics of children being served in them. Developing information about the availability of PRTF beds and the characteristics of the children served could provide useful, additional data for future reports.
4. Care for older adults (ages 65 and over) with complex needs, such as co-occurring mental health disorders and neurocognitive disorders is a challenge states are starting to address as the older adult population in the United States grows. Collecting information about where older adults with these complex needs are being served, and the necessary appropriate services can be helpful to states and others working to assure appropriate treatments and supports are available.
5. The July 2022 launch of the national three-digit 988 crisis call center system and the growing adoption of the Crisis Now model of crisis services has great potential to help many individuals experiencing psychiatric crises be diverted to less-intensive service settings. The impact of more states providing comprehensive crisis service systems on the future need for psychiatric inpatient and 24-hour residential treatment services should be studied.
6. NASMHPD's 2017 "Beyond Beds" report and framework argues for a robust continuum of care as opposed to inpatient beds as a single policy solution to current access challenges. In August 2022, the American Psychiatric Association's Presidential Task Force on Assessment of Psychiatric Bed Needs in the United States issued the report: "*The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions 2022.*" Supporting states and communities to test and refine the bed-need models proposed in the APA report (models that factor in crisis and community resources) could greatly enhance understanding of the appropriate number and types of mental health treatment beds needed in different communities or regions.

**Limitations:** This report focuses on the number of individuals in mental health treatment beds in 2018 and trends until 2018. Some 2020 data on individuals in mental health beds are available, however, due to the COVID-19 pandemic, 2020 data likely reflect substantial underreporting by facilities. COVID resulted in many mental health providers experiencing major staffing shortages that resulted in them focusing their attention on serving clients rather than responding to surveys, and also reflect temporary closures of mental health beds due to staff shortages and requirements for social distancing measure (e.g., limiting occupancy to one bed per room). As a result, SAMHSA's 2020 N-MHSS data show an overall reduction of 35.4% of beds between 2018 and 2020 (a decrease of over 66,500 beds). Before the 2020 data collected during COVID, there had been a substantial increase of psychiatric beds every time-period from 2010 to 2018, with a net increase of 16.8% (27,620 residents).

Psychiatric inpatient and residential treatment beds are the most expensive and typically considered the most restrictive form of mental health treatment, but are a critical safety net service for individuals who are experiencing psychiatric crises that require high levels of clinical support and 24-hour treatment. Every state government operates some psychiatric inpatient beds, and provides a variety of psychiatric inpatient and other 24-hour residential treatment beds. However, state operated mental health beds are only a small portion of the overall behavioral health system and the role of state operated inpatient beds within the larger behavioral health system (including private provider beds and community mental health services) are important to understanding whether a system or region has sufficient inpatient bed capacity compared to other complimentary services across a psychiatric continuum of care.<sup>3</sup> To that end, in 2017, NASMHPD produced its seminal “Beyond Beds” framework,<sup>4</sup> arguing for more clarity on what is meant by “Beds” and noting that a robust continuum of psychiatric care should be the primary focus, rather than rely upon one intensive service-state hospital or inpatient psychiatric care-as the single solution to address the needs of all individuals with mental illness. This has spawned further discourse and this paper articulates further information about data on psychiatric bed availability across time.

### APA Task Force Report

“Mental health systems optimally include a care continuum to meet people’s needs in the most accessible, least restrictive environment. In a broad perspective, this continuum includes a range of services such as crisis services, accessible outpatient services, rehabilitation and recovery support services and inpatient psychiatric care. Access to inpatient psychiatric beds undergirds local mental health systems, providing essential services to help treat adults or young people who are experiencing mental illness, just like inpatient medical hospitalization serves the most acutely ill.”<sup>5</sup>

Since the 1970s, 24-hour inpatient and residential treatment has dramatically shifted away from being provided in state government-operated psychiatric hospitals. As this paper shows, in 1970, 78.5% of mental health inpatients were served in a state psychiatric hospital, compared with 19% in 2018 (and 16.2% in 2020). For older adults and children who require inpatient and residential-level care, treatment has shifted away from state psychiatric hospitals at an even greater rate.

Shortages of psychiatric beds are often highlighted in media headlines and a Google search for the term “mental health bed shortage” conducted on July 22, 2022, returned over 10.9 million hits.



**Sample Newspaper Headlines within the last 2 month of google search:**

**“Shortage of beds in state mental hospitals delays treatment in North Texas”**

WFAA news (Dallas, Tx) June 30, 2022

<https://tinyurl.com/bdefm9sw>

**“New facilities won’t solve Southwest Michigan’s shortage of inpatient psychiatric beds”**

Mlive.com (Kalamazoo, MI) June 3, 2022

<https://tinyurl.com/yj28x3z8>

**“‘Clearly our children are in crisis’: Mental health resources scarce, legislation looks to improve access”**

Buck County Courier Times, (PA) July 6, 2022

<https://tinyurl.com/5ewnhd3s>

**“Waiting on Treatment: Bed shortage leaves mentally ill Nebraskans in jail for months”**

KOLN (Lincoln, NE) May 26, 2022

<https://tinyurl.com/238kemks>

**“Hundreds of Suicidal Teens Sleep in Emergency Rooms Every Night.”**

New York Times (NY, NY) May 9, 2022

<https://tinyurl.com/yzwcab9v>

The initiation of 988, the new three-digit national mental health suicide and behavioral health crisis line in July 2022 is projected to greatly increase the demand for mental health services. Although the 988 crisis lines are expected to immediately address the urgent needs of callers, a few callers will require higher levels of care, including crisis stabilization, crisis residential, as well as inpatient treatment for clients needing the most intensive levels of care. Early intensive crisis services may help resolve behavioral health crises and reduce the need for psychiatric hospitalizations, but the projected doubling of 988 calls over the next several years may result in increased demand for more intensive level services.<sup>6</sup> As such, as articulated in *From Crisis to Care*,<sup>7</sup> it will be important for policymakers to continue to build out community-based services and understand their system need for different aspects of the care continuum. This paper’s review of the historical trends in inpatient beds provides a record for posterity while offering insights into current trends and future directions.

## Methodology

This report relies on data collected by multiple data sources over time:

### 2018 Data Sources

1. SAMHSA’s National Mental Health Services Survey (2018<sup>8</sup>, also N-MHSS data from 2010,<sup>9</sup> 2014,<sup>10</sup> 2016,<sup>11</sup> and 2020<sup>12</sup> are used in this report). N-MHSS is an annual survey to collect information on the location, organization, structure, services, and utilization of mental health treatment facilities. It is designed to collect statistical information on all known mental health treatment facilities in the United States. This includes the 50 states, the District of Columbia, and all U.S. territories. Every other year, starting in 2014, N-MHSS also collects information on the numbers and demographics of persons served in these treatment centers.
2. SAMHSA Uniform Reporting System (URS).<sup>13</sup> The URS provides annual information about the number of patients being served in state psychiatric hospitals on the first day of the reporting

year. States submit URS data every December as part of their Annual Mental Health Block Grant Implementation Report.

3. NRI State Profiles System 2020. The State Profiles System information is compiled by NRI every 2 years and focuses on state level policy, services, and financing information about public mental health services. State Mental Health Agency leaders guide the development of questions to collect and NRI maintains this data. The State Profiles builds on existing data and collects information that adds context to more quantitative data systems, by compiling information about state policies, regulations, and organization that allows better use of quantitative data.
4. CMS Nursing Home Minimum Data Set: Reported annually by nursing facilities includes information about the number and percent of residents in nursing homes with a diagnosis of schizophrenia and/or bi-polar disorders for which they received active treatment.

*Historical Data Sources*

1. NIMH/SAMHSA Inventory of Mental Health Organizations (IMHO): the IMHO was a mental health treatment facility survey similar to the current N-MHSS that was conducted every two years by NIMH and then SAMHSA (after it was created). The historical IMHO reports include information about the number of residential patients on a single day who were in either psychiatric inpatient or other 24-hour residential treatment beds. Unlike the N-MHSS datasets, historical IMHO data sets only contain a combined count of individuals in inpatient or other 24-hour residential treatment beds (e.g., separate numbers are not available for inpatient or other-24-hour residential treatment beds)
2. NIMH-SAMHSA Annual Survey of Patient Characteristics—annual report--State and County Mental Hospital Inpatient Services (data available from 1971 through 2005).<sup>14</sup>
3. NIMH/SAMHSA Statistical Notes: these are brief summaries of research studies written by NIMH or SAMHSA staff that often include historical data on inpatient and residential treatment services.

*Data Sources for Information about Mental Health Treatment Beds*

Mental Health Bed Settings	Current Data Sources	Historical Data Sources
<p><b>Psychiatric Inpatient Residents</b>  <b>Settings:</b> State Hospitals, Private Psych Hospitals, General Hospitals with Separate Psych Units, VA Medical Centers, RTCs, Other Psych Beds</p>	<p><b>N-MHSS: (2010 to present)</b>            N-NMHSS provides separate counts for Psych Inpatient and Other 24-Hour Residential Treatment</p>	<p><b>IMHO (1970 to 2008)</b>            IMHO data combines Psychiatric Inpatient and Other 24-Hour Residential Treatment</p>
<p><b>State Psychiatric Hospitals:</b>            Several data sources include more details on patients in state psychiatric hospitals</p>	<p><b>Uniform Reporting System (2002 to present)</b>            Number of residents in state hospitals on the first day of years (by Children and Adults)</p>	<p><b>Annual Survey of Patient Characteristics (1971 to 2005)</b>            Number of Residents in state hospitals on a single day:            Information by age and major diagnoses.</p>

Mental Health Bed Settings	Current Data Sources	Historical Data Sources
<p><b>NRI State Mental Health Agency Profiles</b></p> <p>The State Profiles information is collected by NRI approximately every two years and includes information about the organization, policies, services, and funding of state mental health agencies. Information about the number of state hospitals, policies regarding the use of state hospitals, and financing of state hospitals are collected each cycle.</p>	<p><b>SAMHSA Sponsored State Profiles: (1990 to 2015)</b></p> <p>With financial support from SAMHSA, NRI conducted State Profile reports regularly from 1990 to 2015. State expenditures for state hospitals was collected from FY 1981 to FY 2015.</p>	<p><b>State Sponsored State Profiles: (2020 to present)</b></p> <p>In 2020, NRI re-launched State Profiles with financial support directly from state mental health agencies. Information about the use of state hospitals, their financing, and patient legal characteristics are included in the data set.</p>

## Use of Psychiatric Beds and the Policies Focusing on Transition to Community-based Services

The decline in psychiatric inpatient capacity over the past 65 years has been part of a historic transformation of how and where services to individuals with serious mental illness are provided. Until the 1960s, the Federal collection of information about mental health services focused exclusively on psychiatric hospitals, as they were the primary settings where individuals with serious mental illnesses received services.

Today, psychiatric beds are used as one piece of a continuum of mental health care for individuals in acute crises and those with complex needs that may not be met by community services, often with multiple diagnoses—and individuals with criminal justice involvement who are sent to psychiatric institutions by the judicial system for evaluations and treatment. In 2020, state mental health systems provided mental health services to over 8 million individuals, but only 1.6% received mental health services in state psychiatric hospitals.<sup>15</sup> Although fewer than 2% of clients received services in state psychiatric hospitals, states expended \$11.5 billion providing those intensive services (24% of total SMHA expenditures).<sup>16</sup>

The shift of state mental health services from state psychiatric hospitals to community mental health services and supports reflects an over 50-year evolution in mental health treatment philosophy and treatment objectives. Several authors have investigated how the development of first-generation antipsychotic and antidepressant medications in the 1950s permitted the movement of patients out of state psychiatric hospitals that had grown into large institutions—some of which were essentially “warehousing” over 10,000 patients with little successful treatment prior to the new medications.<sup>17,18,19,20</sup> In 1963, President Kennedy pushed the adoption of the Community Mental Health Act (CMHA),<sup>21</sup> funding the establishment of comprehensive community mental health centers (CMHCs) across the country. One of the explicit goals of the CMHA was to reduce the use of psychiatric hospitals by adopting a philosophy of making community mental health centers the central location for mental health services, including inpatient care as a key service. The Act also considered individuals with intellectual and developmental disabilities (I/DD) in its formulation as the organization of services were generally combined at the time for individuals with I/DD and those with serious mental illness.

Implementation of the CMHA never met the goals originally envisioned, and failed to end the need for specialized psychiatric hospitals.<sup>22,23,24</sup> In 1982, the CMHA was transitioned into the MHBG.<sup>25</sup> The MHBG directs community mental health funds through each state's SMHA, with the requirement that states use the MHBG funds to plan and implement comprehensive community-based mental health service system that minimizes the use of restrictive inpatient care. The MHBG statute requires SMHAs enable individuals receiving comprehensive community mental health services to function outside of inpatient or residential institutions to the maximum extent of their capabilities.<sup>26</sup> In implementing the MHBG, SAMHSA also developed and worked with states to implement Community Support Program (CSP) model services that uses trained mental health case managers to help individuals with serious mental illnesses access the services and supports necessary to live in their own communities. While appropriations for the MHBG have failed to keep up with inflation and population growth, the MHBG remains a critical source supporting state development of comprehensive community mental health systems designed to minimize the use of hospital level of care.

During the 1980s and 1990s, the National Institute of Mental Health (NIMH), SAMHSA, and others developed evidence-based model community-based mental health treatment options with the goal of helping individuals with serious mental illness to receive services in their own communities and avoid hospitalizations—services such as ACT, supportive housing, supported employment, Cognitive Behavioral Therapy (CBT), and recovery-focused psychosocial rehabilitation services.

The development of community-based services over the past 50 years was further supported by the passage of state and Federal laws that drastically increased financial support for community mental health services.<sup>27</sup> In particular, Medicaid and Medicare have expanded as major sources of reimbursement for community mental health services. Also, in recent years the passage state and Federal mental health parity laws mandate that private insurance plans eliminate restrictions on payment for mental health services that are not on parity with restrictions on payment for analogous medical/surgical services, creating more access to mental health services and healthcare coverage and reimbursement for them. In the 1990s, the use of managed care for both private insurance and Medicaid increased the potential funding of community mental health services, but also added new levels of oversight/utilization review that limited payments for psychiatric inpatient care.<sup>28,29</sup>

Finally, since the 1970s, the Federal Government, through a series of laws and court cases has been actively pursuing policies that reduce the use of psychiatric hospitals unless absolutely necessary. Federal policy has challenged inappropriate hospitalizations, incentivized community-based treatments, and supported the development of evidence-based community-based alternatives to hospitalization such as Assertive Community Treatment (ACT) services and Coordinated Specialty Care for individuals experiencing a first episode of psychosis.

Federal policies that explicitly limit funding or use of psychiatric inpatient services include:

1. **Federal Medicaid Institutions of Mental Disease (IMD) Coverage Limitations (1965)** — When the Social Security Act Amendments of 1965<sup>30</sup> creating the Medicaid program were enacted, they set limits on Medicaid payment for services in IMDs. Over the years, exceptions to the limits were carved out for inpatient services provided to older adults and children. The current Medicaid regulations prohibit Federal Medicaid matching payments for adults' ages 22 to 64 in inpatient and other 24-hour residential treatment settings in institutions with more than 16 beds where more than half the patients have a mental illness.<sup>31</sup> The IMD rule has incentivized states to shift acute psychiatric treatment for adults from state psychiatric hospitals (which are IMDs and thus unable to

bill Medicaid) to general hospital psychiatric beds (which are able to bill Medicaid). For example, if a state closes an acute unit in a state hospital that relied on \$10 million in state general revenue funds, the state could use those \$10 million as match for Medicaid billing of acute psychiatric inpatient services in a general hospital to leverage an additional \$10 to \$20 million of federal Medicaid funds (the Federal Medical Assistance Percentage (FMAP) match rates range from 50% state-50% federal contribution to 18% state-82% federal depending on a state's per capita income level).

A recent change to Medicaid managed care regulations<sup>32</sup> also allows coverage of 15 days or less in a month for residential substance use disorder services and psychiatric inpatient services in a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services through the capitated payments made to Medicaid managed care organizations.<sup>33</sup>

Medicaid Disproportionate Share (DSH) Payments have allowed some states to receive reimbursements from Medicaid for providing services to individuals without insurance. However, while Medicaid DSH has been an important source of funding for some state and private psychiatric hospitals, the use of DSH to cover IMD services varies considerably from state to state.<sup>34</sup> The Affordable Care Act (ACA) has increased the number of individuals with insurance coverage and as a result, the ACA is scheduled to phase out DSH funding over the next few years. If DSH funds are eliminated, an additional federal source of support for psychiatric inpatient care will disappear.

2. **Mental Health Block Grant (MHBG) Law** —The MHBG law requires SMHAs to use block grant monies to “enable individuals receiving comprehensive community mental health services to function outside of inpatient or residential institutions, to the maximum extent of their capabilities.” The MHBG statute prohibits any expenditure of MHBG funds for inpatient services.<sup>35</sup>
3. **Civil Rights of Institutionalized Persons (CRIPA)** — The Federal law intended to protect the rights of individuals in state and local psychiatric hospitals, nursing homes, institutions for individuals with intellectual/developmental disabilities, or in correctional facilities has been the basis of a number of lawsuits and settlements focusing on overuse and inappropriate care in state psychiatric hospitals. The goal of that litigation is frequently the reduction in use of inpatient care and an expansion of community-based alternatives.
4. **Americans with Disability Act of 1990 (ADA)** – The ADA is a Federal statute that requires several accommodations for individuals with disabilities, prohibits unjustified segregation of them.<sup>36</sup> In 1990, the Supreme Court determined in the *Olmstead* decision<sup>37</sup> that the ADA applies to patients in state psychiatric hospitals and that states must make reasonable accommodations to support the community integration of individuals with mental illnesses who are clinically appropriate for discharge and community-based settings. The *Olmstead* decision has been the focus of much litigation, and many settlements have focused on inappropriate or overuse of institutional care.
5. **Fair Labor Standards Act and the 1973 Souder v Brennan Federal Court Decision** – Although not often cited as a reason for deinstitutionalization, the Federal District Court for the District of Columbia held in a 1973 decision that hospital patients who perform work within state institutions are entitled to payment for their labor, even where such employment is considered to be therapeutically advisable for the patient.<sup>38</sup> The result of this decision was that volunteer patient laborers working in state hospitals to maintain the hospital (working in the laundry, kitchen, maintenance or to grow food in rural areas on hospital farms) or in workshops contained within the hospital that produce products for the hospital and outside sale now needed to receive minimum wage for hours worked.<sup>39</sup> An example of the impact of this decision is found in a 1974 Michigan budget document that appropriated

\$800,000 for wages for patients in state hospitals, citing the *Souder* decision.<sup>40</sup> After the *Souder* decision, the increased costs of having to pay for kitchen, laundry, workshops, farms and other state hospital operations led some states to close their workshops and farms and downsize the hospitals.

6. **New Behavioral Health Crisis Services** In 2020, SAMHSA issued the “National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit.”<sup>41</sup> The Crisis Toolkit identifies three core service elements for crisis systems:

- Regional or statewide crisis call centers coordinating in real time. In July 2022, the National Suicide Lifeline transitioned to a three-digit (988) number that connects individuals in crisis with over 200 regional crisis centers for phone, text, and chat services.
- Centrally deployed, 24/7 mobile crisis teams.
- 23-hours crisis receiving and stabilization programs.

The new national initiative to expand behavioral health crisis services has great potential to reduce the need for psychiatric bed use by helping individuals experiencing a behavioral health crisis to receive immediate care and avoid using emergency rooms or hospitalization. The Crisis Now model in Arizona has documented that by offering these three sets of coordinated behavioral health services, that they have greatly reduced the number of individuals receiving psychiatric hospitalization services while providing immediate services to meet needs in the community.

## **Availability of Psychiatric Inpatient Services in 2018**

Beds available to provide 24-hour mental health treatment to individuals requiring a high level of intensive and expensive treatment are available in a variety of settings, including as noted above specialized psychiatric hospitals (run by state government, city/county governments or private corporations), specialty psychiatric inpatient and licensed residential treatment units in general hospitals and other organizations, RTCs for children and adults (organizations that provide intensive 24-hour treatment services but are not licensed as “inpatient” services), DOD and VA facilities, nursing homes, and psychiatric inpatient units within jails and prisons. Unfortunately, there is no single source of information that documents all psychiatric inpatient capacity across the various types of organizations that provide these services. This paper combines available information from multiple data sources to estimate the overall inpatient and other 24-hour inpatient capacity in the U.S. in 2018.

The most recent year for which information on psychiatric inpatient capacity is available across multiple settings is 2020, but that information is confounded by data being collected during the start of the COVID-19 pandemic. Information on resident patients (inpatient and other 24-hour treatment) in 2020 reflects a 35.4% decrease in the number of residents over the 2018 data (a 40% reduction in inpatients and 26% reduction in patients in other 24-hour residential treatment beds). The number of organizations reporting inpatient data also decreased by 6% from 2020 to 2018. While some of the decrease may be due to temporary closing of beds during the early stages of COVID, analysis of some state data shows some facilities may have not reported any data during the COVID epidemic. For example, one state reports that they did not close any of their state psychiatric hospitals during COVID, but the 2020 N-MHSS shows a decline of six public psychiatric hospitals from 2018 to 2020. Because of the uncertainty of the 2020 data, this report includes some tables that show the 2020 data, but predominately relies on 2018 in discussing trends and current inpatient capacity.

The SAMHSA National Mental Health Service Survey (N-MHSS) is collected every two years and documents inpatient and other 24-hour mental health treatment beds in organizations that provide



specialized mental health units. Organizations covered by SAMHSA surveys include (1) state and county psychiatric hospitals, (2) private psychiatric hospitals, (3) general hospitals with psychiatric units, (4) VA Medical Centers with psychiatric units, (4) Residential Treatment Centers (RTCs) for Children and Adults, and (5) other mental health treatment organizations that provide inpatient or other 24-hour treatment beds (organizations such as community mental health centers). RTCs are a type of mental health treatment provider that provides specialized mental health residential treatment (usually licensed separately from inpatient beds) that has grown rapidly in their capacity over the past decades.

### Psychiatric Inpatient Capacity in Mental Health Specialty Organizations

SAMHSA and its predecessor agency, the Alcohol, Drug Abuse, and Mental Health Administration, have been routinely conducting surveys of all specialty mental health providers since the 1970s. These surveys, called the Inventory of Mental Health Organizations (IMHO) in the 1980s and 1990s and recently revised into the National-Mental Health Services Survey (N-MHSS) compile information on the number of specialty mental health providers that provide psychiatric inpatient and residential services and information on the number of residents in these facilities on the last day of the year.

The 2018 N-MHSS documents that 187,877 individuals were patients in specialty psychiatric beds at the end of the year (Table 1). Sixty-nine percent of those individuals were residents in licensed inpatient beds at the end of the year, and 31% were residents in other types of 24-hour residential beds at the end of the year.

**Table 1: Number and Rate per 100,000 population of psychiatric inpatients and other 24-hour residential treatment patients at end of year 2018**

Type of Organization	Patients in Inpatient Settings at End of Year			Patients in Other 24-Hour Residential Treatment at End of Year			Patients in Inpatient and Other 24-Hour Residential Treatment at End of Year		
	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate per 100,000 Population
State & County Psychiatric Hospitals	33,225	26%	10.2	2,500	4%	0.8	35,725	19%	10.9
Private Psychiatric Hospitals	50,200	39%	15.3	4,196	7%	1.3	54,396	29%	16.6
General Hospital with Separate Psychiatric Units	40,052	31%	12.2	478	1%	0.1	40,530	22%	12.4
VA Medical Centers	2,662	2%	0.8	4,330	7%	1.3	6,992	4%	2.1
Residential Treatment Centers (RTCs)	454	0%	0.1	36,391	62%	11.1	36,845	20%	11.3
Other Specialty Mental Health Providers with Inpatient/Residential Beds	2,522	2%	0.8	10,867	18%	3.3	13,389	7%	4.1
<b>Total in specialty MH Provider Organizations</b>	<b>129,115</b>	<b>100%</b>	<b>39.5</b>	<b>58,762</b>	<b>100%</b>	<b>18.0</b>	<b>187,877</b>	<b>100%</b>	<b>57.4</b>

Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a

Among specialty inpatient providers, private psychiatric hospitals were the largest single source of inpatient residents (50,200) in 2018, followed by general hospitals with separate psychiatric units (40,052 residents), and state and county psychiatric hospitals (33,325, as counted on patients in a bed on April 30th). Note that 2018 is the first time that more individuals were residents in private psychiatric hospitals and general hospitals than in state psychiatric hospitals.

Among specialty mental health providers with 24-hour residential treatment beds, RTCs, with 36,391 patients on the last day of the year) and other specialty mental health providers (such as community mental health centers), were the second largest setting for other 24-hour psychiatric treatment patients. Combining inpatient residents with other 24-hour treatment units, private psychiatric hospitals (with 54,396 residents) were the largest provider of psychiatric beds in 2018.

#### *Rates of Psychiatric Inpatient Capacity and 24-Hour Treatment Capacity per 100,000 Population*

In analyzing the use of psychiatric inpatient capacity between states and over time, it is important to factor in the differences in the size of individual state populations and population changes over time. A standard method used to adjust for variation in population size and growth over time is to calculate a ratio per 100,000 population (dividing the number of patients by the relevant population number and then multiplying by 100,000).

Using this approach, in 2018, there were 39.5 psychiatric inpatient residents per 100,000 in specialty mental health providers and an additional 18.0 patients per 100,000 in 24-hour residential treatment beds. A total of 57.4 residents per 100,000 were in various specialty psychiatric treatment beds on the last day of 2018.

#### *Children in 24-hour mental health beds in Specialty Programs, 2018*

The types of organizations where children (under age 18) receive 24-hour inpatient and residential treatment differ greatly from the types of organizations and settings where adults receive treatment (Table 2). Among children treated in psychiatric inpatient settings, 65% were served in private psychiatric hospitals, followed by general hospitals with separate psychiatric units (26%). Only 6% of children receiving inpatient services received those services at a state psychiatric hospital. A 2021 NRI report found that by policy 31 states do not treat any children in their state psychiatric hospitals.<sup>42</sup>

Children were more likely to receive 24-hour treatment in residential treatment programs (60% of children) than in psychiatric inpatient programs (40%). Most children received 24-hour residential treatment services in RTCs (79%), followed by private psychiatric hospitals (10%) and other specialty settings (including community mental health centers).

**Table 2: Number and Rate of Children (under age 18) per 100,000 population of psychiatric inpatients and other 24-hour residential treatment patients at end of year 2018**

Year/Setting	Children in Psychiatric Inpatient Settings at End of Year			Children in Other 24 Hour Residential Treatment at End of Year			Total Numbers of Children in either Inpatient or Other 24 Hour Residential Treatment at End of Year		
	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate Per 100,000 Population	Residents	Percent	Rate per 100,000 Population
State & County Psychiatric Hospitals	1,000	6%	1.4	41	0%	0.1	1,041	2%	1.4
Private Psychiatric Hospitals	10,827	65%	14.8	2,564	10%	3.5	13,391	32%	18.2
General Hospital with Separate Psychiatric Units	4,298	26%	5.9	110	0%	0.1	4,408	11%	6.0
VA Medical Centers	14	0%	0.0	15	0%	0.0	29	0%	0.0
Residential Treatment Centers (RTCs)	182	1%	0.2	20,069	79%	27.3	20,251	48%	27.6
Other Specialty Mental Health Providers with Inpatient/ Residential Beds	336	2%	0.5	2,470	10%	3.4	2,806	7%	3.8
<b>Total Specialty MH Providers</b>	<b>16,657</b>	<b>100%</b>	<b>22.7</b>	<b>25,269</b>	<b>100%</b>	<b>34.4</b>	<b>41,926</b>	<b>100%</b>	<b>57.1</b>

Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

### Legal Status of Inpatients in Specialty Programs, 2018

Psychiatric patients may enter inpatient and other 24-hour residential treatment facilities either on a voluntary basis or involuntarily basis. There are two types of involuntary admissions that are tracked in the SAMHSA datasets: “involuntary, non-forensic” (persons civilly committed) and “involuntary, forensic” (individuals ordered by a criminal court to evaluation or treatment). Under their state’s civil commitment statute, individuals may be held on involuntarily commitment orders if they are determined by a court to be at risk to harming themselves or others as a result of the symptoms of their mental illness. Classes of forensic patients include individuals sent to hospitals for:

1. assessment of competency to stand trial (CST),
2. competency restoration before trial for individuals found incompetent to stand trial (IST)
3. evaluation or treatment of individuals found Not Guilty by Reason of Insanity (NGRI)
4. treatment of individuals found Guilty but Mentally Ill (GBMI),
5. evaluation and/or treatment of patients transferred from jail or prisons for psychiatric treatment not available in those settings
6. in some states, convicted sexual offenders requiring psychiatric treatment.

In 2018, under half (43%) of psychiatric inpatients in specialty settings were voluntary patients, while 41% were “involuntary, non-forensic” and 16% were involuntary-forensic status.

**Table 3: Patients in 24-hour psychiatric inpatient settings in specialty mental health organizations, by legal status, 2018**

	Voluntary Patients		Involuntary, non-Forensic		Involuntary, Forensic	
	Number	Percent	Number	Percent	Number	Percent
State And County Psychiatric Hospitals	3,099	11%	10,429	36%	15,734	54%
Private Psychiatric Hospitals	22,877	50%	21,173	47%	1,438	3%
General Hospitals With Separate Psychiatric Units	20,548	56%	14,608	40%	1,407	4%
VA Medical Centers	1,535	74%	453	22%	79	4%
RTC For Children	116	79%	29	20%	1	1%
RTC For Adults	130	45%	138	47%	24	8%
Other facilities providing specialized psychiatric inpatient care	1,229	53%	961	42%	119	5%
<b>Total</b>	<b>49,534</b>	<b>43%</b>	<b>47,791</b>	<b>41%</b>	<b>18,802</b>	<b>16%</b>

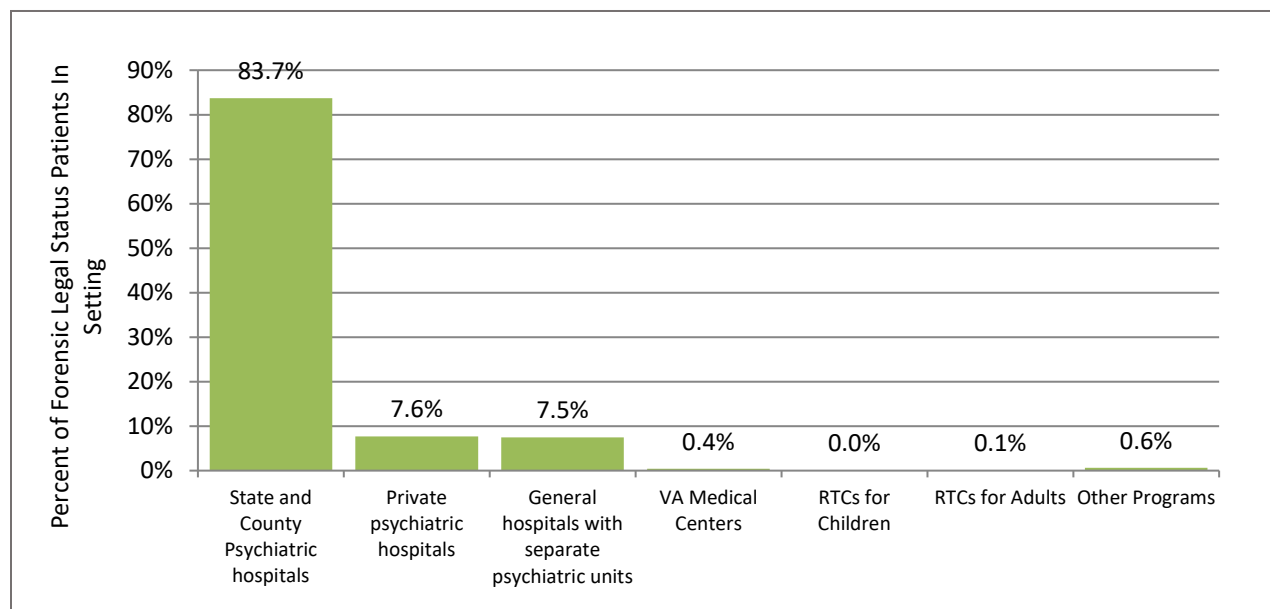
Source: Table compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

**Table 3** shows that the legal status of patients differs significantly by type of treatment setting. Forensic status patients were the largest patient group (54%) in state and county psychiatric hospitals but were 5% or less of patients in every other psychiatric inpatient setting.

Patients voluntarily admitted comprised the largest groups in all settings other than state and county psychiatric hospitals. Only 16% of patients in state and county psychiatric hospitals had a voluntary legal status. The low percentage of voluntary patients in state and county psychiatric hospitals may reflect policies developed in some states that reserve state psychiatric hospital beds for involuntary civil and forensic admissions and direct persons seeking voluntary admission into other settings.

The majority of involuntary, forensic legal status patients (84%) were patients in state and county psychiatric hospitals. Only 6% were residents in private psychiatric hospitals and four percent were in general hospital special psychiatric inpatient units (Figure 1).

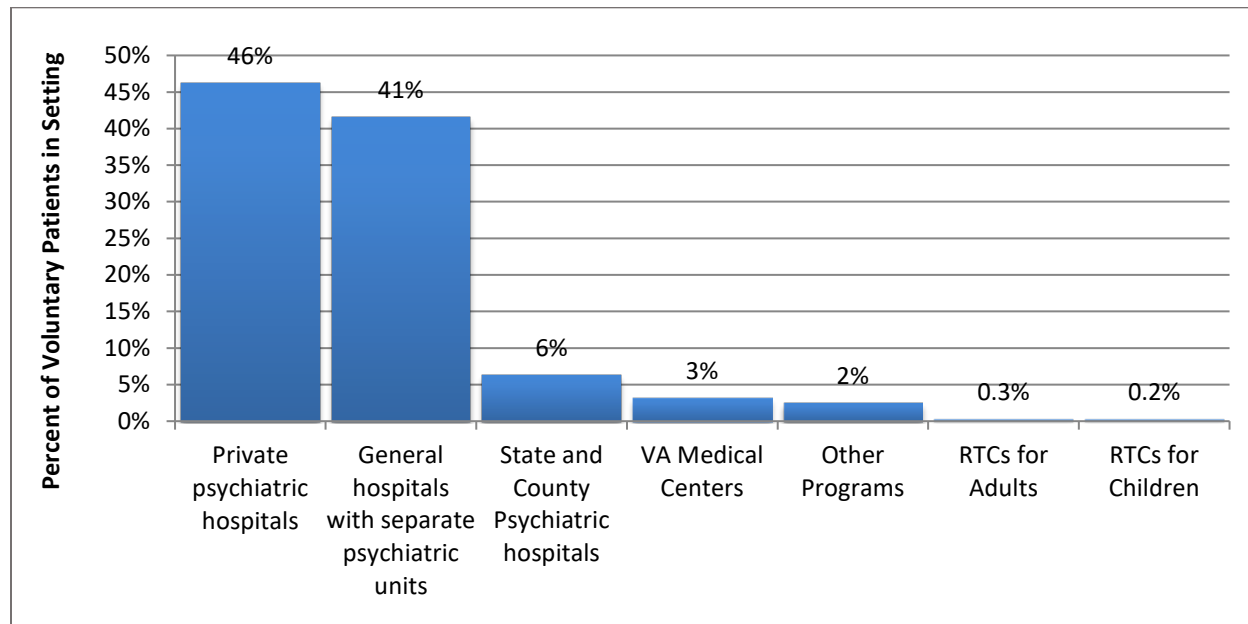
**Figure 1: Inpatient Settings where Involuntary-Forensic Patients were served, 2018**



Source: Figure compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

In another way of examining the data, inpatients with a voluntarily legal status in psychiatric inpatient beds were most frequently served in private psychiatric hospitals (46%) and general hospitals with separate psychiatric units (41%). Only 6% of patients voluntarily admitted to inpatient units were in state and county psychiatric hospitals (Figure 2).

**Figure 2: Inpatient Settings where Voluntary patients were served 2018**



Source: Figure compiled by NRI from SAMHSA 2018 N-MHSS Tables 3.1a and 3.2a.

### *Number of Organizations with Specialized Inpatient and Other 24-Hour Residential Mental Health Treatment Programs*

In 2018, there were 1,920 different mental health organizations nationally providing psychiatric inpatient services and, 1,932 mental health organizations providing 24-hour residential (i.e., non-hospital) mental health treatment (note many mental health treatment organizations provide both inpatient and 24-hour residential treatment). General hospitals were the most frequent setting providing psychiatric inpatient care, representing 55% of organizations providing inpatient treatment and 31% of psychiatric inpatients. Private psychiatric hospitals were the second largest group of providers of inpatient care, with 25% of psychiatric inpatient organizations serving 39% of psychiatric inpatients. State and county psychiatric hospitals represented only 11% of the organizations providing psychiatric inpatient care, but since they were the largest organization in terms of beds, they served 26% of psychiatric inpatients in 2018.

Residential Treatment Centers (RTCs) were the most common type of organization providing other non-inpatient 24-hour treatment services in 2018—76% of all organizations providing other 24-hour treatment serving 62% of residents—followed by other specialty mental health organizations (12% of organizations serving 18% of residents) and private psychiatric hospitals (5% of organizations, representing 7% of patients receiving 24-hours residential treatment).

**Table 4: Number of Organizations Providing Psychiatric Inpatient Services or Other 24-hour Residential Treatment and Number of Individuals in Beds in these Settings on April 30, 2018**

Year/Setting	Psychiatric Inpatient Settings			Other 24-Hour Residential Treatment Settings		
	Number of Organizations	Number Individuals in Inpatient Beds	Average Inpatient Bed Per Organization	Number of Organizations	Number Individuals in Residential Treatment Beds	Average Individuals in a Residential Treatment Bed Per Organization
State & County Psychiatric Hospitals	206	33,225	161.3	24	2,500	104.2
Private Psychiatric Hospitals	482	50,200	104.1	102	4,196	41.1
General Hospital with Separate Psychiatric Units	1,053	40,052	38.2	26	478	18.4
VA Medical Centers	101	2,662	26.4	82	4,330	52.8
Residential Treatment Centers (RTCs)	14	454	32.4	1,475	36,391	24.7
Other Specialty Mental Health Providers with Inpatient/Residential Beds	64	2,522	39.4	223	10,867	48.7
<b>Total Specialty MH Providers</b>	<b>1,920</b>	<b>129,115</b>	<b>401.7</b>	<b>1,932</b>	<b>58,762</b>	<b>289.9</b>

*Note, many organizations provide both inpatient and other 24-hour residential treatment services*

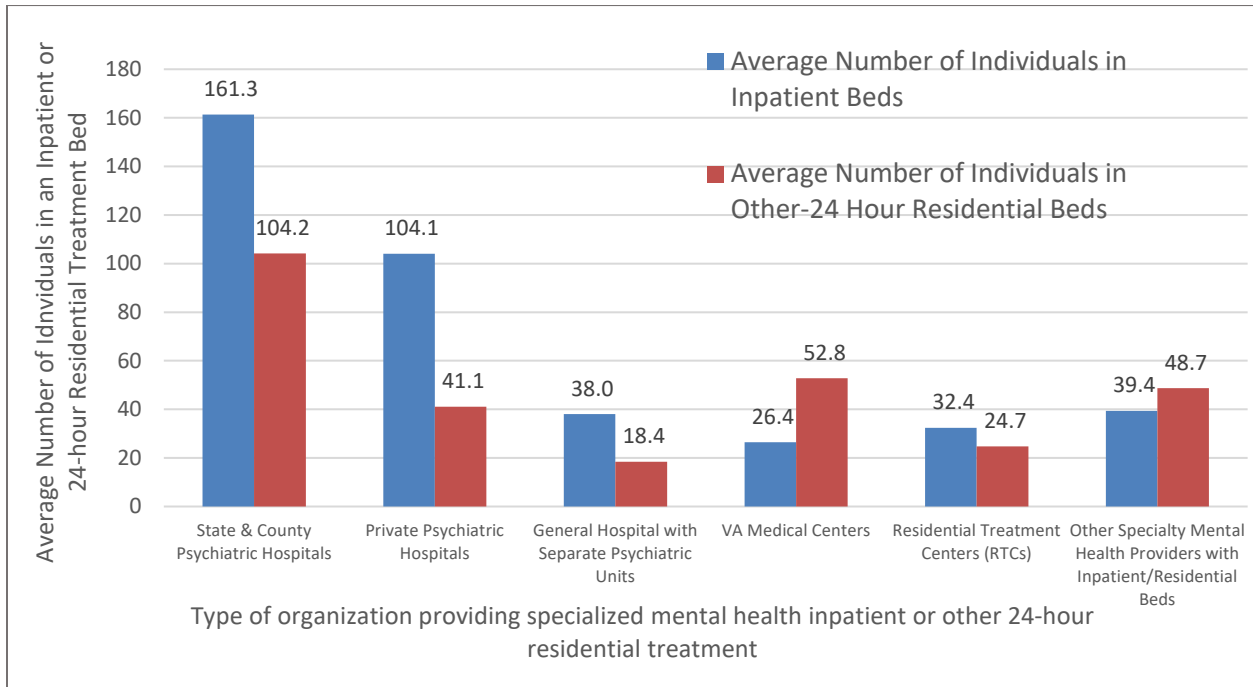
*Source: N-MHSS 2018: Tables 2.3, 2.5, 3.1a, and 3.2a*

**Table 4** and **Figure 3** show that, on average in 2018, state and county psychiatric hospitals have the largest capacity for psychiatric inpatient services, averaging 161 patients per hospital, followed by private psychiatric hospitals with an average of 104 patients per hospital, General hospitals with separate psychiatric units averaged 38.2 inpatients per hospital, and VA Medical Centers averaged 26.4 patients per hospital.

Among other 24-hour mental health residential treatment providers, state and county psychiatric hospitals had the largest patient populations—with an average of 104 patients per state and county hospital providing this service—followed by VA Medical Centers with 52.8 patients per hospital, and other specialty mental health providers (48.7 patients per organization). RTCs, although the most frequent provider of 24-hour residential treatment had a smaller average size of 24.7 patients per RTC.



**Figure 3: Average Number of individuals in Inpatient Beds and Other 24-Hour Residential Treatment Beds, by type of Mental Health Organization, 2018**



## Other Settings with Psychiatric Inpatient and 24-hour Residential Treatment in 2014

### *Use of Nursing Homes to Serve Individuals with Mental Illnesses and Systems Considerations in Serving Older Adults with Dementias*

With support from Medicaid, Medicare, and private health insurance, nursing homes have become one of the major sites for long-term health care, not only for older adult individuals, but also for patients with complex health conditions who do not need intensive inpatient psychiatric level care but are unable to live independently and need active nursing and other services. Nursing home residents may have a variety of mental health-related diagnoses, including major mental illnesses such as schizophrenia, depression, and bipolar disorders, as well as other brain diseases related to aging such as Alzheimer’s disease and other neurocognitive disorders (commonly referred to as dementias).

The Centers for Medicare and Medicaid (CMS) maintain a Minimum Data Set (MDS) that includes information about major diagnoses of patients in nursing homes. Since most state psychiatric hospitals currently focus on serving persons with major psychiatric illnesses, they have ceased to focus on Alzheimer’s and dementia disorders for older adult individuals, though will still have patient populations with these conditions for a variety of reasons, and often these patients have co-occurring mental illness with their neurocognitive challenges. For example, many are sent in via criminal justice or forensic processes. In 2021, 34 SMHAs reported responsibility for Alzheimer’s services are no longer a primary target population of the SMHA and are instead the responsibility of a different state government agency. Some have noted that more work needs to be done to understand the older adult population with dementia that are caught between systems especially the criminal and forensic systems.<sup>43</sup> Because states no longer view the state hospitals as the placement for these populations, data on their prevalence in state and other psychiatric settings is difficult to get.

For purposes of this estimate of psychiatric bed utilization now found in nursing homes, we have limited the review to the count of nursing home capacity for residents with schizophrenia or bipolar disorders. In 2018, 13% of residents in nursing facilities had a diagnosis of schizophrenia or bipolar disorders residing in nursing homes (about 152,149 residents).<sup>44</sup> The MDS system identifies much higher numbers of residents with other mental disorders (616,804 residents or 48.74% had an active diagnosis (last 7 days) of depression and 372,055 residents or 29.36% had an active diagnosis (last 7 days) of anxiety disorders.<sup>45</sup>

But we advise caution: while this report identifies more than 180,000 patients with serious mental illnesses in nursing facilities, it is not possible to determine from the MDS database if a patient is residing in a nursing facility due to a mental health diagnosis or due to other health conditions that require nursing facility level of care.

### **Gaps in information about inpatient psychiatric beds**

There are several settings where individuals are known to receive 24-hour inpatient or residential mental health treatment, but for which estimates of the number of beds or residents were not available for 2018 (or 2020). Two potentially major areas that are missing from these bed estimates are inpatient psychiatric units or the equivalent available in jails and prisons, and general hospitals providing mental health services in non-specialty units (sometimes referred to as ‘scatter beds’).

#### *Inpatient Psychiatric Units in Jails and Prisons*

The level of mental illness among inmates in prisons and jails is enormous, with estimates ranging from 15% to 20% of inmates in prison and up to 44% of individuals in jails having some kind of mental distress.<sup>46</sup> Just like in society generally, many of the inmates within jails and prisons do not require the intensive level of mental health treatment of an inpatient psychiatric unit. Only a portion of the population of inmates with mental illness would require intensive inpatient psychiatric treatment and, for most of these patients, the need for inpatient psychiatric treatment is likely short-term acute care to stabilize their illnesses. In a few states, inmates with mental illness who need an inpatient level care may be transferred to a state psychiatric hospital to receive intensive inpatient services. (The companion Forensic Trends White Paper details some of the number of patients transferred from jails and prisons to state psychiatric hospitals.)

To meet the acute psychiatric inpatient needs of inmates with mental illnesses, some jails and prisons have opened and staffed inpatient mental health units within their correctional facilities. Unfortunately, these units are not subject to the routine SAMHSA data collection efforts and no comprehensive and historical data on the treatment capacity of these units has been identified, nor have their standards as inpatient settings been consistently applied, making it difficult to know what level of care is needed or received. The Federal Bureau of Justice Statistics (BJS) indicates it is planning to include identification of such resources in future surveys of jails and prisons.

#### *General Hospitals Providing Mental Health Services in Non-Specialty Units*

In 2019, there were 5,262 community (general) hospitals in the United States,<sup>47</sup> of which 1,053 had specialty psychiatric units that reported to SAMHSA in the 2018 NMHSS.<sup>48</sup> In some areas of the country—particularly rural and frontier areas—there may be no specialized psychiatric beds available, and in other areas the limited number of available psychiatric beds may all be filled when a person needs admission for intensive psychiatric services. General hospitals often provide acute inpatient

services to patients with mental health disorder. As noted above, when these services are provided in general hospitals on medical or pediatric beds, these are often labeled psychiatric “scatter beds”.<sup>49</sup>

No routine data collection exists that identifies “scatter beds” in general hospitals. The SAMHSA NMHSS survey focuses on general hospitals that have specialized mental health treatment units and does not estimate scatter beds being used to provide mental health treatment in general hospitals without specialty units. The Federal Agency for Health Care Research and Quality (AHRQ) produces annual reports through its Healthcare Cost and Utilization Project (HCUP) that identifies patients discharged from all general hospitals in various diagnostic groupings, including a set of mental health and substance abuse diagnostic groupings, but this data set does not allow for identifying if the discharges are from specialized or non-specialized general hospital units. The HCUP database has been used by other researchers to estimate the use of general hospital scatter beds to provide mental health inpatient care. A 2010 study by Mark, et.al, found that approximately 6% of mental health care discharges came from scatter beds.<sup>50</sup>

#### *Summary: All Psychiatric Inpatient and Other 24-Hour Capacity*

The 2018 SAMHSA N-MHSS survey identified a total of 187,877 person in a mental health bed (both inpatient and 24-hour residential treatment beds). This equates to a ratio of 56.8 residents in a mental health bed occupied per 100,000 population in 2018.

In addition to the residents in inpatient psychiatric beds and other 24-hour residential treatment beds, estimates of the number of individuals with serious mental illnesses (schizophrenia and bipolar disorders) served in nursing homes add an additional 152,149 residential treatment patients to the 58,762 mental health patients identified by the SAMHSA N-MHSS study. Therefore, an estimated 210,911 patients with mental illness were in a 24-hour residential treatment bed in 2018 (a ratio of 63.8 per 100,000 population).

**Table 5**, below, shows the combined estimate that 411,794 individuals with mental illness were in either an inpatient or other 24-hour residential treatment bed during a day in 2018. The 411,794 mental health patients in a mental health inpatient or other 24-hour residential treatment bed when adjusted for the U.S. population means there were at least 124.5 patients per 100,000 population in an overnight bed on a single day in 2018.

**Table 5: Psychiatric Inpatients and Other 24-hour Patients in Specialty and Non-Specialty Psychiatric Organizations, 2018**

Year/Setting	Patients in Inpatient Settings at End of Year		Patients in Other 24-hour Residential Treatment at End of Year		Patients in Inpatient and Other 24- hour Residential Treatment at End of Year	
	Residents	Rate Per 100,000 Population	Residents	Rate Per 100,000 Population	Residents	Rate per 100,000 Population
NMHSS Identified Specialty Mental Health Organizations	129,115	39.0	58,762	17.8	187,877	56.8
Nursing Homes - patients with diagnosis of schizophrenia or bipolar disorders (2019)			223,917	67.7	223,917	67.70
Scatter Beds in General Hospitals	Estimate <6% of discharges		Estimate Not Available		Estimate Not Available	
Psychiatric Treatment Units in Jails	Estimate Not Available		Estimate Not Available		Estimate Not Available	
Psychiatric Treatment Units in Prisons	Estimate Not Available		Estimate Not Available		Estimate Not Available	
<b>Total Known Psychiatric Inpatient/Residential</b>	<b>129,115</b>	<b>39.0</b>	<b>282,697</b>	<b>85.5</b>	<b>411,794</b>	<b>124.5</b>

## Trends in Total Psychiatric Inpatient and Other 24-Hour Treatment 1970 to 2018

Since 1970, the number of individuals in a psychiatric inpatient or other 24-hour residential treatment bed on any given day has decreased by over 283,000 (a decrease of 60.1%). Most of this decline has been observed in state and county psychiatric hospitals, where patient census decreased by 90.3%, and VA Medical Center psychiatric units, with decreases of 86.5%. However, some of the other types of specialty mental health providers increased the number of inpatient and other 24-hour residential treatment patients they served in that time. Private psychiatric hospital inpatient census increased by 43,433 or 396.2%. Patients in general hospitals with separate psychiatric units increased by 22,722 (127.6%). RTCs increased by 23,356 (173.1.%). And other specialty mental health providers increased by 5,863, or 77.9% (Table 6).

**Table 6: Trends over time in combined psychiatric inpatients and other 24-hour treatment residents in specialty mental health organizations, 1970 to 2018 (resident patients in the facility on a given day)**

Year/ Setting	State & County Psychiatric Hospitals	Private Psychiatric Hosp	General Hospital with Separate Psychiatric Units	VA Medical Centers	RTCs	Other (Inpatient & Residential Treatment beds)	Total Psychiatric Inpatient & Residential Care
1970	369,969	10,963	17,808	51,696	13,489	7,526	471,451
1975	193,436	11,576	18,851	31,850	16,307	12,138	284,158
1979	140,355	12,921	18,753	28,693	18,276	11,188	230,186
1983	117,084	16,079	32,127	20,187	15,791	23,079	224,347
1986	111,135	24,591	34,474	24,322	23,171	20,152	237,845
1988	100,615	29,404	34,858	19,499	23,301	20,186	227,863
1990	90,572	32,268	38,327	17,233	27,785	20,768	226,953
1994	72,096	26,519	35,841	18,019	29,493	54,142	236,110
1998	63,765	20,804	37,053	14,329	29,049	56,216	221,216
2000	56,716	16,113	27,385	8,228	30,272	38,746	177,460
2002	52,612	17,858	28,460	8,386	35,709	37,518	180,543
2010	43,854	24,025	32,395	5,602	41,536	12,845	160,257
2014	39,907	28,461	31,453	7,010	42,930	20,439	170,200
2016	37,478	35,706	36,716	6,948	43,604	13,594	174,046
2018	35,725	54,396	40,530	6,992	36,845	13,389	187,877
2020*	31,817	25,386	21,522	3,799	29,607	9,235	121,366
<b>Percent Change Over Time</b>							
1970 to 1979	-62.1%	17.9%	5.3%	-44.5%	35.5%	48.7%	-51.2%
1979 to 1990	-35.5%	149.7%	104.4%	-39.9%	52.0%	85.6%	-1.4%
1990 to 2000	-37.4%	-50.1%	-28.5%	-52.3%	9.0%	86.6%	-21.8%
2000 to 2010	-22.7%	49.1%	18.3%	-31.9%	37.2%	-66.8%	-9.7%
2010 to 2018	-18.5%	126.4%	25.1%	24.8%	-11.3%	4.2%	17.2%
1970 to 2018	-90.3%	396.2%	127.6%	-86.5%	173.1%	77.9%	-60.1%
1970 to 2020*	-91.4%	131.6%	20.9%	-92.7%	119.5%	22.7%	-74.3%
<b>Annualized Percent Change</b>							
1970 to 1979	-10.2%	1.8%	0.6%	-6.3%	3.4%	4.5%	-7.7%
1979 to 1990	-3.9%	8.7%	6.7%	-4.5%	3.9%	5.8%	-0.1%
1990 to 2000	-4.6%	-6.7%	-3.3%	-7.1%	0.9%	6.4%	-2.4%
2000 to 2010	-2.5%	4.1%	1.7%	-3.8%	3.2%	-10.5%	-1.0%
2010 to 2018	-2.5%	10.8%	2.8%	2.8%	-1.5%	0.5%	2.0%
1970 to 2018	-4.8%	3.4%	1.7%	-4.1%	2.1%	1.2%	-1.9%

1970 to 1979 data from NIMH Surveys

1983 to 2002 data from NIMH and SAMHSA Inventory of Mental Health Organization Surveys

2010 to 2020 from SAMHSA N-MHSS Surveys, Note, the 2012 N-MHSS did not collect client counts

\* 2020 N-MHSS data shown, but likely reflects temporary closures and reduced reporting due to COVID.

During the last decade (2010 to 2018) the number of patients in mental health inpatient and residential treatment beds increased by 17.2%. However, not all types of providers grew. State and county psychiatric hospitals decreased by 18.5% and residential treatment providers decreased their patients by 11.3%. During the same period, however, private psychiatric hospitals more than doubled their capacity (up 126.4% and general hospital specialty units (up 24.1%) and Veterans Department Medical Centers (up 24.8%) also increased.

*“During the last decade (2010 to 2018) the number of patients in mental health inpatient and residential treatment beds increased by 17.2%.*

*At the same time, given population growth, psychiatric bed capacity per 100,000 population increased by 9.2%”*

If one examines psychiatric bed capacity in relation to the total population, numbers are declining. The population of the United States has grown by 65.7% since 1970. As a result, the psychiatric bed capacity per 100,000 population as a ratio of patients per population (Table 7) shows an even greater total capacity decline than the decline in the total number of patients in **Table 6**. From 1970 to 2018, the number of patients in psychiatric beds in specialty providers declined from 236.8 patients per 100,000 population to 56.8 patients in beds per 100,000 population (a total reduction of 76%—an average annual drop of 2.9% per year from 1970 to 2018 [note 2020 numbers are also listed in **Table 7**, due to issues with the collection of 2020 data during the COVID-19 pandemic, discussion of changes over time utilize the 2018 data]). This may not be as dire as it seems, as with that decreased reliance upon inpatient psychiatric level of care has come an array of other community-based services that have continued to grow.

**Table 7: Trends over Time in Residents per 100,000 population Residents in Psychiatric inpatients and other 24-hour treatment beds in specialty mental health organizations, 1970 to 2018**

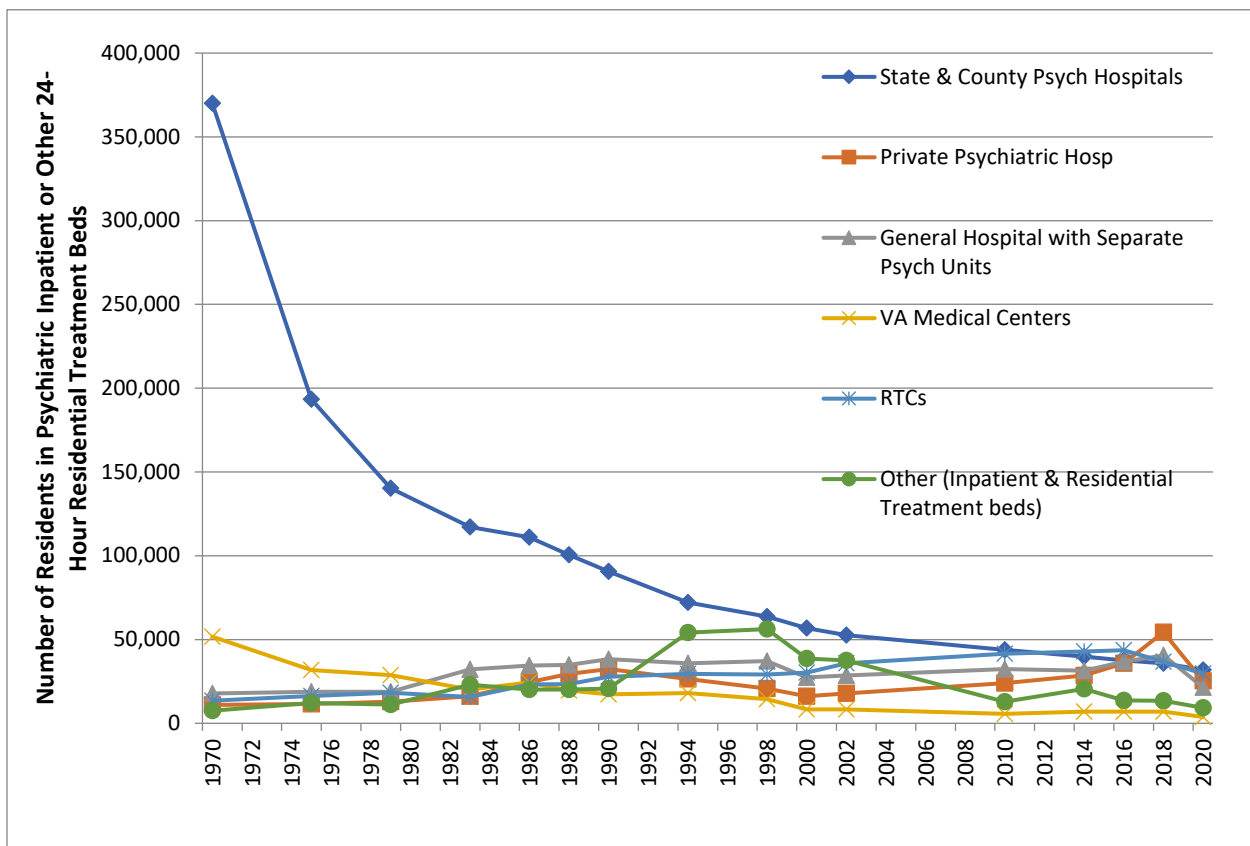
Year/ Setting	State & County Psychiatric Hospitals	Private Psychiatric Hospitals	General Hospital with Separate Psychiatric Units	VA Medical Centers	RTCs	Other (Inpatient & Residential Treatment beds)	Total psychiatric Inpatient & Residential Care
<i>Rate per 100,000 population</i>							
1970	185.80	5.50	8.90	26.00	6.80	3.80	236.80
1975	91.50	5.50	8.90	15.10	7.70	5.70	134.40
1979	63.00	5.80	8.60	13.30	8.20	5.00	103.90
1983	50.40	6.90	13.80	8.70	6.80	9.90	96.50
1986	46.50	10.30	14.40	10.20	9.70	8.50	99.60
1988	41.20	12.00	14.30	8.00	9.50	8.30	93.30
1990	37.10	13.20	15.70	7.10	11.40	8.50	93.00
1994	27.80	10.20	13.80	7.00	11.40	20.90	91.10
1998	23.70	7.70	13.80	5.30	10.80	20.90	82.20
2000	20.10	5.70	9.70	2.90	10.70	13.70	62.80
2002	18.30	6.20	9.90	2.90	12.40	13.00	62.70
2010	14.23	7.80	10.51	1.82	13.48	4.17	52.01
2014	12.56	8.96	9.90	2.21	13.52	6.43	53.58
2016	11.47	10.92	11.23	2.13	13.34	4.16	53.25
2018	10.80	16.45	12.26	2.11	11.14	4.05	56.81
2020	9.58	7.65	6.48	1.14	8.92	2.78	36.56



Percent Change Over Time							
1970 to 1979	-616.1%	5.5%	-3.4%	-48.8%	20.6%	31.6%	-56.1%
1979 to 1990	-41.1%	127.6%	82.6%	-46.6%	39.0%	70.0%	-10.5%
1990 to 2000	-45.8%	-56.8%	-38.2%	-59.2%	-6.1%	61.2%	-32.5%
2000 to 2010	-29.2%	36.8%	8.4%	-37.3%	26.0%	-69.6%	-17.2%
2010 to 2018	-24.1%	111.0%	16.6%	16.3%	-17.4%	-2.9%	9.2%
1970 to 2018	-94.2%	199.1%	37.7%	-91.9%	63.9%	6.5%	-76.0%
1970 to 2020	-94.8%	39.0%	-27.2%	-95.6%	31.1%	-26.8%	-84.6%
Annualized Percent Change							
1970 to 1979	-11.3%	0.6%	-0.4%	-7.2%	2.1%	3.1%	-8.7%
1979 to 1990	-4.7%	7.8%	5.6%	-5.5%	3.0%	4.9%	-1.0%
1990 to 2000	-5.9%	-8.1%	-4.7%	-8.6%	-0.6%	4.9%	-3.9%
2000 to 2010	-3.4%	3.2%	0.8%	-4.6%	2.3%	-11.2%	-1.9%
2010 to 2018	-3.4%	9.8%	1.9%	1.9%	-2.4%	-0.4%	1.1%
1970 to 2018	-5.8%	2.3%	0.7%	-5.1%	1.0%	0.1%	-2.9%

Source: Table created by NRI using historical data from NIMH, SAMHSA, and SAMHSA N-MHSS

Figure 4: Number of Residents in Psychiatric Inpatient and Other 24-Hour Residential Treatment Beds at End of Year, 1970 to 2018



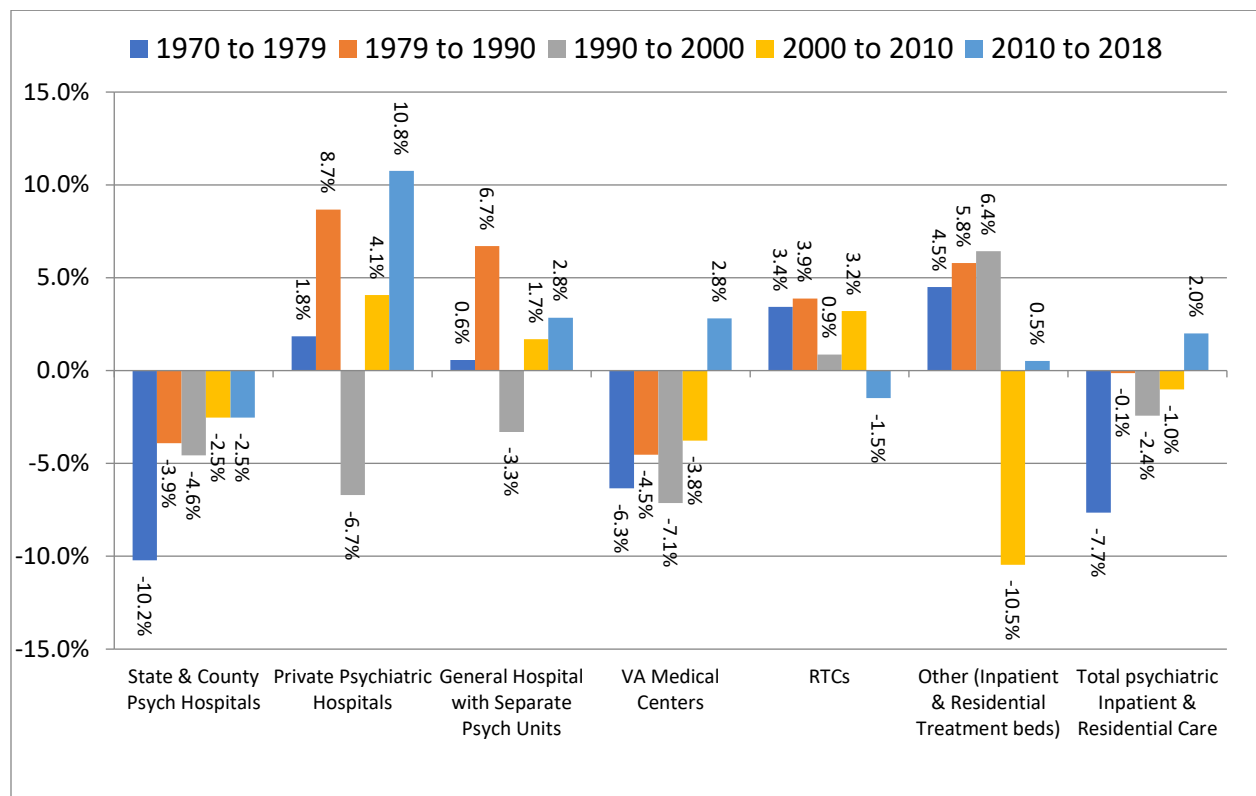
Tables 6 and 7 and Figure 4 show that not all types of organizations experienced changes in psychiatric bed inventory at the same rates or in the same direction. While state and county psychiatric hospitals and VA Medical Centers both display long-term reductions in inpatient census, other types of organizations providing specialized mental health beds experienced much more complicated bed

inventory patterns over time. From 1970 to 2018, the number of individuals in beds in private psychiatric hospitals almost doubled (up 199%). Private psychiatric hospital utilization has varied greatly by decade, increasing by 150% during the 1980s and then dropping 50% during the 1990s, before growing again in the last 18 years (up 49% during the period from 2000 to 2010 and then up by 126% from 2010 to 2018, until the decrease during the COVID-19 pandemic).

Residential Treatment Centers and general hospitals with separate psychiatric units also both more than doubled their patients from 1970 to 2018 (RTCs increased by 173% and general hospitals increased by 127.6%). In the last decade, 2010 to 2018, general hospitals increased their caseload by 25%, while RTCs decreased by 11.3%.

**Figure 5** shows that for state psychiatric hospitals, most of their decrease in the number of mental health patients occurred in the 1970s' when they had a reduction of over 10% every year. In the past two decades (since 2000), state hospital residents have decreased only 2.5% per year. The number of residents being served in private psychiatric hospitals increased every decade, except the 1990s when they decreased by 5.7% per year. In the 2010s, private psychiatric hospitals experienced the largest growth in mental health patients (increasing 10.8% per year).

**Figure 5: Annualized Percent Change in Psychiatric population, by Setting and Decade: 1970 to 2018**



## Trend in Child and Adult Psychiatric Inpatient Populations, 2010 to 2018

SAMHSA's N-MHSS datasets allow separate analysis of trends of psychiatric inpatient units, whereas the earlier IMHO SAMHSA reports combined inpatient and other 24-hour residential treatment data. The 2010 to 2018 N-MHSS data provide a better understanding of the changing use of types of organizations and settings serving for children and adults needing 24-hour treatment over the last decade.

**Table 8** shows that from 2010 to 2018, the number of children who were in a mental health bed decreased by 20% (a decrease of 10,579 individuals). The majority (60%) of children in a mental health bed in 2018 were in receiving care in a 24-hour residential bed (mostly in Residential Treatment Centers (48%) followed by private psychiatric hospitals (32%) and general hospital psychiatric units (10.5%). Only 2.5% of children in a mental health bed were in a state psychiatric hospital in 2018 (a decrease of 71% from 2010). As described above, 31 states reported in 2020 that by policy they do not serve children in their state psychiatric hospital.<sup>51</sup>

1. Over time the child and adolescent population has moved from inpatient settings to residential treatment settings (60% of children in a mental health treatment bed in 2018 were in a 24-hour residential treatment bed and 40% were in an inpatient bed). Residential Treatment Centers (RTCs) are where 48% of children who were in a mental health bed were served, and Private Psychiatric hospitals were the next most frequently used setting for children (32% of children in a mental health bed were in an RTC). The number of children who were being served in state psychiatric hospitals decreased by 71% from 2010 to 2018.
2. Adults who were in a mental health bed are still more likely to be in inpatient beds than in 24-hour residential treatment beds, and their treatment in private psych hospitals and general hospital inpatient has grown in the last 8 years (separate from the numbers related to the COVID-19 most intense years), while adult patients in state psychiatric hospitals had a slight decrease.

### *Trend in Children in Inpatient and Other 24-Hour Residential Treatment Beds, 2010 to 2018*

During the last decade, the number of children in a mental health bed has dropped by 20% (with children in psychiatric inpatient beds decreasing 19% and children in residential treatment beds decreasing by 21%). Forty percent of children receiving 24-hour mental health treatment were patients in an inpatient bed and 60% received care in a 24-hour residential treatment bed.

Children served in state psychiatric hospitals had the largest decrease (71%). The only inpatient or residential organizational setting that had an increase in the number of children in mental health treatment beds were private psychiatric hospitals (up 33% overall with a 36% increase in child inpatients and a 19% increase in children in residential treatment beds).

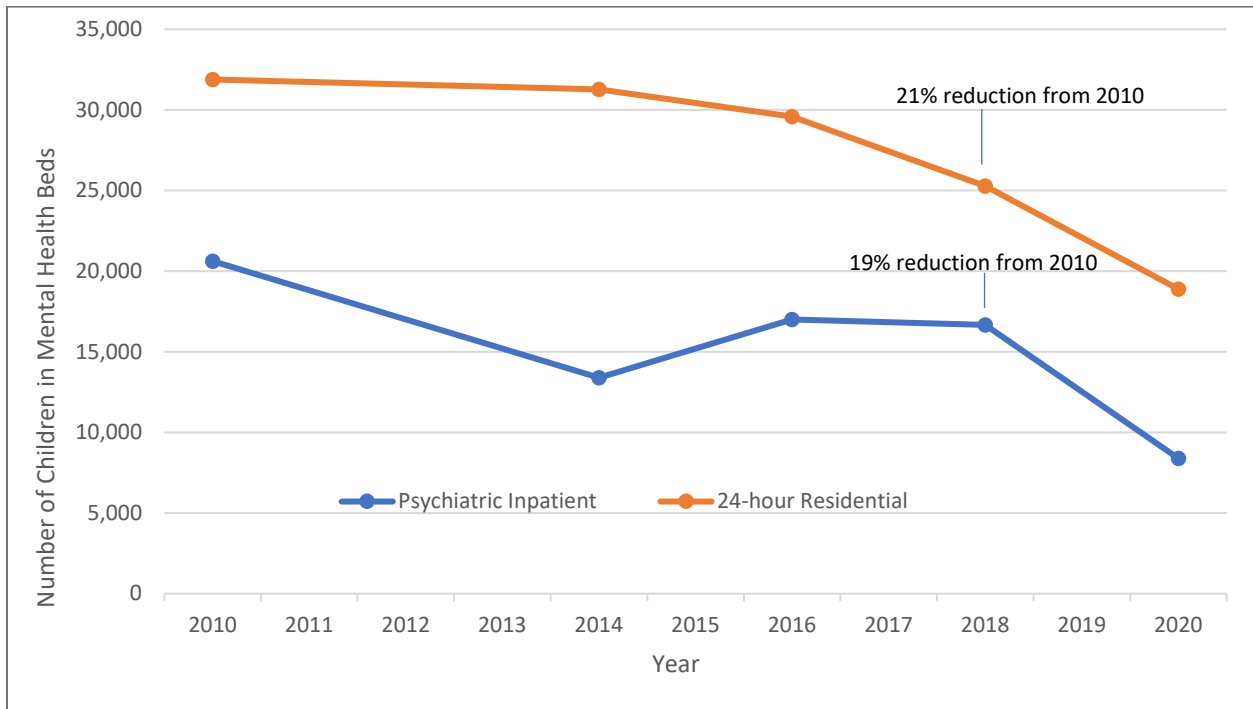
**Table 8: Children (under age 18) in psychiatric inpatient and other 24-hour residential treatment beds, end of year, 2010 to 2020**

Organization	Bed Type	Year					Change 2010 to 2018
		2010	2014	2016	2018	2020	
State & County Psych Hospitals	Inpatient	3,447	2,468	1,382	1,000	1,098	-71%
	24-hour Residential	177	203	169	41	33	-77%
	Total	3,624	2,671	1,551	1,041	1,131	-71%
Private Psychiatric Hospitals	Inpatient	7,941	7,141	7,570	10,827	5,149	36%
	24-hour Residential	2,146	2,432	2,376	2,564	1,836	19%
	Total	10,087	9,573	9,946	13,391	6,985	33%
General Hospital with Separate Psych Units	Inpatient	7,826	2,743	2,914	4,298	1,589	-45%
	24-hour Residential	512	236	395	110	102	-79%
	Total	8,338	2,979	3,309	4,408	1,691	-47%
VA Medical Centers	Inpatient	414	139	95	14	0	-97%
	24-hour Residential	1	241	110	15	0	*
	Total	415	380	205	29	0	-93%
RTCs	Inpatient	428	491	2,804	182	440	-57%
	24-hour Residential	25,653	23,918	23,368	20,069	14,324	-22%
	Total	26,081	24,409	26,172	20,251	14,764	-22%
Other (Inpatient & Residential Treatment beds)	Inpatient	565	408	2,247	336	112	-41%
	24-hour Residential	3,395	4,233	3,159	2,470	2,595	-27%
	Total	3,960	4,641	5,406	2,806	2,707	-29%
Total psychiatric Inpatient & Residential Care	Inpatient	20,621	13,390	17,012	16,657	8,388	-19%
	24-hour Residential	31,884	31,263	29,577	25,269	18,890	-21%
	Total	52,505	44,653	46,589	41,926	27,278	-20%

Table created by NRI using N-MHSS data from 2010, 2014, 2016, 2018, and 2020.

The number of children in both psychiatric inpatient beds and 24-hour residential treatment beds has declined this decade (Figure 6).

**Figure 6: Children (under age 18) in Mental Health Inpatient and Residential Treatment Beds, 2010 to 2018**



**Trend in Adults in Inpatient and Other 24-Hour Residential Treatment Beds, 2010 to 2018**

The number of adults who were in a mental health treatment bed (inpatient or residential treatment) increased by 24% from 2010 to 2018 (Table 9). Adults were also most likely to be in an inpatient bed (77%) with only 23% in a 24-hour residential treatment bed (again very different from children where only 40% were in an inpatient bed and 60% were in a residential treatment bed).

Adults in psychiatric inpatient beds alone grew by 31% from 2010 to 2018, while adults in residential treatment beds increased by only six% over that time period. Private psychiatric hospital inpatient beds (up 187%) and general hospital psychiatric unit inpatient beds (up 40%) were the psychiatric inpatient setting that grew the most from 2010 to 2018. Adults in State psychiatric hospital inpatient beds decreased by 23% during this time period.

As a result of the downsizing of state psychiatric hospital inpatient beds and the increase in private psychiatric hospital adult patients, in 2018 private psychiatric hospitals were the largest location of adult inpatient beds (39 in 2018, up from 16% of adult patients in 2010) and state hospitals decreased from 48% of inpatients in 2010 to 26% of inpatients in 2018.

**Table 9: Adults (age 18 and over) in psychiatric inpatient and other 24-hour residential treatment beds, end of year, 2010 to 2020**

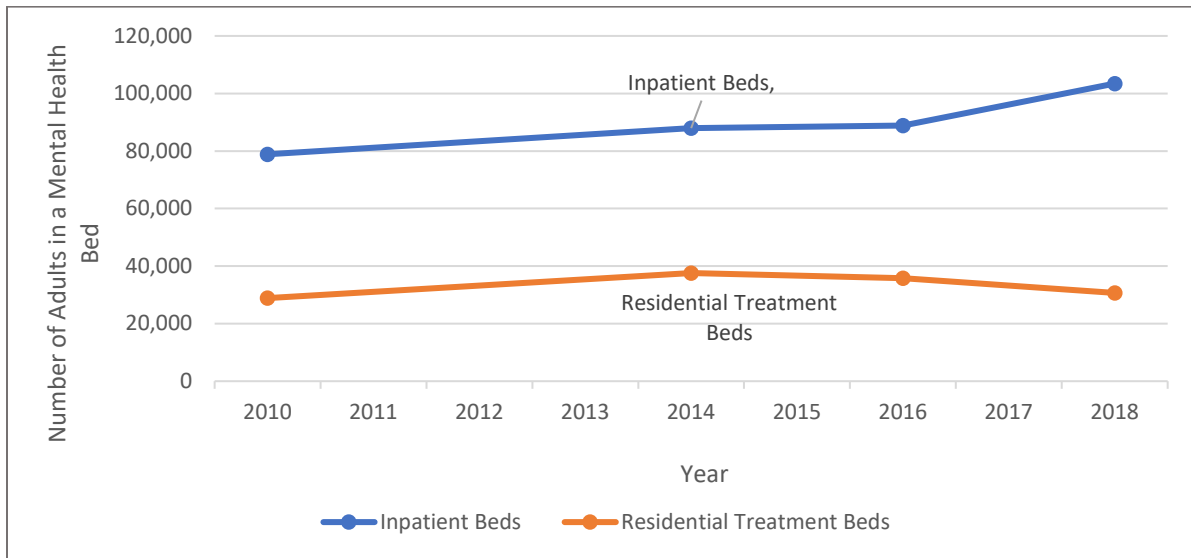
Organization	Bed Type	Year					Change 2010 to 2018
		2010	2014	2016	2018	2020	
State & County Psych Hospitals	Inpatient	38,238	34,741	29,003	29,618	28,245	-23%
	24-hour Residential	1,992	2,495	3,613	2,103	1,943	6%
	Total	40,230	37,236	32,616	31,721	30,188	-21%
Private Psychiatric Hospitals	Inpatient	12,876	17,663	22,161	36,962	16,623	187%
	24-hour Residential	1,062	1,225	1,831	1,485	1,431	40%
	Total	13,938	18,888	23,992	38,447	18,054	176%
General Hospital with Separate Psych Units	Inpatient	23,355	28,121	30,593	34,012	18,919	46%
	24-hour Residential	702	353	622	283	323	-60%
	Total	24,057	28,474	31,215	34,295	19,242	43%
VA Medical Centers	Inpatient	1,787	2,985	2,946	1,667	1,709	-7%
	24-hour Residential	3,400	3,645	3,624	3,645	1,879	7%
	Total	5,187	6,630	6,570	5,312	3,588	2%
RTCs	Inpatient	394	1,360	1,231	262	271	-34%
	24-hour Residential	15,061	23,031	19,130	14,889	10,998	-1%
	Total	15,455	24,391	20,361	15,151	11,269	-2%
Other (Inpatient & Residential Treatment beds)	Inpatient	2,222	3,091	2,914	920	905	-59%
	24-hour Residential	6,663	6,837	6,927	8,248	6,424	24%
	Total	8,885	9,928	9,841	9,168	7,329	3%
Total psychiatric Inpatient & Residential Care	Inpatient	<b>78,872</b>	<b>87,961</b>	<b>88,848</b>	<b>103,441</b>	<b>66,672</b>	<b>31%</b>
	24-hour Residential	<b>28,880</b>	<b>37,586</b>	<b>35,747</b>	<b>30,653</b>	<b>22,998</b>	<b>6%</b>
	Total	<b>107,752</b>	<b>125,547</b>	<b>124,595</b>	<b>134,094</b>	<b>89,670</b>	<b>24%</b>

Table created by NRI using N-MHSS data from 2010, 2014, 2016, 2018, and 2020.

Figure 7 shows that the growth in mental health beds for adults has been primarily in psychiatric inpatient beds, which increased by 31% from 2010 to 2018. Residential treatment beds used by adults increased by 6% from 2010 to 2018, with the number of adults in residential treatment beds peaking in 2014 and then decreasing in 2016 and 2018.

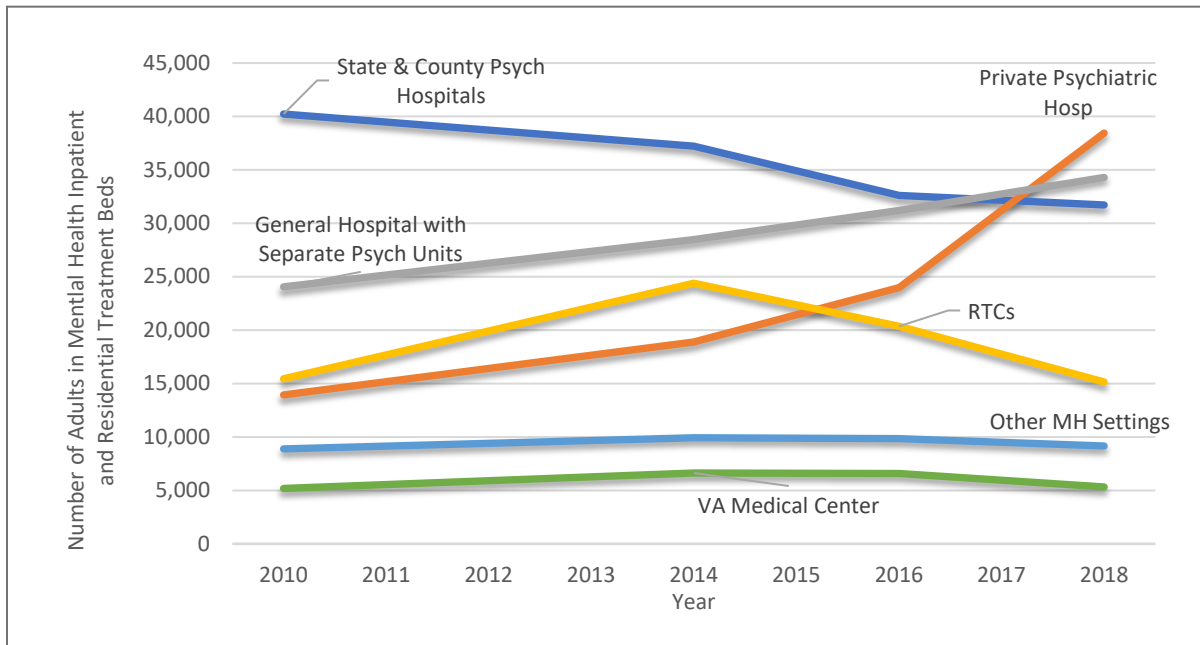


**Figure 7: Number of Adults in Mental Health Inpatient and 24-Hour Residential Treatment Beds, 2010 to 2018**



**Figure 8** highlights that private psychiatric hospitals have experienced the largest increase in use by adults, followed by general hospitals with separate psychiatric units. The number of adults in state psychiatric hospitals dropped 21% and are now only the third most frequent location where adults are receiving mental health treatment in a bed.

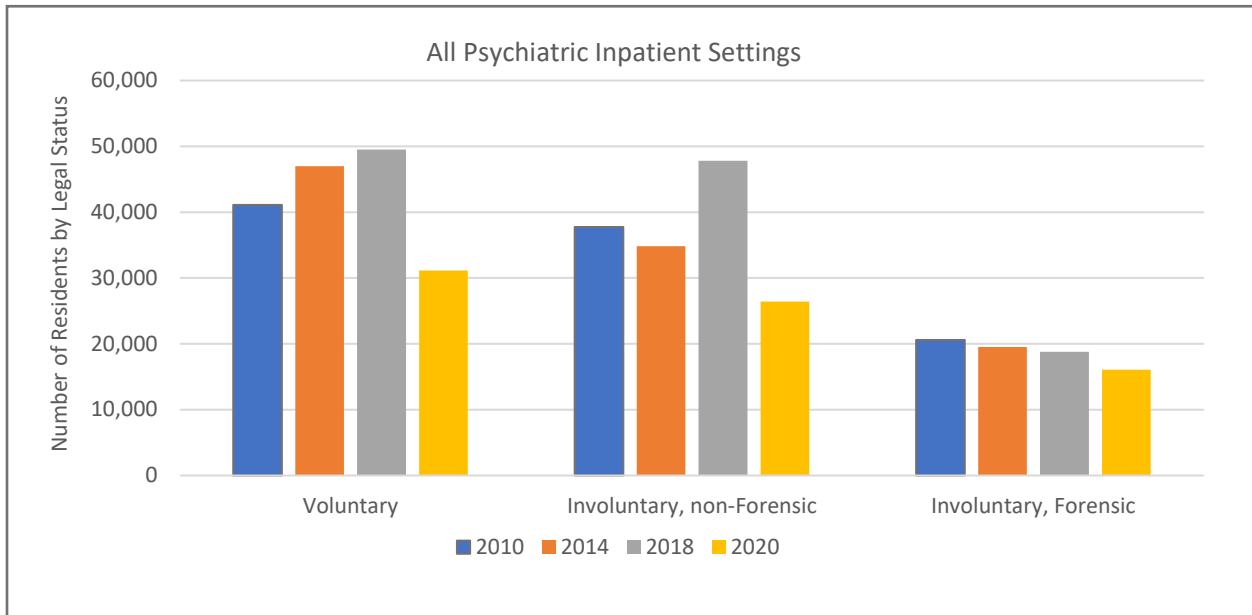
**Figure 8: Number of Adults (age 18 and over) in Mental Health Inpatient and Residential Treatment Beds, by type of Organization, 2010 to 2018**



## Trend in Legal Status of Patients: 2010 to 2018

Over the last decade, the number of voluntary patients in psychiatric inpatient settings increased by 20% and the number of involuntary-civil status patients increased by 27%, while the number of forensic patients (legal status involuntary-criminal) decreased by 9% (a decrease of 1,795 patients) (Figure 9). Note, SAMHSA has specialty providers report on the admission legal status of individuals in inpatient and other 24-hour residential treatment beds. Legal status of individuals may change during their course of treatment (e.g., forensic clients may have their legal status change to involuntary-civil status or vis-a-versa while receiving treatment).

**Figure 9: Legal Status of Patients in a mental health Inpatient bed, 2010 to 2020**



State psychiatric hospitals mostly decreased their use of beds for voluntary patients (down 52% from 2010 to 2018) and involuntary civil status patients (down 42% from 2010 to 2018) (Table 10). Forensic patients served in state and county psychiatric hospitals decreased by only 8% from 2010 to 2018.

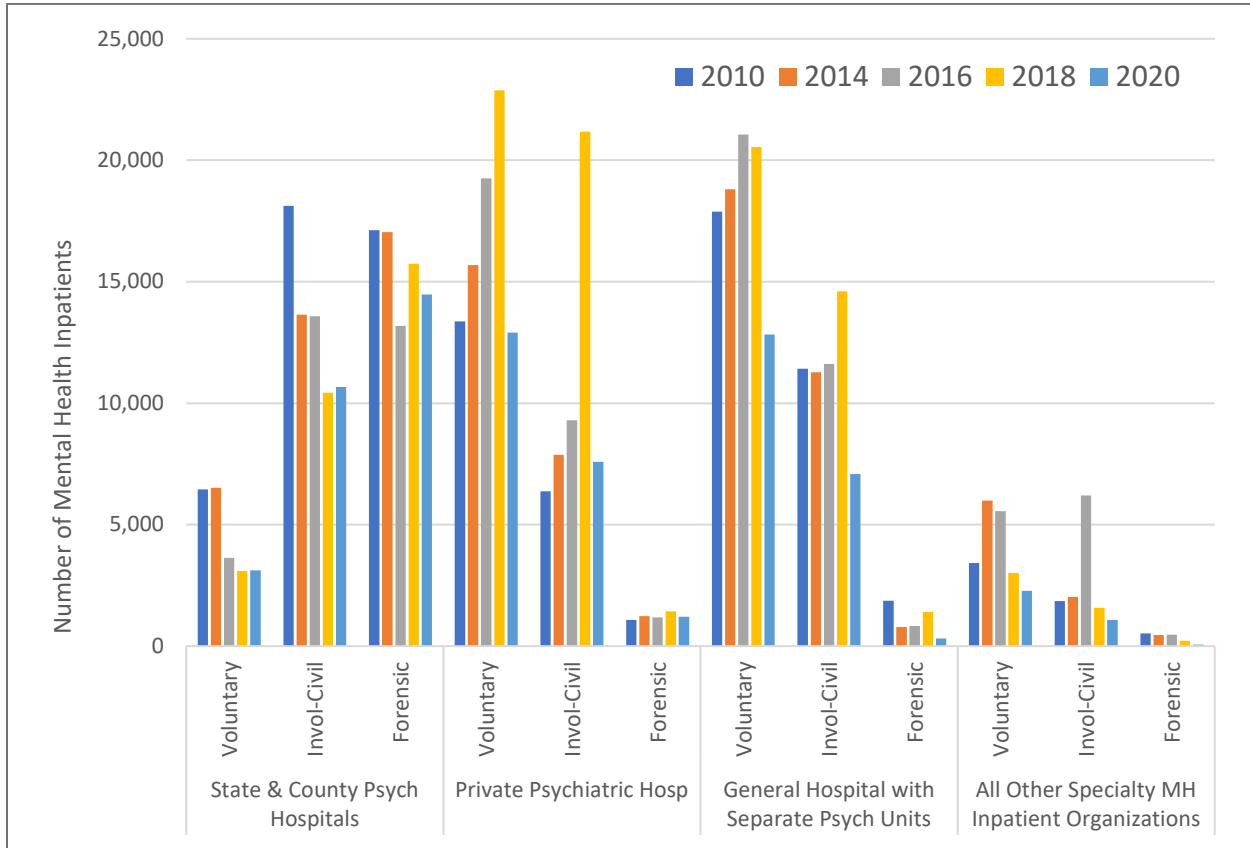
The number of involuntary-civil status clients served by private psychiatric hospitals had the largest percentage increase (up 232% from 2010 to 2018) of any client legal status or setting, followed by voluntary clients in private psychiatric hospitals (up 71% from 2010 to 2018).

**Table 10: Number of Mental Health Inpatients by Legal Status and Organization Type, 2010 to 2020**

Year		2010	2014	2016	2018	2020	2010 to 2018
State & County Psych Hospitals	Voluntary	6,448	6,523	3,636	3,099	3,117	-52%
	Involuntary-Civil	18,118	13,640	13,572	10,429	10,661	-42%
	Forensic	17,119	17,046	13,178	15,734	14,472	-8%
	Total	41,685	37,209	30,386	29,262	28,250	-30%
Private Psychiatric Hosp	Voluntary	13,365	15,691	19,248	22,877	12,901	71%
	Involuntary-Civil	6,377	7,876	9,299	21,173	7,582	232%
	Forensic	1,075	1,237	1,184	1,438	1,204	34%
	Total	20,817	24,804	29,731	45,488	21,687	119%
General Hospital with Separate Psych Units	Voluntary	17,885	18,801	21,062	20,548	12,827	15%
	Involuntary-Civil	11,423	11,278	11,616	14,608	7,086	28%
	Forensic	1,873	785	829	1,407	311	-25%
	Total	31,181	30,864	33,507	36,563	20,224	17%
VA Medical Centers	Voluntary	1,887	2,501	2,420	1,535	1,254	-19%
	Involuntary-Civil	277	476	522	453	451	64%
	Forensic	37	147	99	79	6	114%
	Total	2,201	3,124	3,041	2,067	1,711	-6%
RTCs	Voluntary	406	1,100	1,135	246	492	-39%
	Involuntary-Civil	350	525	2,789	167	211	-52%
	Forensic	66	226	111	25	9	-62%
	Total	822	1,851	4,035	438	712	-47%
Other (Inpatient beds)	Voluntary	1,131	2,393	2,004	1,229	531	9%
	Involuntary-Civil	1,229	1,021	2,890	961	414	-22%
	Forensic	427	85	267	119	49	-72%
	Total	2,787	3,499	5,161	2,309	994	-17%
Total psychiatric Inpatient	Voluntary	41,122	47,009	49,505	49,534	31,122	20%
	Involuntary-Civil	37,774	34,816	40,688	47,791	26,405	27%
	Forensic	20,597	19,526	15,668	18,802	16,051	-9%
	Total	99,493	101,351	105,861	116,127	73,578	17%

Table created by NRI using SAMHSA N-MHSS data from 2010, 2014, 2016, 2018, and 2020

**Figure 10: Number of Mental Health Inpatients by Legal Status and Organizational Setting, 2010 to 2020**



### Trend in State and County Psychiatric Hospital Capacity

The historical decrease in patients being served in state psychiatric hospitals is often attributed to increases in persons with mental illness residing in jails, increases of homelessness and other societal ills. Articles often cite the decline from over 500,000 individuals residing in state hospitals in the 1950s, or for slightly more recent analysis from 1970 when there were still over 300,000 individuals in state hospitals every day to pivot toward the argument that there has been a complete “transinstitutionalization” of this population to jails and prisons.<sup>52</sup>

However, these analyses often fail to address other factors about the historical use of state psychiatric hospitals, and the current population in carceral settings and among the homeless. In the 1950s and even the 1970s many of the clients who were in state hospitals in those eras when state hospitals had hundreds of thousands of residents were individuals with serious health or behavioral issues, but not mental illnesses, and who would not be treated in any psychiatric hospital today. Using historical NIMH data from their “Annual Survey of State and County Psychiatric Hospitals, data from (1971 is the earliest year that this series is available) can be used to better understand the characteristics of patients in state hospitals back in an era when there were 309,852 residents in state hospital beds on a single day. In the 1971 data, only 49% of patients in state psychiatric hospitals had a diagnosis of schizophrenia or other psychosis and 5.9% had a diagnosis of depression. However, state hospitals in 1971 contained significant numbers of residents with diagnoses of neurocognitive disorders (reported in the SAMHSA series as “Organic Brain Syndrome”), this was the second largest diagnostic group in state psychiatric hospitals in 1971), intellectual disability/developmental disorders, and alcohol and substance abuse. Patients with these diagnoses that are no longer a focus of treatment in state hospitals represented over one-third

(36.1% or 111,839 of the patients in 1971. Moreover, there are broad assumptions that the incarcerated population with mental illness is currently so symptomatic at any moment that they would be meet hospital level of care criteria. Thus, the data and experience with these populations points to a much more complicated picture.

### Change in State psychiatric hospital patients, by Patient Age Group 1970 to 2020

In 1970, state and county psychiatric hospitals provided 78% of the psychiatric inpatient and other 24-hour mental health residential treatment capacity. Since 1970, state and county psychiatric hospital case load on a single day has decreased by over 330,000 patients. However, most of the decrease in state and county psychiatric hospitals beds occurred over 30 years ago—during the 1970s, with a decrease of 229,600 patients between 1970 and 1979, a reduction of 62%. The rate of downsizing of state and county psychiatric hospitals has drastically slowed in the last 15 years. From 2001 to 2010, state and county hospital census declined by 2.5% per year. From 2010 to 2018, state and county hospital census declined by 2.5% per year.

**Table 11** shows that that older adult patients are the age group that has had the largest decrease in receiving services in state psychiatric hospitals, with a decrease of 96% from 1970 to 2005 (after 2005, that SAMHSA report series no longer collected data on older adults as a separate service population).

**Table 11: Change in State Psychiatric Hospital Patients Served, by Age, 1970 to 2020**

Decade	Children (under Age 18)	Adults (ages 18-64)	Older adult (age 65+)	Total
1970 to 1980	-49%	-57%	-57%	-57%
1980 to 1990	-18%	-20%	-61%	-31%
1990 to 2000	-39%	-35%	-68%	-40%
2000 to 2005	-23%	-6%	-30%	-9%
2005 to 2010	-37%	-7%	included w/ Adults*	-15%
2010 to 2020	-10%	-6%	included w/ Adults*	-6%
1970 to 2005	-80%	-79%	-96%	-84%
1970 to 2020	-89%	-82%	included w/ Adults*	-87%

\* Data systems shifted and separate counts for age 65 and over are not available after 2005 and “adult” numbers for 2005 to 2020 include all individuals in a state psychiatric hospital bed ages 18 and over.

### Changing Patient Diagnostic Groups Served in State Psychiatric Hospitals, 1971 to 2020

Changing Service Populations Being Served by State Psychiatric hospitals: The Annual Census of State and County Psychiatric Hospitals shows how the age and diagnostic groups being served in state psychiatric hospitals in 1971 are different from clients being served today.

**In 1971**

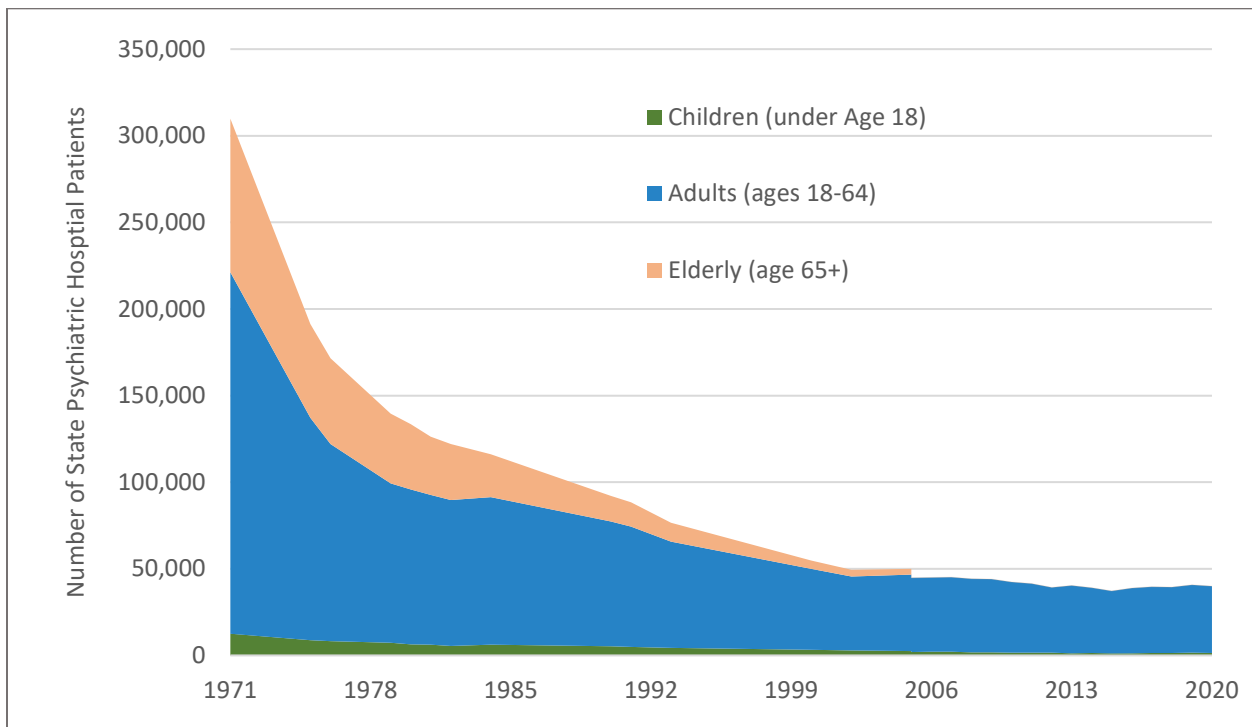
- 29.3% (99,087) Patients were age 65 and Over
- 24% (81,621) had an Organic Brain Syndrome
  - (45,811 of whom were Older Adults)
- 9% (31,884) had a Diagnosis of Intellectual Disability (reported then as “Mental Retardation.”)
- 7% (18,098) had an Alcohol or Drug Disorder (1973 data)

**In 2005:** (After 2005, state hospital patients by diagnosis was no longer collected and reported by SAMHSA)

- 3.8% of patients had an Intellectual Disability diagnosis,
- 3.6% had an Organic Brain disorder and
- 5.1% had an Alcohol or Drug Disorder

**Figure 11** below shows how the number of patients by three age groups, served in state hospitals on a single day, has decreased over the past 50 years. Older adult patients (age 65 and over) decreased by 96% from 1970 to 2005, while children (under age 18) decreased by 79% (to 2020) and adults (ages 18 to 64) decreased by 80%. Note again that for populations age 65 and older, data available ends in 2005.

**Figure 11: State Psychiatric Hospital Patients Served, by Age, 1970 to 2020**

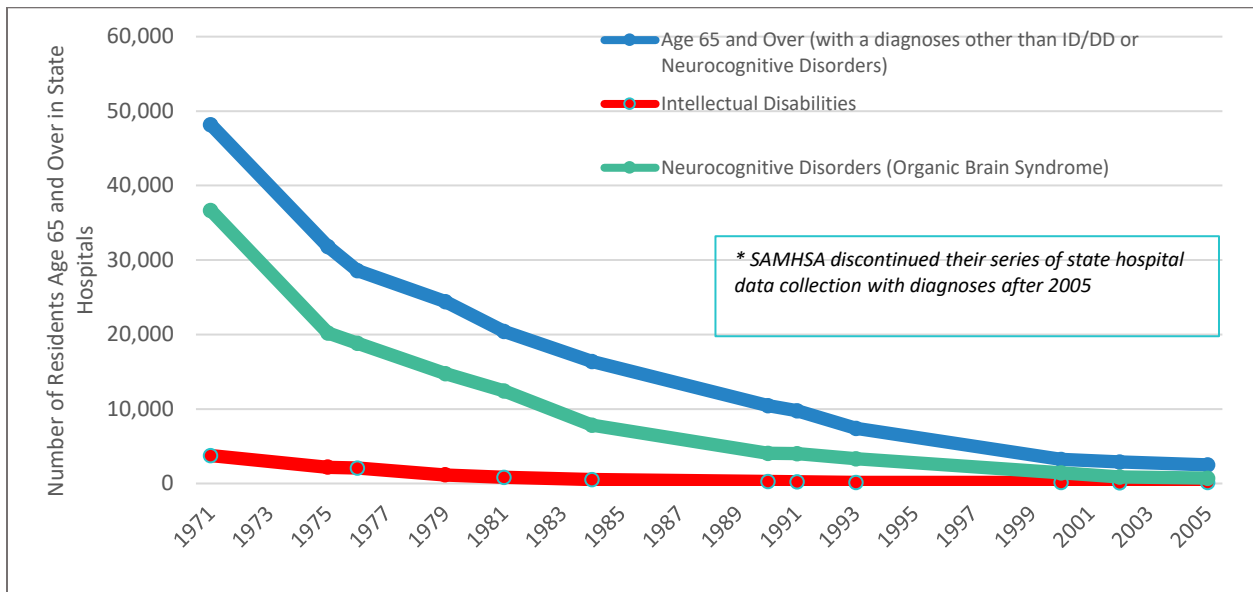


Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States, 2002, and SAMHSA Uniform Reporting System: 2004 to 2020

State hospital patients with a diagnosis of neurocognitive disorders (at the time labeled as “Organic Brain Syndrome or OBS”), ID/DD or SUD have decreased from almost 112,000 patients in 1971 (36% of all state hospital patients) to just over 6,000 patients in 2005 (12.5% of patients).

**Figure 12** shows the reduction in older adult patients in state psychiatric hospitals from 1971 to 2005 for clients with a diagnosis of neurocognitive disorders (green line), Intellectual/ Developmental Disability (red line) and all other diagnoses (blue line). In 1971, there were over 36,000 older adult patients with a diagnosis of neurocognitive disorders in state hospitals. By 2005, that number had decreased to 750 patients. Many of the older adult patients with primary neurocognitive disorders who were historically treated in state hospitals are likely now receiving care in nursing homes and or receiving Medicaid and Medicare supported home and community-based services (services not widely available in the 1970s) with diagnoses of Alzheimer’s disease, though a subset of the current psychiatric hospital patients may have co-occurring mental illness and neurocognitive challenges.

**Figure 12: Resident Patients Ages 65 and Over in State Psychiatric Hospitals, by Diagnostic Group: 1971 to 2005**

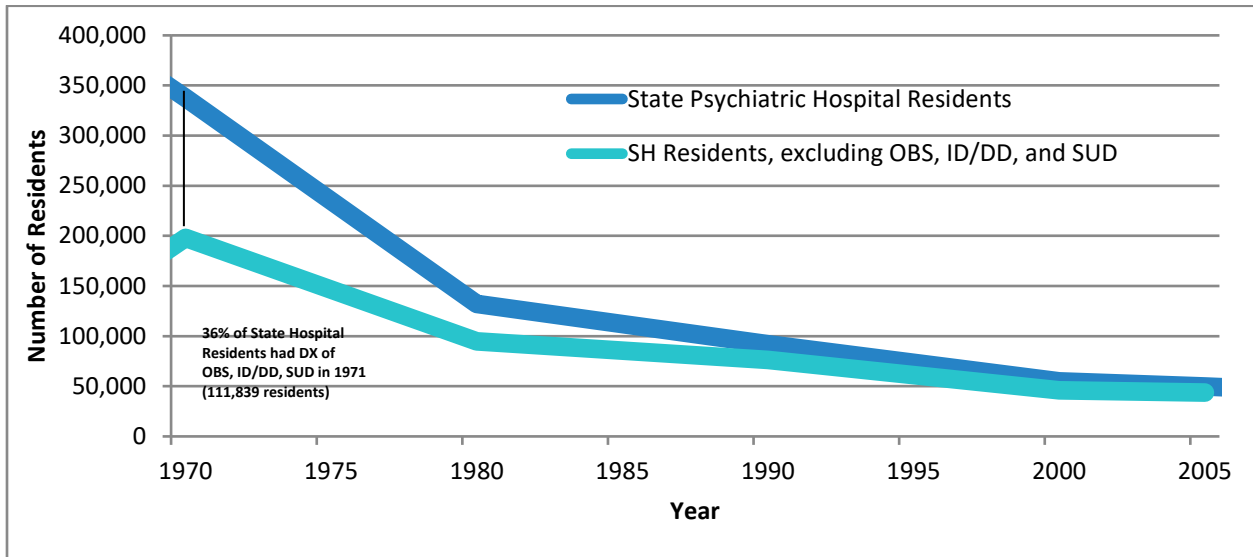


Sources: State Psychiatric Hospitals from: CMHS Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States series, 1971 to 2005 annual reports.

**Figure 13** shows a how the trend in state psychiatric hospital patients is very different if patients with diagnoses of Organic Brain Syndrome, Intellectual Disabilities, and substance use disorders (111,839 residents served in 1971) are backed out of state hospital patient data from 1971 to 2005. The lower line of patients with diagnoses likely to still be treated in state hospitals in 2020 shows a reduction of 157,430 patients from 1971 to 2020 (an 80% reduction), but a much lower reduction than the 297,036 decrease that is frequently used (counting all clients in state hospitals in the 1970s).



**Figure 13: Residents in State Psychiatric Hospitals, with and without Diagnoses not Currently Focus of Treatment in State Hospitals, 1970 to 2005**

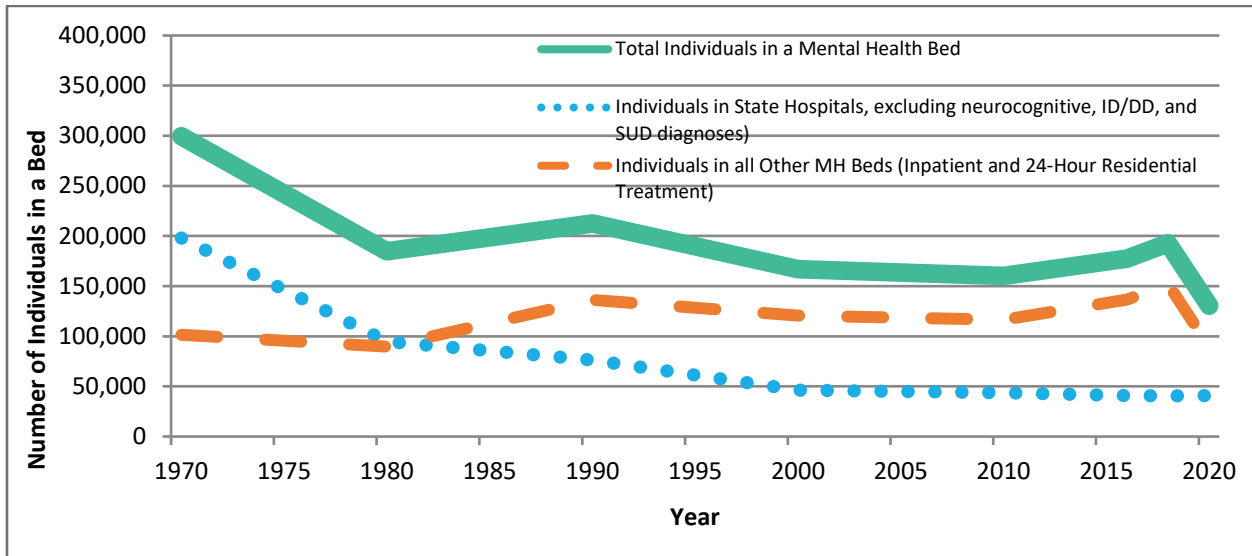


*Change in individuals in any inpatient and 24-hour residential treatment beds excluding historical rates of neurocognitive and ID/DD clients in state hospitals:*

In addition to references seen in the literature using total clients served in state hospitals over time, not adjusting for clients whose diagnoses would likely exclude them from care in a state psychiatric hospital today, a focus on only state psychiatric hospital patients and beds also leaves out the major growth (an increase of over 50% from 1970 to 2020) in other inpatient and 24-hour residential treatment beds over the past 50 years.

**Figure 14** shows what the number of clients served in any psychiatric bed would be from 1970 to 2020 if the subpopulation of state hospital clients with diagnoses no longer treatment focuses in state hospitals are excluded and private psychiatric hospital, general hospital specialty beds, residential treatment center, and other behavioral health provider beds are included. The net result of this adjusted number of mental health patients, is not a decrease of 297,036 patients, but rather a decrease of 36% over the 48 years (from 1970 to 2018) that is a decrease of 106,760 patients being served on a given day.

**Figure 14: Number of Individuals in a Mental Health Beds (State hospital and other inpatient and 24-hour treatment beds) excluding historical SH Patients with Diagnoses not Currently Focus of Treatment in State Hospitals, 1970 to 2020**



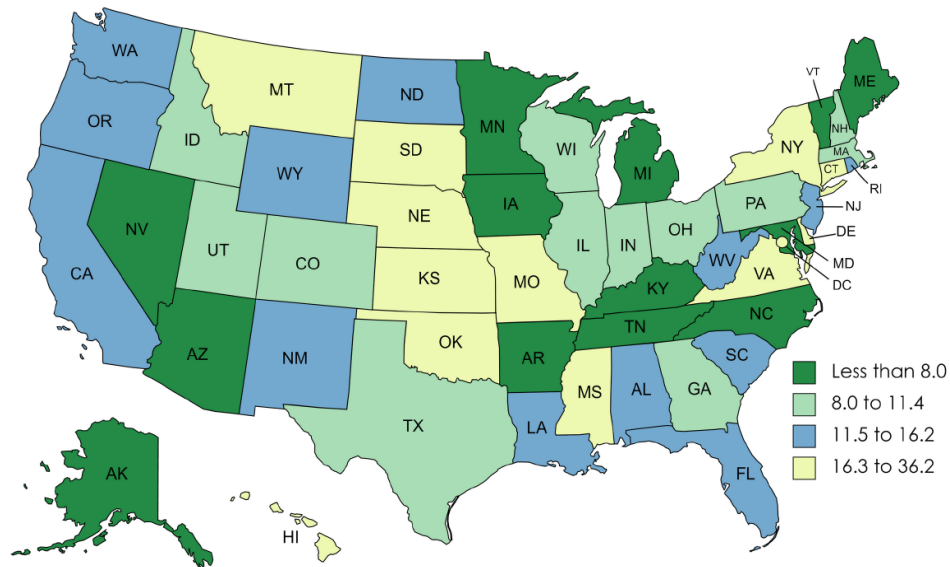
## State Psychiatric Hospital Use in 2020

NRI’s State Profiles data includes information about policies for the intended use of state psychiatric hospitals to serve children and adults in acute (30 day or less length of stay) or long units and also their use to provide forensic and sex offender client services. SAMHSA Uniform Reporting System data allows analysis of the number of clients admitted to and served in state hospitals.

### *Patients Served in State Psychiatric Hospitals, 2020*

In 2020, 39,963 patients were in a bed in a state psychiatric hospital at the start of the year and state hospitals served 124,519 unique patients throughout the year—each bed was used by an average of 3.1 patients during the year (2020 Uniform Reporting System, SAMHSA). States varied from having 6,104 resident patients in California to 21 patients in Vermont. Adjusting for state population, states averaged 12.1 patients per 100,000 population, but varied from a high of 36.2 per 100,000 in Virginia to a low of 2.9 per 100,000 in Arizona (Figure 15). Although some advocates have called for 50 beds per 100,000 population, NASMHPD in its *Beyond Beds* analysis by Pinals and Fuller urged caution about this metric, given that no set formula has been adopted and that bed need also depends on the level of the psychiatric care continuum that is available to a population.<sup>53</sup> This was further supported in the recently released report of the American Psychiatric Association.<sup>54</sup>

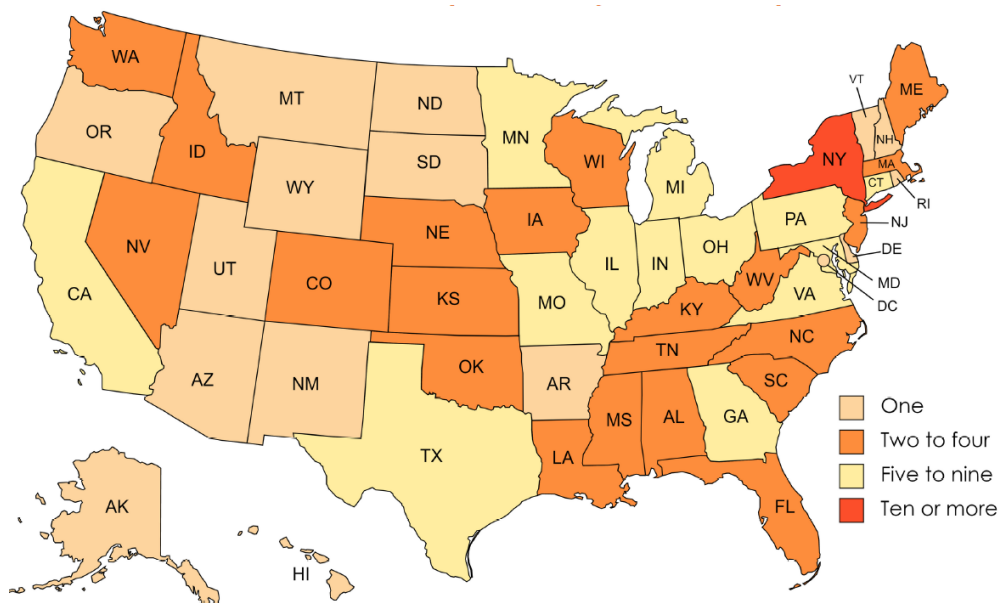
**Figure 15: Resident Patients in State Psychiatric Hospitals per 100,000 State Population, 2020 (URS data)**



**Number of State Operated Psychiatric Hospitals 2020**

In 2020 there were 177 state-operated psychiatric hospitals, with the median state operating two separate hospitals. The number of state psychiatric hospitals in each state ranges from a high of 23 hospitals in New York, to a low of one hospital in 16 states (Figure 16). Of note, Rhode Island and Massachusetts, for example, run specific state-operated psychiatric inpatient beds within state-operated general hospital. In 42 states, there were 150 state psychiatric hospitals accredited by the Joint Commission or other independent accrediting organization (80% of state hospitals were accredited). This was very different from the 1960s, when only 33% (97 out of 292 state psychiatric hospitals in 1966) were accredited.<sup>55</sup>

**Figure 16: Number of State Operated Psychiatric Hospitals, 2020**



The majority of SMHAs are responsible for both the oversight and management of state psychiatric hospitals and community mental health services. However, in 16 states, responsibility for state psychiatric hospitals is located in a different state agency than the SMHA agency responsible for community mental health services. Those states that have their hospital system managed by a separate state agency from the SMHA are Arizona, California, Maine, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Washington, and West Virginia. With Medicaid having become a predominant funder of community-based services, and only contributing a small portion of payment for state hospitals (see below), some of these shifts show community service SMHAs more closely aligning with the state’s Medicaid office, leaving the state hospital organizational structure as its own entity or built within other aspects of state agencies.

*How States Prioritize their Use of State Psychiatric Hospitals, 2020*

NRI’s State Profiles datasets include information about policies for how they use their state psychiatric hospitals. Thirty-one states reported their state psychiatric hospitals do not treat children (Table 12). Three states use their state hospitals to only provide acute (short-term 30 day or less) services for adults and six states focus their state hospital services for adults on longer term services (more than 30 days), but most states use their state hospitals to provide both short and long-term care services.

**Table 12: Number of States using State Hospitals by Length of Stay and Age/Forensic Status, 2020**

State Psychiatric Hospital Use	Children	Adults	Forensic Patients
Acute (30 day LOS) Only	7 states	3 states	0 states
Long Term Only	3 states	6 states	6 states
Both Acute and Long Term	7 states	37 states	41 states

*Legal Status of Patients Served in State Psychiatric Hospitals, 2020*

NRI’s state Profiles system collects information about the legal status of patients served in state hospitals in two ways. It collects the legal status of patients at admission to a state hospital through the year (status at any admission over 365 days and one individual may have multiple admissions during the year with different legal statuses for each admission. Second, NRI collects the current legal status of all individuals who were patients in a state hospital on the first day of the reporting year (July 1 for most states).

**Legal Status of Admissions throughout the Year:** Forensic legal status patients were 30% of all admissions during the year, but patients in the hospital for a short-term involuntary hold, and civil status involuntary clients constituted a much larger share of admissions throughout the year than the number of patients in a hospital bed on the first day of the reporting year (Table 13). States varied considerably in how they use their state hospitals for forensic patients or civil status patients. In six states, over 70% of patients on the first day of the year had a forensic or sex offender legal status (California, Illinois, Maryland, and Wisconsin) and in six states over 70% of admissions had a forensic or sex offender legal status (California, Colorado, Florida, Louisiana, Maryland, and Rhode Island).

**Legal Status of Patients in state hospitals on the first day of the reporting year:** Over 56% of patients in state psychiatric hospitals at the start of the year had a forensic (criminal justice or sex offender) legal status. Only 5.1% of patients on the first day of the year were in the hospital as a voluntary patient. In four states, over 70% of patients on the first day of the year had a forensic or sex offender legal status (California, Illinois, Maryland, and Wisconsin).

**Table 13: Legal Status of Patients in State Psychiatric Hospitals (Admissions during the Year and Patient at Start of Year, 2020)**

Patient Legal Status	Admissions		Patients In Hospital on First Day of Year	
	N	%	N	%
<b>Voluntary</b>	4,443	6.9%	1,729	5.1%
<b>Involuntary Holds</b>	20,166	31.4%	2,217	6.5%
<b>Involuntary Civil</b>	17,478	27.2%	9,526	28.1%
<b>Involuntary Forensic</b>	18,965	29.5%	16,868	49.8%
<b>Sex Offender</b>	379	0.6%	2,055	6.1%
<b>Dual Legal Status</b>	70	0.1%	15	0.0%
<b>Other</b>	2,653	4.1%	1,470	4.3%
<b>Total</b>	64,211	100.0%	33,880	100.0%
<b>Number of States Reporting</b>	37		32	

Source: NRI 2020-2021 State Profiles

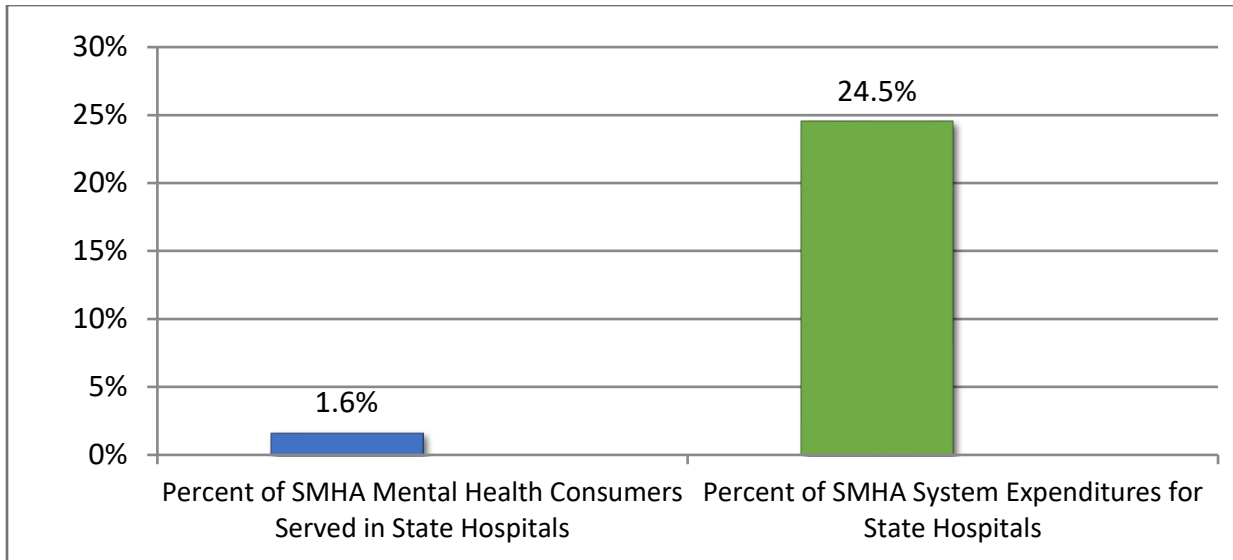
### Expenditures for State Psychiatric Hospitals in FY 2019

SAMHSA does not collect information about expenditures for all psychiatric bed settings in the N-MHSS or other routine surveys, but NRI has a State Mental Health Agency Revenues and Expenditures data base that routinely compiles expenditures for state psychiatric hospitals and state community-based services from Fiscal Year 1981 up through 2019 (collection of FY 2021 data is currently underway).

In FY 2019, State Mental Health Agencies (SMHAs) controlled the expenditure of over \$47.9 billion for mental health services that paid for services to over 8 million persons. (Note, these expenditure and service counts are for mental health services only—they exclude substance use disorder (SUD) expenditures except for co-occurring mental health and SUD services. State psychiatric hospital expenditures were 24.5% (\$11.5 billion) of total state mental health expenditures for mental health. Note, while state psychiatric hospitals in several states are the organizational responsibility of a separate state agency than community mental health services, both SAMHSA reporting and NRI data systems collect and combine client counts and expenditures for both community mental health programs and state psychiatric hospitals to permit better comparisons of total state specialty agency mental health services and expenditures.

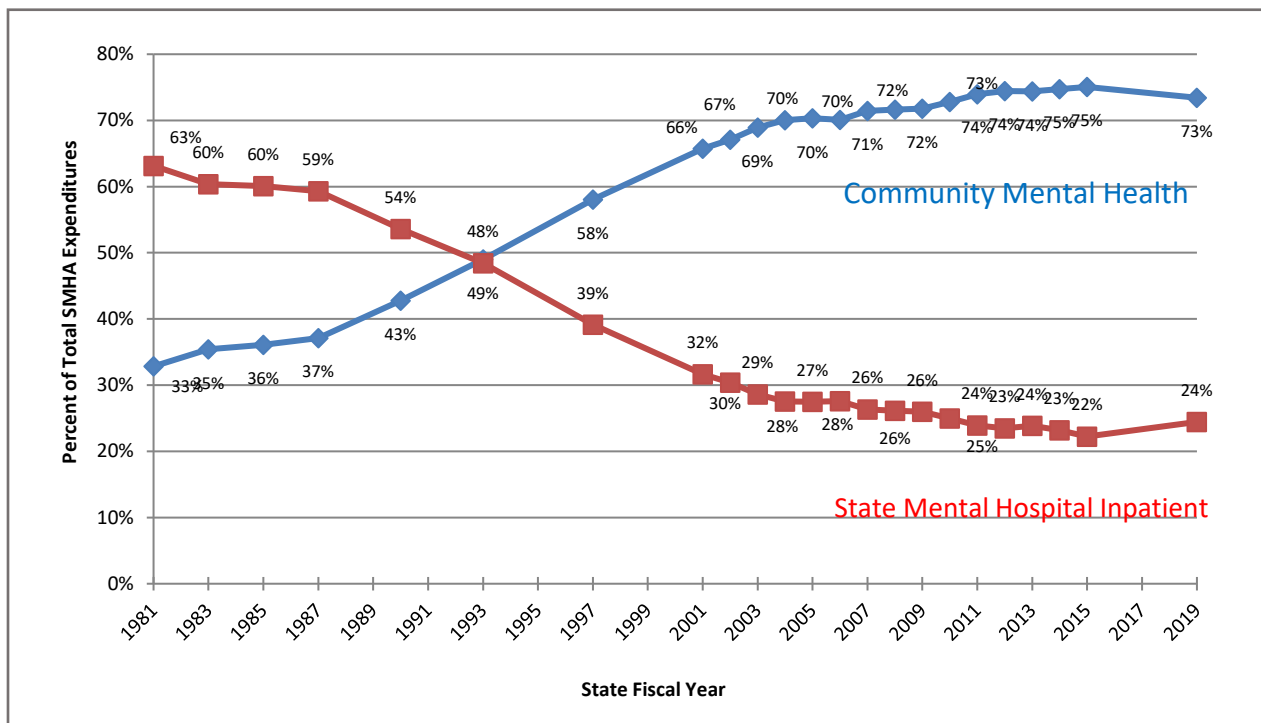
Although almost one quarter of state mental health expenditures were spent on state psychiatric hospitals, state hospitals only served 125,305 or 1.6% of the 8 million individuals served by SMHA systems in 2019. **Figure 17** shows how state hospitals are an expensive set of services used to serve the small percentage of mental health clients.

**Figure 17: Patients in State Psychiatric Hospitals as a Share of SMHA Mental Health Clients Served and State Hospital Expenditures as a Share of Total SMHA Expenditures: FY 2019**



The 24.5% of state mental health expenditures devoted to state psychiatric hospitals in FY 2019 represents a major shift in where states devoted their mental health resources historically. **Figure 18** shows how the percentage of state mental health expenditures devoted to state hospitals has decreased from 63% of state mental health expenditures in FY 1981 to 24.5% FY 2019. During that same time period, expenditures for community mental health services have increased from 33% in FY 1981 to 73% in FY 2019.

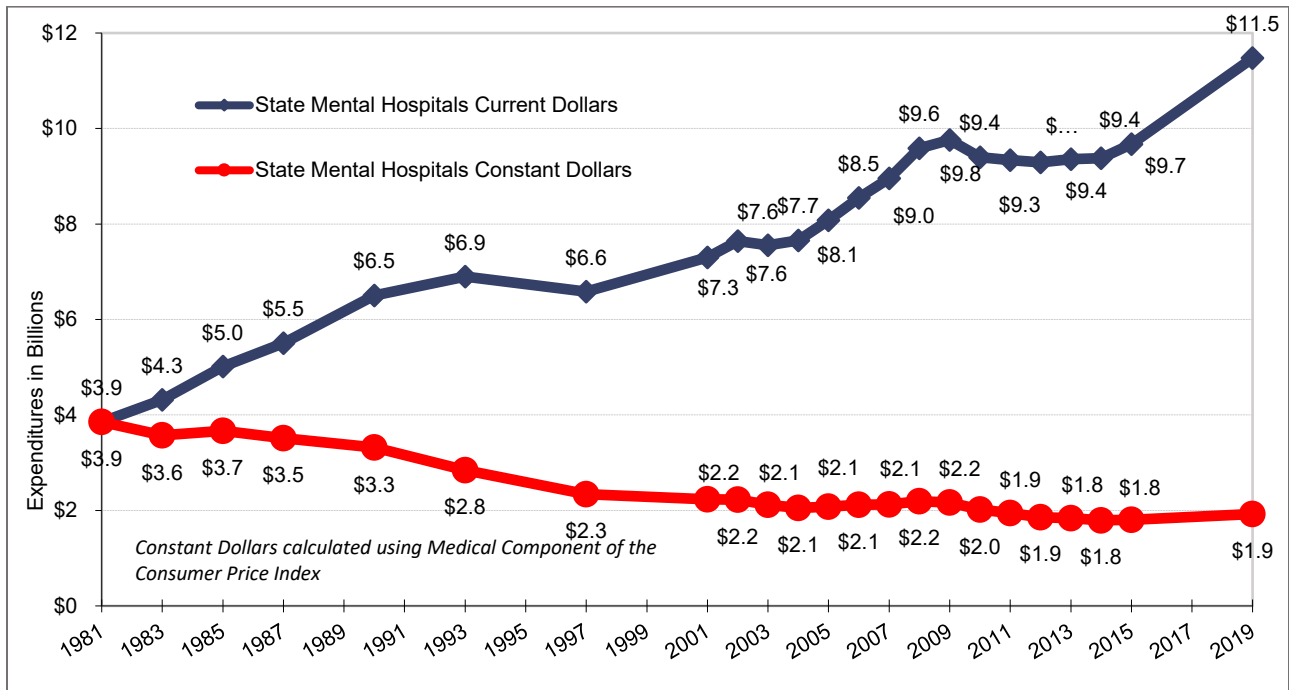
**Figure 18: State Mental Health Agency-Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2019**



**Total SMHA Expenditures for Mental Health Over Time:** from FY 1981 to FY 2019, SMHA expenditures for mental health services grew over six-fold, from \$6.1 billion in FY 1981 to \$47.5 billion in FY 2019. During the last decade, from FY 2010 to FY 2019, SMHA expenditures for mental health grew by 24.8%. However, when SMHA expenditures are adjusted to account for medical inflation, SMHA spending for mental health services decreased by 2.8% (from FY 2010 to 2019).

**SMHA Expenditures for State Hospitals Over Time:** from FY 1981 to FY 2019, state psychiatric hospital expenditures increased from \$3.9 billion to over \$11.5 billion in FY 2019 (an increase of 197% or an annual average increase of 2.9% per year). However, if state psychiatric hospital expenditures are adjusted to account for medical inflation, state psychiatric hospital expenditures do show a decrease from \$3.9 billion in FY 1981 to \$1.9 billion in FY 2019 (Figure 19).

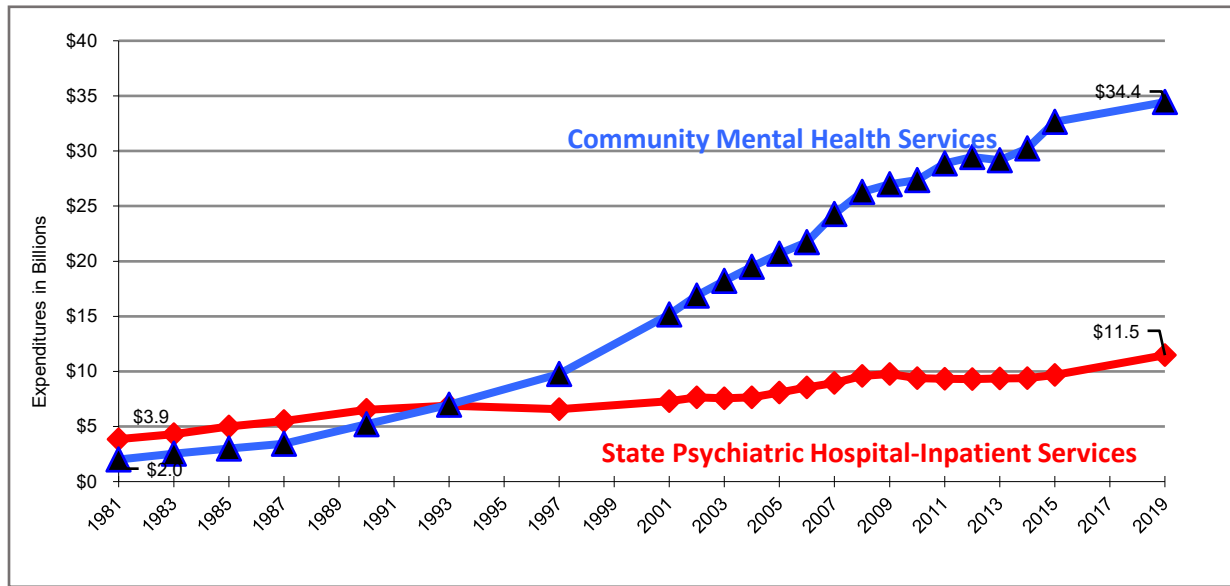
**Figure 19: SMHA Controlled Expenditures for State Psychiatric Hospital Inpatient Services, FY 1981 to FY 2019**



**SMHA Expenditures for Community Mental Health Over Time:** Community mental health expenditures controlled by SMHA systems grew much faster than state hospital expenditures. Community mental health expenditures grew from \$2 billion in FY 1981 to over \$34.4 billion in FY 2019, an annual increase of 7.8% per year (Figure 20).



**Figure 20: SMHA-Controlled Expenditures for Inpatient Mental Health Services in State Hospitals and Community-Based Mental Health Services, FY 1981 to FY 2019**

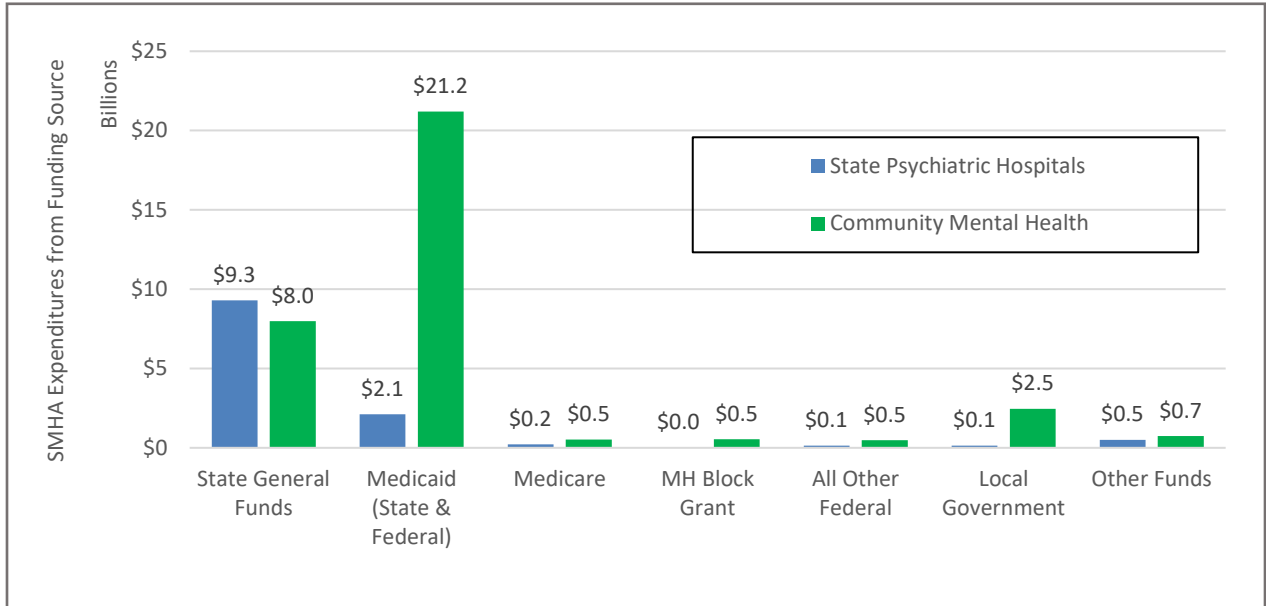


### Funding Sources Paying for State Hospital Services, FY 2019

State General Revenues were the largest single payment source for state psychiatric hospitals, representing \$9.3 billion of state hospital funding in FY 2019. Medicaid was the next largest funding source (at \$2.1 billion) and Medicare paid over \$200 million for state hospital services (note, the SAMSHA Mental Health Block Grant is prohibited by statute from paying for care in psychiatric hospitals).

**Figure 21** shows the funding sources for both state psychiatric hospitals and community mental health services in FY 2019. Medicaid has become the major funding source for public mental health services, but the majority (\$21.2 billion) of Medicaid is used to pay for community mental health services and only \$2.1 billion supports care in state hospitals. The reliance on state general funds instead of Medicaid to pay for state hospital services is mostly due to Medicaid’s Institution for Mental Disease (IMD) restriction that prohibits Medicaid payment for services to individuals between the ages of 21 and 64 in an IMD (any institution with over 16 beds where the majority of are mental health patients).

**Figure 21: SMHA Funding Sources for State Psychiatric Hospitals and Community-Based Programs: FY 2019**

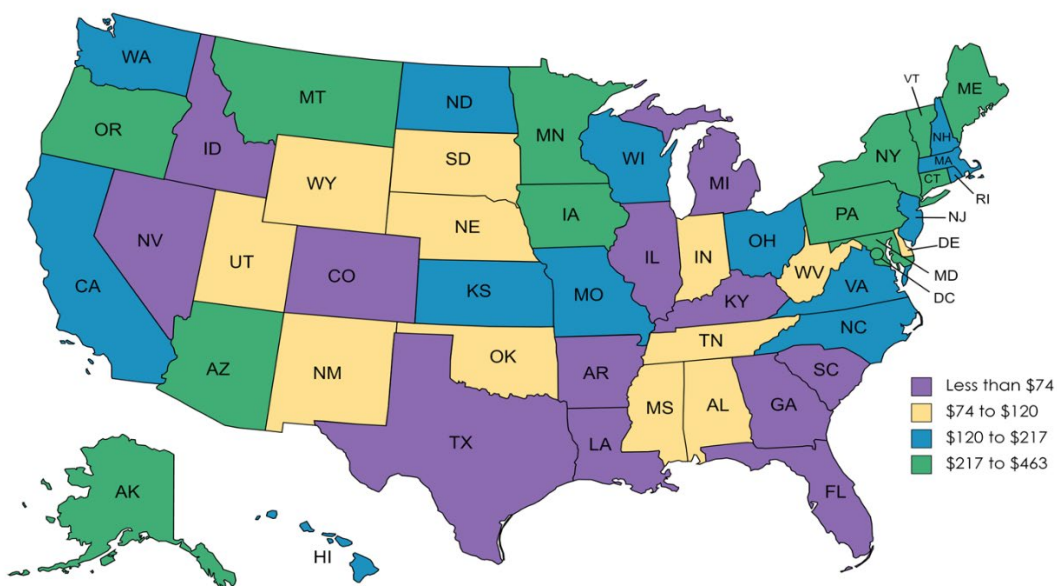


Medicaid payments supporting community mental health have grown by 245% from FY 2001 (\$6.1 billion) to FY 2019 (\$21.2 billion), while Medicaid support for state psychiatric hospitals decreased by 9.3% over this time period (from \$2.2 billion in FY 2010 to \$2.1 billion in FY 2019).

*State per capita expenditures for state psychiatric hospitals*

States varied considerably regarding how much they expended on state psychiatric hospitals in FY 2019, with states on average expending \$34.87 per resident (Figure 22). States in the South tended to expend the lowest amounts per capita and states in the Northeast and West expended the most per capita.

**Figure 22: Total FY 2019 SMHA-Controlled Per-Capita Expenditures for Mental Health Services**



## Conclusion

Historical comparisons of the number of mental health patients often focus only on state psychiatric hospital data and do not account for the growth of mental health treatment beds in non-state hospital providers, nor adequately account for how state hospitals have changed the populations they serve over time.

In the most recent decade (2010 to 2018), despite many discussions about bed shortages, overall inpatient psychiatric beds in all types of organizations increased 17% between 2010 to 2018. The increase in overall psychiatric beds occurred even while state psychiatric hospital beds decreased 18.5%. During this decade private psychiatric hospital patients more than doubled, and general hospital psychiatric unit beds increased more than 25%.

While the total number of individuals in a mental health bed increased from 2010 to 2018, there was a major shift in the age of patients in these beds, with the increase in beds focusing on adults while the number of children in a mental health treatment bed decreased.

- Children in mental health inpatient or residential treatment beds decreased by 20% from 2010 to 2018.
- The number of adults in inpatient or residential treatment beds increased by 24% from 2010 to 2018.

Over the past 50 years, State psychiatric hospitals have closed many of their beds and have greatly transitioned their focus on the types of individuals they serve. From 1970 to 2018, there was an 84% reduction in state hospital beds, but most of those bed closures occurred decades ago during the 1970s and 1980s (65% of all state hospital beds that closed between 1970 and 2020 were closed during the first decade (1970 to 1980)).

- 70% of state hospital beds for adults (ages 18-64) that closed between 1970 and 2020 closed during the 1970s.
- 60% of state hospital beds for older adults (ages 65+) that closed between 1970 and 2020 closed during the 1970s, and 27% closed during the 1980s.
- Children in state hospital beds closed at a slightly slower rate than those for adults & older adults. Of the beds closed from 1970 to 2018, 50% were closed during the 1970s, 10% during the 1980s, 18% during the 1990s, 15% during the 2000s, and only 1% during the 2010s

Historical data from the 1970s and 1980s show that major populations then being served in state hospitals included older adults (often with neurocognitive disorders) and individuals with intellectual or developmental disabilities. Individuals with these diagnoses are no longer the focus of state psychiatric hospital treatment (unless they have a co-occurring mental health disorder) and are now largely treated in community settings or nursing facilities. Older adult patients (and especially those with diagnoses of dementia) historically occupied a large share of state psychiatric hospital beds (24% in 1970). Only 6% of patients served in state hospitals in 2020 were aged 65 and over.

State hospitals in many states no longer serve children and are increasingly focusing on providing services treating clients with criminal justice (forensic) legal statuses. As states refocus their state hospitals to serve forensic adults, individuals who need intensive inpatient or 24-hour residential treatment without criminal justice involvement are increasingly being served by private psychiatric

hospitals, general hospital specialty psychiatric units, residential treatment centers (RTCs) and other mental health providers.

An increasing majority of SMHAs are reporting shortages of psychiatric beds, but the state policies to address these shortages are not focused on reopening state hospital beds and are instead focusing on community-based services and Crisis Now-model services, including the new three-digit 988 behavioral health crisis and suicide number, mobile crisis teams, and crisis stabilization centers to divert many individuals away from inpatient care.

SMHA expenditures for state psychiatric hospitals increased over the last decade, but states have increased expenditures for community mental health services even more. State Mental Health Agency support for community mental health services increased from \$2 billion in FY 1981 to over \$34.4 billion in FY 2019, an annual increase of 7.8% per year. In 2019, over 8 million individuals received community mental health services from SMHA systems.

Medicaid's role in paying for mental health services, especially community-based services, has grown over time helping to support alternatives to inpatient and residential care, and Medicaid's Institution for Mental Disease (IMD) policy continues to restrict Medicaid's role in financing inpatient mental health services.

## **Appendix Information with State-by-state data about psychiatric beds**

**Appendix A:** shows state-by-state information about the number of state psychiatric hospitals in each state, the number of residents in the hospital at the start of the year, the number of additions to the hospital during the year, the percent of clients who had a forensic or civil legal status, and information about the intended use of state hospitals by patient age group. This Appendix uses information from NRI's 2020-2021 State Profiles system combined with public information from SAMHSA's 2020 Uniform Reporting System (Table 6).

**Appendix B:** Shows state-by-state the number of organizations with mental health treatment beds in 2018, the number of inpatient residents and the number of 24-hour residential treatment patients in a bed and the utilization rates per 100,000 state population. This table was created by NRI using information from SAMHSA's 2018 N-MHSS report.

**Appendix C:** Shows state-by-state the number of inpatient residents, other 24-hour residential treatment patients, and total mental health treatment patients for the years 2010 to 2020. These tables were created by NRI using information from SAMHSA's 2010, 2014, 2018, and 2020 N-MHSS reports.

## Appendix A: 2020 State Psychiatric Hospital Data, by State

Table 14: Patients in State Psychiatric Hospitals, by State, 2020

State	Number of State Hospitals (2020)	Number of Patients (Start of 2020)	Patients per 100,000 population (2020)	State Population: 2020	State Hospital Admissions (2020)	Admissions per 100,000 Pop (2020)	Forensic Percent of Admissions (2020)	Forensic Percent of Patients (2020)
Alabama	3	567	11.5	4,921,532	238	4.8	30.3%	30.3%
Alaska	1	31	4.2	731,158	538	73.6	NR	NR
Arizona	1	216	2.9	7,421,401	65	0.9		
Arkansas	1	215	7.1	3,030,522	318	10.5		
California	5	6,104	15.5	39,368,078	4,602	11.7	98.7%	92.7%
Colorado	2	528	9.1	5,807,719	757	13.0	73.6%	67.0%
Connecticut	6	581	16.3	3,557,006	715	20.1	35.4%	35.4%
Delaware	1	174	17.6	986,809	98	9.9	46.7%	46.7%
District of Columbia	1	237	33.2	712,816	233	32.7	77.0%	58.8%
Florida	3	2,631	12.1	21,733,312	2,173	10.0	72.7%	65.2%
Georgia	5	947	8.8	10,710,017	2,740	25.6	23.2%	57.6%
Hawaii	1	258	18.3	1,407,006	331	23.5	NR	NR
Idaho	2	152	8.3	1,826,913	1,044	57.1	22.0%	
Illinois	7	1,155	9.2	12,587,530	3,190	25.3	18.8%	77.3%
Indiana	6	606	9.0	6,754,953	499	7.4		
Iowa	3	NA	NA	3,163,561	0	0.0	6.6%	6.6%
Kansas	2	649	22.3	2,913,805	2,371	81.4		
Kentucky	3	349	7.8	4,477,251	6,225	139.0	3.2%	
Louisiana	2	687	14.8	4,645,318	369	7.9	82.0%	42.3%
Maine	2	102	7.6	1,350,141	2,231	165.2		
Maryland	5	NA	NA	6,055,802	0	0.0	84.7%	83.2%
Massachusetts	2	597	8.7	6,893,574	846	12.3	13.7%	
Michigan	5	623	6.3	9,966,555	1,381	13.9	46.9%	
Minnesota	8	174	3.1	5,657,342	889	15.7		
Mississippi†	4	654	22.0	2,966,786	2,131	71.8	4.3%	6.5%
Missouri	6	1,184	19.2	6,151,548	450	7.3	73.1%	66.4%
Montana	1	228	21.1	1,080,577	759	70.2	14.5%	21.8%
Nebraska	2	595	30.7	1,937,552	198	10.2	66.7%	66.5%
Nevada	2	125	4.0	3,138,259	2,331	74.3	3.6%	98.7%
New Hampshire	1	118	8.6	1,366,275	1,227	89.8	2.5%	2.5%
New Jersey	4	1,321	14.9	8,882,371	1,007	11.3	16.0%	16.0%
New Mexico	1	344	16.3	2,106,319	420	19.9		
New York	23	3,779	19.5	19,336,776	4,900	25.3		
North Carolina	3	757	7.1	10,600,823	1,469	13.9	6.3%	6.3%
North Dakota	1	115	15.0	765,309	732	95.6	11.4%	

State	Number of State Hospitals (2020)	Number of Patients (Start of 2020)	Patients per 100,000 population (2020)	State Population: 2020	State Hospital Admissions (2020)	Admissions per 100,000 Pop (2020)	Forensic Percent of Admissions (2020)	Forensic Percent of Patients (2020)
Ohio	6	1,059	9.1	11,693,217	4,734	40.5		
Oklahoma	2	667	16.8	3,980,783	1,547	38.9		
Oregon	1	605	14.3	4,241,507	1,051	24.8		6.7%
Pennsylvania	6	1,458	11.4	12,783,254	943	7.4	32.1%	
Rhode Island†	1	135	12.8	1,057,125	54	5.1	100.0%	
South Carolina	3	763	14.6	5,218,040	932	17.9	51.5%	51.5%
South Dakota	1	184	20.6	892,717	1,323	148.2	11.4%	11.4%
Tennessee	4	433	6.3	6,886,834	8,278	120.2	8.2%	41.8%
Texas	9	2,407	8.2	29,360,759	16,395	55.8		
Utah	1	306	9.4	3,249,879	262	8.1		
Vermont	1	21	3.4	623,347	92	14.8		
Virginia	9	3,113	36.2	8,590,563	7,526	87.6	22.9%	41.2%
Washington	3	1,180	15.3	7,693,612	1,172	15.2		
West Virginia	2	240	13.4	1,784,787	2,362	132.3	6.6%	6.6%
Wisconsin	2	505	8.7	5,832,655	7,043	120.8	72.9%	72.9%
Wyoming	1	84	14.4	582,328	191	32.8	26.5%	26.5%
<b>Total</b>	<b>177</b>	<b>39,963</b>	<b>12.1</b>	<b>329,484,123</b>	<b>101,382</b>	<b>30.8</b>	<b>30.0%</b>	<b>56.0%</b>
<b>Median</b>	<b>2</b>	<b>567</b>	<b>12.1</b>	<b>4,477,251</b>	<b>943</b>	<b>20.1</b>	<b>25.0%</b>	<b>42.0%</b>
<b>Maximum</b>	<b>23</b>	<b>6,104</b>	<b>36.2</b>	<b>39,368,078</b>	<b>16,395</b>	<b>165.2</b>	<b>100.0%</b>	<b>99.0%</b>
<b>Minimum</b>	<b>1</b>	<b>21</b>	<b>2.9</b>	<b>582,328</b>	<b>0.0</b>	<b>0.0</b>	<b>2.0%</b>	<b>2.0%</b>

Notes on Table:

Number of Admissions and Residents from 2020 URS Table 6

Number of State Psychiatric Hospitals, Percent Forensic, and Use of State Hospitals from 2020 State Mental Health Profiles

† State submitted updated information different from their URS submission

‡ Rhode Island has state-operated psychiatric inpatient beds that are part of a general hospital

State Hospital Admissions and Discharges can be duplicated (e.g., one client can have multiple admissions/discharges during the year)



**Table 15: Use of State Psychiatric Hospitals, by State, 2020**

State	Hospitals are used for Short or Long-Term Care (2020 Profiles)		
	Children & Adolescents	Adults/Older adult	Forensic Patients
Alabama		Acute & Long	Acute & Long
Alaska	No Data Available	No Data Available	No Data Available
Arizona		Acute & Long	Acute & Long
Arkansas		Acute & Long	Acute & Long
California		Acute & Long	Acute & Long
Colorado	Acute & Long	Acute & Long	Acute & Long
Connecticut		Acute & Long	Acute & Long
Delaware		Acute & Long	Acute & Long
District of Columbia		Acute & Long	Acute & Long
Florida		Long Term	Long Term
Georgia		Acute & Long	Long Term
Hawaii			
Idaho		Acute & Long	Acute & Long
Illinois		Acute & Long	Acute & Long
Indiana	Long Term	Long Term	Long Term
Iowa	Acute & Long	Acute & Long	Acute & Long
Kansas			
Kentucky		Acute & Long	Acute & Long
Louisiana		Acute & Long	Acute & Long
Maine		Acute & Long	Acute & Long
Maryland		Acute & Long	Acute & Long
Massachusetts		Acute & Long	Acute & Long
Michigan	Long Term	Long Term	Long Term
Minnesota	Acute & Long	Acute & Long	Acute & Long
Mississippi	Acute	Acute & Long	Acute & Long
Missouri	Acute		Acute & Long
Montana		Acute & Long	Acute & Long
Nebraska		Acute & Long	Acute & Long
Nevada			Acute & Long
New Hampshire	Acute	Acute & Long	Acute & Long
New Jersey		Acute & Long	Acute & Long
New Mexico		Acute & Long	Long Term
New York	Acute & Long	Acute & Long	Acute & Long
North Carolina	Acute & Long	Acute & Long	Acute & Long
North Dakota		Acute	Acute & Long
Ohio		Acute	Acute & Long
Oklahoma	Acute	Acute & Long	Acute & Long
Oregon		Long Term	Acute & Long
Pennsylvania		Long Term	Long Term
Rhode Island <sup>§</sup>		Acute & Long	Acute & Long
South Carolina	Acute & Long	Acute & Long	Acute & Long
South Dakota		Acute & Long	Acute & Long
Tennessee		Acute & Long	Acute & Long
Texas	Acute & Long	Acute & Long	Acute & Long
Utah	Acute	Acute	
Vermont		Acute & Long	Acute & Long
Virginia	Acute	Acute & Long	Acute & Long
Washington	Long Term	Long Term	Acute & Long
West Virginia		Acute & Long	Acute & Long
Wisconsin	Acute	Acute & Long	Acute & Long
Wyoming		Acute & Long	Acute & Long

<sup>§</sup> Rhode Island had state-operated psychiatric inpatient beds that are part of a general hospital

## Appendix B: Patients in Psychiatric Beds (All Types of Organizations), 2018

Table 16: Patients in Mental Health Inpatient and 24-Hour Residential Treatment Beds on April 1, 2018, by State

State	Organizations with Inpatient Beds	Inpatient Clients	Inpatients per 100,000 State Population	Organizations with Residential Treatment Beds	Residential Clients	24-Hour Residential TX Clients per 100,000 State Population	Total MH Patients in Bed (April 30, 2018)	Total Inpatient and 24-Hour Residential TX Clients per 100,000 State Population
Alabama	40	1,650	33.8	47	1,070	21.9	2,801	57.3
Alaska	9	286	38.8	27	487	66.0	839	113.7
Arizona	36	8,041	112.1	97	1,468	20.5	9,718	135.5
Arkansas	39	1,456	48.3	29	1,307	43.4	2,840	94.2
California	128	13,157	33.3	169	5,462	13.8	18,821	47.6
Colorado	22	6,582	115.6	42	987	17.3	7,727	135.7
Connecticut	28	2,107	59.0	34	2,898	81.1	5,098	142.7
Delaware	5	377	39.0	4	71	7.3	491	50.8
District of Columbia	5	350	49.8	1	12	1.7	413	58.8
Florida	110	14,992	70.4	94	2,914	13.7	18,070	84.8
Georgia	37	2,006	19.1	21	1,187	11.3	3,233	30.7
Hawaii	8	344	24.2	3	92	6.5	463	32.6
Idaho	9	352	20.1	5	107	6.1	484	27.6
Illinois	78	3,962	31.1	70	1,769	13.9	5,832	45.8
Indiana	64	2,080	31.1	55	1,801	26.9	3,967	59.3
Iowa	27	763	24.2	18	587	18.6	1,392	44.1
Kansas	23	1,122	38.5	19	825	28.3	2,005	68.8
Kentucky	32	1,323	29.6	40	1,371	30.7	2,764	61.8
Louisiana	67	5,889	126.4	6	265	5.7	6,286	134.9
Maine	12	422	31.5	52	396	29.6	902	67.4
Maryland	32	1,608	26.6	34	953	15.8	2,622	43.4
Massachusetts	55	2,248	32.6	63	1,888	27.4	4,232	61.3
Michigan	56	2,979	29.8	24	1,295	13.0	4,328	43.3
Minnesota	33	1,310	23.3	51	1,637	29.2	3,021	53.8
Mississippi	37	1,152	38.6	22	1,093	36.6	2,306	77.2
Missouri	53	5,063	82.6	37	1,477	24.1	6,660	108.7
Montana	8	576	54.2	21	444	41.8	1,095	103.1
Nebraska	15	599	31.0	22	534	27.7	1,186	61.5
Nevada	12	559	18.4	6	191	6.3	774	25.5
New Hampshire	9	277	20.4	16	324	23.9	637	47.0
New Jersey	44	3,751	42.1	45	1,172	13.2	5,010	56.2
New Mexico	15	670	32.0	9	286	13.6	997	47.6
New York	129	8,306	42.5	100	4,032	20.6	12,481	63.9
North Carolina	53	2,627	25.3	96	987	9.5	3,735	36.0
North Dakota	7	293	38.5	10	169	22.2	511	67.2
Ohio	72	3,370	28.8	62	2,123	18.2	5,584	47.8
Oklahoma	33	844	21.4	15	334	8.5	1,214	30.8
Oregon	16	1,066	25.4	55	937	22.4	2,083	49.7
Pennsylvania	100	4,578	35.7	79	2,517	19.7	7,210	56.3
Rhode Island*	8	438	41.4	21	304	28.8	804	76.1
South Carolina	24	1,351	26.6	12	510	10.0	1,900	37.4
South Dakota	5	169	19.2	7	372	42.2	567	64.3
Tennessee	44	1,893	28.0	40	1,585	23.4	3,546	52.4
Texas	101	7,151	24.9	47	2,281	7.9	9,504	33.1

State	Organizations with Inpatient Beds	Inpatient Clients	Inpatients per 100,000 State Population	Organizations with Residential Treatment Beds	Residential Clients	24-Hour Residential TX Clients per 100,000 State Population	Total MH Patients in Bed (April 30, 2018)	Total Inpatient and 24-Hour Residential TX Clients per 100,000 State Population
Utah	17	912	28.9	30	984	31.1	1,955	61.8
Vermont	6	193	30.8	29	306	48.9	559	89.2
Virginia	47	2,781	32.6	38	1,792	21.0	4,644	54.5
Washington	30	1,883	25.0	41	1,120	14.9	3,069	40.7
West Virginia	17	822	45.5	17	633	35.1	1,518	84.0
Wisconsin	38	1,418	24.4	25	825	14.2	2,292	39.4
Wyoming	8	212	36.7	9	254	44.0	512	88.6
Puerto Rico	14	730	22.8	16	327	10.2	1,096	34.3
Other Jurisdictions	3	25					25	
US Total	1,920	129,115	39.1	1,932	58,762	17.8	191,821	58.1

Table created by NRI using NMHSS 2018 Tables 4.6 and 4.8 and US Census Data.

## Appendix C: Trend in Psychiatric Patients, 2010 to 2020

Table 17: Mental Health Inpatients in Beds on April 30 each year, 2010 to 2020

State/Year	Inpatient Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Alabama	1,785	1,116	1,650	1,144	-135	-8%
Alaska	190	243	286	63	96	51%
Arizona	1,274	1,398	8,041	1,569	6,767	531%
Arkansas	1,021	1,166	1,456	1,091	435	43%
California	8,220	13,318	13,157	8,941	4,937	60%
Colorado	693	1,222	6,582	1,815	5,889	850%
Connecticut	2,167	1,693	2,107	645	-60	-3%
Delaware	431	393	377	427	-54	-13%
District of Columbia	528	450	350	275	-178	-34%
Florida	5,261	5,950	14,992	6,373	9,731	185%
Georgia	2,592	1,407	2,006	1,568	-586	-23%
Hawaii	324	321	344	353	20	6%
Idaho	380	462	352	316	-28	-7%
Illinois	3,725	3,965	3,962	3,568	237	6%
Indiana	1,948	3,385	2,080	1,587	132	7%
Iowa	805	671	763	868	-42	-5%
Kansas	1,187	993	1,122	708	-65	-5%
Kentucky	1,715	1,116	1,323	993	-392	-23%
Louisiana	2,073	1,971	5,889	1,936	3,816	184%
Maine	422	411	422	323	0	0%
Maryland	1,857	2,060	1,608	1,269	-249	-13%
Massachusetts	2,373	2,405	2,248	2,499	-125	-5%
Michigan	2,302	2,441	2,979	1,421	677	29%
Minnesota	1,003	1,445	1,310	803	307	31%
Mississippi	1,893	1,352	1,152	783	-741	-39%
Missouri	2,772	3,062	5,063	2,024	2,291	83%
Montana	256	886	576	562	320	125%
Nebraska	648	632	599	1,685	-49	-8%
Nevada	498	726	559	533	61	12%
New Hampshire	386	308	277	230	-109	-28%
New Jersey	4,322	3,497	3,751	2,538	-571	-13%
New Mexico	342	591	670	217	328	96%
New York	9,526	9,544	8,306	4,077	-1,220	-13%
North Carolina	1,945	2,402	2,627	1,770	682	35%
North Dakota	518	116	293	416	-225	-43%
Ohio	2,894	2,447	3,370	2,275	476	16%
Oklahoma	1,496	1,454	844	790	-652	-44%
Oregon	1,166	888	1,066	772	-100	-9%
Pennsylvania	5,965	4,976	4,578	3,780	-1,387	-23%
Rhode Island	373	485	438	313	65	17%

State/Year	Inpatient Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
South Carolina	1,061	1,274	1,351	756	290	27%
South Dakota	314	105	169	84	-145	-46%
Tennessee	1,404	1,773	1,893	1,771	489	35%
Texas	6,301	5,691	7,151	4,792	850	13%
Utah	629	580	912	823	283	45%
Vermont	246	154	193	112	-53	-22%
Virginia	2,618	2,081	2,781	2,662	163	6%
Washington	3,436	1,843	1,883	1,483	-1,553	-45%
West Virginia	1,014	818	822	530	-192	-19%
Wisconsin	1,049	1,513	1,418	972	369	35%
Wyoming	184	187	212	152	28	15%
Puerto Rico	1,938	1,964	730	141	-1,208	-62%
Jurisdictions	23	NA	25	24	2	9%
<b>US Total</b>	<b>99,493</b>	<b>101,351</b>	<b>129,115</b>	<b>77,622</b>	<b>29,622</b>	<b>30%</b>
<b>Median</b>	<b>1,187</b>	<b>1,313</b>	<b>1,323</b>	<b>868</b>	<b>2</b>	<b>6%</b>
<b>Minimum</b>	<b>23</b>	<b>105</b>	<b>25</b>	<b>24</b>	<b>-1,553</b>	<b>-62%</b>
<b>Maximum</b>	<b>9,526</b>	<b>13,318</b>	<b>14,992</b>	<b>8,941</b>	<b>9,731</b>	<b>850%</b>
<b>States</b>	<b>53</b>	<b>52</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>53</b>

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.

**Table 18: Inpatient Patients per 100,000 State Population on April 30 Each Year, 2010 through 2020**

State/Year	Inpatients Patients per 100,000 State Population				2010 to 2018*
	2010	2014	2018	2020	% Change
Alabama	37.30	23.08	33.76	23.24	-10%
Alaska	26.61	34.00	38.78	8.62	46%
Arizona	19.87	20.83	112.12	21.14	464%
Arkansas	34.95	39.40	48.31	36.00	38%
California	22.01	34.46	33.26	22.71	51%
Colorado	13.73	22.97	115.56	31.25	742%
Connecticut	60.61	47.17	58.98	18.13	-3%
Delaware	47.90	42.18	38.98	43.27	-19%
District of Columbia	87.29	68.65	49.83	38.58	-43%
Florida	27.93	30.01	70.39	29.32	152%
Georgia	26.69	14.03	19.07	14.64	-29%
Hawaii	23.76	23.39	24.22	25.09	2%
Idaho	24.19	28.34	20.07	17.30	-17%
Illinois	29.01	30.85	31.10	28.35	7%
Indiana	30.01	51.34	31.08	23.49	4%
Iowa	26.39	21.61	24.18	27.44	-8%
Kansas	41.52	34.46	38.54	24.30	-7%
Kentucky	39.45	25.40	29.61	22.18	-25%
Louisiana	45.61	42.56	126.37	41.68	177%
Maine	31.79	30.93	31.53	23.92	-1%
Maryland	32.10	34.64	26.61	20.96	-17%
Massachusetts	36.20	35.68	32.57	36.25	-10%
Michigan	23.31	24.64	29.80	14.26	28%
Minnesota	18.89	26.49	23.35	14.19	24%
Mississippi	63.74	45.38	38.57	26.39	-39%
Missouri	46.23	50.65	82.64	32.90	79%
Montana	25.83	86.88	54.22	52.01	110%
Nebraska	35.41	33.71	31.05	86.97	-12%
Nevada	18.42	25.68	18.42	16.98	0%
New Hampshire	29.31	23.24	20.42	16.83	-30%
New Jersey	49.12	39.17	42.11	28.57	-14%
New Mexico	16.55	28.51	31.97	10.30	93%
New York	49.12	48.40	42.50	21.08	-13%
North Carolina	20.34	24.42	25.30	16.70	24%
North Dakota	76.78	15.84	38.55	54.36	-50%
Ohio	25.08	21.12	28.83	19.46	15%
Oklahoma	39.79	37.69	21.40	19.85	-46%
Oregon	30.38	22.38	25.44	18.20	-16%
Pennsylvania	46.90	38.94	35.75	29.57	-24%
Rhode Island	35.44	46.14	41.43	29.61	17%
South Carolina	22.88	26.60	26.57	14.49	16%

State/Year	Inpatients Patients per 100,000 State Population				2010 to 2018*
	2010	2014	2018	2020	% Change
South Dakota	38.45	12.36	19.16	9.41	-50%
Tennessee	22.08	27.16	27.96	25.72	27%
Texas	24.95	21.21	24.91	16.32	0%
Utah	22.66	19.74	28.85	25.32	27%
Vermont	39.30	24.60	30.82	17.97	-22%
Virginia	32.63	25.34	32.65	30.99	0%
Washington	50.96	26.30	24.99	19.28	-51%
West Virginia	54.68	44.24	45.52	29.70	-17%
Wisconsin	18.43	26.29	24.39	16.66	32%
Wyoming	32.59	32.18	36.69	26.10	13%
Puerto Rico	48.58	54.62	22.89	4.42	-53%
Jurisdictions					
<b>US Total</b>	<b>32.16</b>	<b>31.91</b>	<b>39.46</b>	<b>23.56</b>	23%
<b>Median</b>	<b>31.94</b>	<b>29.26</b>	<b>31.31</b>	<b>23.37</b>	0%
<b>Minimum</b>	<b>13.73</b>	<b>12.36</b>	<b>18.42</b>	<b>4.42</b>	-53%
<b>Maximum</b>	<b>87.29</b>	<b>86.88</b>	<b>126.37</b>	<b>86.97</b>	742%
<b>States</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.



**Table 19: Number of Patients in 24-Hour Residential Treatment Beds on April 30 Each Year, by State, 2010 through 2020**

State/Year	24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Alabama	1,763	1,613	1,070	985	-693	-39%
Alaska	286	534	487	179	201	70%
Arizona	781	1,478	1,468	1,274	687	88%
Arkansas	561	1,249	1,307	963	746	133%
California	3,508	4,824	5,462	4,762	1,954	56%
Colorado	898	1,008	987	338	89	10%
Connecticut	919	1,099	2,898	677	1,979	215%
Delaware	189	124	71	21	-118	-62%
District of Columbia	15	300	12	0	-3	-20%
Florida	4,174	3,988	2,914	1,874	-1,260	-30%
Georgia	1,707	1,197	1,187	806	-520	-30%
Hawaii	123	386	92	111	-31	-25%
Idaho	207	251	107	119	-100	-48%
Illinois	3,275	2,538	1,769	1,188	-1,506	-46%
Indiana	2,026	1,933	1,801	1,375	-225	-11%
Iowa	1,186	1,023	587	626	-599	-51%
Kansas	296	1,635	825	584	529	179%
Kentucky	1,440	1,127	1,371	661	-69	-5%
Louisiana	61	125	265	258	204	334%
Maine	478	564	396	590	-82	-17%
Maryland	1,593	1,831	953	902	-640	-40%
Massachusetts	2,636	2,257	1,888	1,175	-748	-28%
Michigan	1,716	1,444	1,295	598	-421	-25%
Minnesota	1,391	1,201	1,637	1,351	246	18%
Mississippi	925	1,139	1,093	663	168	18%
Missouri	1,722	1,663	1,477	2,365	-245	-14%
Montana	483	787	444	576	-39	-8%
Nebraska	603	570	534	309	-69	-11%
Nevada	116	64	191	42	75	65%
New Hampshire	542	493	324	372	-218	-40%
New Jersey	1,138	1,585	1,172	1,057	34	3%
New Mexico	547	472	286	208	-261	-48%
New York	4,993	6,517	4,032	2,341	-961	-19%
North Carolina	521	1,312	987	595	466	89%
North Dakota	257	187	169	188	-88	-34%
Ohio	2,159	2,384	2,123	1,080	-36	-2%
Oklahoma	530	694	334	300	-196	-37%
Oregon	1,021	1,613	937	734	-84	-8%
Pennsylvania	3,120	2,852	2,517	1,656	-603	-19%

State/Year	24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018*	
	2010	2014	2018	2020	N	% Change
Rhode Island	445	368	304	386	-141	-32%
South Carolina	534	722	510	298	-24	-4%
South Dakota	718	533	372	334	-346	-48%
Tennessee	897	1,649	1,585	242	688	77%
Texas	1,762	2,750	2,281	1,091	519	29%
Utah	1,326	1,112	984	1,587	-342	-26%
Vermont	541	545	306	1,230	-235	-43%
Virginia	1,659	1,327	1,792	376	133	8%
Washington	978	1,272	1,120	1,407	142	15%
West Virginia	406	360	633	647	227	56%
Wisconsin	1,049	1,071	825	1,351	-224	-21%
Wyoming	443	276	254	641	-189	-43%
Puerto Rico	82	803	327	251	245	299%
Jurisdictions	18	NA	NA	NA		
<b>US Total</b>	<b>60,764</b>	<b>68,849</b>	<b>58,762</b>	<b>43,744</b>	<b>-2,002</b>	<b>-3%</b>
<b>Median</b>	<b>897</b>	<b>1,120</b>	<b>969</b>	<b>644</b>	<b>-76</b>	<b>-13%</b>
<b>Minimum</b>	<b>15</b>	<b>64</b>	<b>12</b>	<b>0</b>	<b>-1,506</b>	<b>-62%</b>
<b>Maximum</b>	<b>4,993</b>	<b>6,517</b>	<b>5,462</b>	<b>4,762</b>	<b>1,979</b>	<b>334%</b>
<b>States</b>	<b>53</b>	<b>52</b>	<b>52</b>	<b>51</b>	<b>52</b>	<b>52</b>

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.

**Table 20: 24-Hour Residential Treatment Patients per 100,000 of State Population on April 30 Each Year, by State, 2010 through 2020**

State/Year	24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018*
	2010	2014	2018	2020	% Change
Alabama	36.84	33.36	21.89	20.01	-41%
Alaska	40.05	74.73	66.04	24.48	65%
Arizona	12.18	22.02	20.47	17.17	68%
Arkansas	19.20	42.20	43.37	31.78	126%
California	9.40	12.48	13.81	12.10	47%
Colorado	17.79	18.95	17.33	5.82	-3%
Connecticut	25.70	30.62	81.12	19.03	216%
Delaware	21.00	13.31	7.34	2.13	-65%
District of Columbia	2.48	45.77	1.71	NA	-31%
Florida	22.16	20.12	13.68	8.62	-38%
Georgia	17.58	11.93	11.28	7.53	-36%
Hawaii	9.02	28.13	6.48	7.89	-28%
Idaho	13.18	15.40	6.10	6.51	-54%
Illinois	25.50	19.75	13.88	9.44	-46%
Indiana	31.21	29.32	26.91	20.36	-14%
Iowa	38.88	32.94	18.60	19.79	-52%
Kansas	10.35	56.75	28.34	20.04	174%
Kentucky	33.12	25.65	30.68	14.76	-7%
Louisiana	1.34	2.70	5.69	5.55	324%
Maine	36.01	42.45	29.59	43.70	-18%
Maryland	27.53	30.79	15.77	14.89	-43%
Massachusetts	40.21	33.49	27.35	17.04	-32%
Michigan	17.37	14.58	12.96	6.00	-25%
Minnesota	26.19	22.02	29.17	23.88	11%
Mississippi	31.14	38.23	36.60	22.35	18%
Missouri	28.72	27.51	24.11	38.45	-16%
Montana	48.74	77.18	41.80	53.30	-14%
Nebraska	32.95	30.40	27.68	15.95	-16%
Nevada	4.29	2.26	6.29	1.34	47%
New Hampshire	41.16	37.20	23.89	27.23	-42%
New Jersey	12.93	17.75	13.16	11.90	2%
New Mexico	26.48	22.77	13.65	9.88	-48%
New York	25.74	33.05	20.63	12.11	-20%
North Carolina	5.45	13.34	9.51	5.61	74%
North Dakota	38.10	25.53	22.23	24.57	-42%
Ohio	18.71	20.58	18.16	9.24	-3%
Oklahoma	14.10	17.99	8.47	7.54	-40%
Oregon	26.60	40.66	22.36	17.31	-16%
Pennsylvania	24.53	22.32	19.65	12.95	-20%

State/Year	24-Hour Residential Treatment Patients per 100,000 State Population (on April 30th)				2010 to 2018*
	2010	2014	2018	2020	% Change
Rhode Island	42.28	35.01	28.75	36.51	-32%
South Carolina	11.52	15.07	10.03	5.71	-13%
South Dakota	87.93	62.73	42.17	37.41	-52%
Tennessee	14.11	25.26	23.41	3.51	66%
Texas	6.98	10.25	7.95	3.72	14%
Utah	47.78	37.85	31.13	48.83	-35%
Vermont	86.43	87.06	48.86	197.32	-43%
Virginia	20.68	16.16	21.04	4.38	2%
Washington	14.50	18.15	14.86	18.29	2%
West Virginia	21.89	19.47	35.05	36.25	60%
Wisconsin	18.43	18.61	14.19	23.16	-23%
Wyoming	78.47	47.50	43.96	110.08	-44%
Puerto Rico	2.06	22.33	10.25	7.87	399%
Jurisdictions					
<b>US Total</b>	<b>19.64</b>	<b>21.68</b>	<b>17.96</b>	<b>13.28</b>	<b>-9%</b>
<b>Median</b>	<b>23.34</b>	<b>25.40</b>	<b>20.55</b>	<b>16</b>	<b>-16%</b>
<b>Minimum</b>	<b>1.34</b>	<b>2.26</b>	<b>1.71</b>	<b>1</b>	<b>-65%</b>
<b>Maximum</b>	<b>87.93</b>	<b>87.06</b>	<b>81.12</b>	<b>197</b>	<b>399%</b>
<b>States</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>51</b>	<b>52</b>

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.

**Table 21: Inpatient and 24-Hour Residential Treatment Patients on April 30 Each Year, by State, 2010 through 2020**

State/Year	Inpatient and 24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018	
	2010	2014	2018	2020	N	% Change
Alabama	3,548	2,729	2,720	2,129	-828	-23%
Alaska	476	777	773	242	297	62%
Arizona	2,055	2,876	9,509	2,843	7,454	363%
Arkansas	1,582	2,415	2,763	2,054	1,181	75%
California	11,728	18,142	18,619	13,703	6,891	59%
Colorado	1,591	2,230	7,569	2,153	5,978	376%
Connecticut	3,086	2,792	5,005	1,322	1,919	62%
Delaware	620	517	448	448	-172	-28%
District of Columbia	543	750	362	275	-181	-33%
Florida	9,435	9,938	17,906	8,247	8,471	90%
Georgia	4,299	2,604	3,193	2,374	-1,106	-26%
Hawaii	447	707	436	464	-11	-2%
Idaho	587	713	459	435	-128	-22%
Illinois	7,000	6,503	5,731	4,756	-1,269	-18%
Indiana	3,974	5,318	3,881	2,962	-93	-2%
Iowa	1,991	1,694	1,350	1,494	-641	-32%
Kansas	1,483	2,628	1,947	1,292	464	31%
Kentucky	3,155	2,243	2,694	1,654	-461	-15%
Louisiana	2,134	2,096	6,154	2,194	4,020	188%
Maine	900	975	818	913	-82	-9%
Maryland	3,450	3,891	2,561	2,171	-889	-26%
Massachusetts	5,009	4,662	4,136	3,674	-873	-17%
Michigan	4,018	3,885	4,274	2,019	256	6%
Minnesota	2,394	2,646	2,947	2,154	553	23%
Mississippi	2,818	2,491	2,245	1,446	-573	-20%
Missouri	4,494	4,725	6,540	4,389	2,046	46%
Montana	739	1,673	1,020	1,138	281	38%
Nebraska	1,251	1,202	1,133	1,994	-118	-9%
Nevada	614	790	750	575	136	22%
New Hampshire	928	801	601	602	-327	-35%
New Jersey	5,460	5,082	4,923	3,595	-537	-10%
New Mexico	889	1,063	956	425	67	8%
New York	14,519	16,061	12,338	6,418	-2,181	-15%
North Carolina	2,466	3,714	3,614	2,365	1,148	47%
North Dakota	775	303	462	604	-313	-40%
Ohio	5,053	4,831	5,493	3,355	440	9%
Oklahoma	2,026	2,148	1,178	1,090	-848	-42%
Oregon	2,187	2,501	2,003	1,506	-184	-8%
Pennsylvania	9,085	7,828	7,095	5,436	-1,990	-22%
Rhode Island	818	853	742	699	-76	-9%

State/Year	Inpatient and 24-Hour Residential Treatment Patients (on April 30th)				2010 to 2018	
	2010	2014	2018	2020	N	% Change
South Carolina	1,595	1,996	1,861	1,054	266	17%
South Dakota	1,032	638	541	418	-491	-48%
Tennessee	2,301	3,422	3,478	2,013	1,177	51%
Texas	8,063	8,441	9,432	5,883	1,369	17%
Utah	1,955	1,692	1,896	2,410	-59	-3%
Vermont	787	699	499	1,342	-288	-37%
Virginia	4,277	3,408	4,573	3,038	296	7%
Washington	4,414	3,115	3,003	2,890	-1,411	-32%
West Virginia	1,420	1,178	1,455	1,177	35	2%
Wisconsin	2,098	2,584	2,243	2,323	145	7%
Wyoming	627	463	466	793	-161	-26%
Puerto Rico	2,020	2,767	1,057	392	-963	-48%
Jurisdictions	41	NA	25	24	-16	
<b>US Total</b>	<b>160,257</b>	<b>170,200</b>	<b>187,877</b>	<b>121,366</b>	27,620	17%
<b>Median</b>	<b>2,055</b>	<b>2,496</b>	<b>2,245</b>	<b>1,994</b>	-76	-6%
<b>Minimum</b>	<b>41</b>	<b>303</b>	<b>25</b>	<b>24</b>	-2,181	-48%
<b>Maximum</b>	<b>14,519</b>	<b>18,142</b>	<b>18,619</b>	<b>13,703</b>	8,471	376%
<b>States</b>	<b>53</b>	<b>52</b>	<b>53</b>	<b>53</b>	53	53

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.

**Table 22: Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population on April 30 Each Year, by State, 2010 through 2020**

State/Year	Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population (on April 30 <sup>th</sup> )				2010 to 2018
	2010	2014	2018	2020	% Change
Alabama	74.14	56.45	55.65	43.26	-25%
Alaska	66.65	108.73	104.82	33.10	57%
Arizona	32.04	42.85	132.59	38.31	314%
Arkansas	54.15	81.60	91.68	67.78	69%
California	31.41	46.94	47.07	34.81	50%
Colorado	31.52	41.92	132.89	37.07	322%
Connecticut	86.31	77.79	140.09	37.17	62%
Delaware	68.90	55.49	46.32	45.40	-33%
District of Columbia	89.77	114.41	51.53	38.58	-43%
Florida	50.08	50.13	84.07	37.95	68%
Georgia	44.26	25.96	30.35	22.17	-31%
Hawaii	32.79	51.52	30.69	32.98	-6%
Idaho	37.36	43.74	26.17	23.81	-30%
Illinois	54.51	50.59	44.98	37.78	-17%
Indiana	61.23	80.65	58.00	43.85	-5%
Iowa	65.27	54.55	42.77	47.23	-34%
Kansas	51.87	91.21	66.87	44.34	29%
Kentucky	72.58	51.05	60.29	36.94	-17%
Louisiana	46.95	45.26	132.06	47.23	181%
Maine	67.80	73.38	61.12	67.62	-10%
Maryland	59.63	65.42	42.38	35.85	-29%
Massachusetts	76.41	69.17	59.92	53.30	-22%
Michigan	40.68	39.22	42.76	20.26	5%
Minnesota	45.08	48.51	52.52	38.07	17%
Mississippi	94.88	83.62	75.17	48.74	-21%
Missouri	74.95	78.15	106.75	71.35	42%
Montana	74.57	164.06	96.02	105.31	29%
Nebraska	68.36	64.11	58.73	102.91	-14%
Nevada	22.70	27.94	24.72	18.32	9%
New Hampshire	70.47	60.43	44.31	44.06	-37%
New Jersey	62.05	56.92	55.26	40.47	-11%
New Mexico	43.03	51.28	45.62	20.18	6%
New York	74.86	81.44	63.14	33.19	-16%
North Carolina	25.79	37.75	34.80	22.31	35%
North Dakota	114.88	41.37	60.78	78.92	-47%
Ohio	43.79	41.70	46.99	28.69	7%
Oklahoma	53.88	55.68	29.88	27.38	-45%
Oregon	56.98	63.04	47.80	35.51	-16%
Pennsylvania	71.44	61.25	55.40	42.52	-22%

State/Year	Inpatient and 24-Hour Residential Treatment Patients per 100,000 State Population (on April 30 <sup>th</sup> )				2010 to 2018
	2010	2014	2018	2020	% Change
Rhode Island	77.72	81.15	70.18	66.12	-10%
South Carolina	34.40	41.67	36.60	20.20	6%
South Dakota	126.38	75.09	61.32	46.82	-51%
Tennessee	36.19	52.42	51.37	29.23	42%
Texas	31.93	31.46	32.86	20.04	3%
Utah	70.44	57.60	59.98	74.16	-15%
Vermont	125.74	111.66	79.67	215.29	-37%
Virginia	53.30	41.50	53.69	35.36	1%
Washington	65.46	44.45	39.85	37.56	-39%
West Virginia	76.58	63.71	80.57	65.95	5%
Wisconsin	36.86	44.90	38.58	39.83	5%
Wyoming	111.06	79.69	80.66	136.18	-27%
Puerto Rico	50.64	76.95	33.14	12.29	-35%
Jurisdictions					
<b>US Total</b>	<b>51.81</b>	<b>53.58</b>	<b>57.43</b>	<b>36.84</b>	<b>11%</b>
<b>Median</b>	<b>60.43</b>	<b>56.06</b>	<b>55.33</b>	<b>38</b>	<b>-10%</b>
<b>Minimum</b>	<b>22.70</b>	<b>25.96</b>	<b>24.72</b>	<b>12</b>	<b>-51%</b>
<b>Maximum</b>	<b>126.38</b>	<b>164.06</b>	<b>140.09</b>	<b>215</b>	<b>322%</b>
<b>States</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>	<b>52</b>

Source: Created by NRI using data from N-MHSS 2010, 2014, 2018, and 2020.

\*2020 data excluded from change calculations due to the unreliability of data during the start of the COVID-19 pandemic.



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# TELLING THE STORY

## Data, Dashboards, and the Mental Health Crisis Continuum

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## **Abstract:**

On July 16, 2022, 988, the new easy-to-remember dialing code for the National Suicide Prevention Lifeline will go live, significantly increasing access to and demand for behavioral health crisis services, including crisis hotlines, mobile crisis response, and crisis stabilization units. The federal government recently awarded the SBHAs nearly \$1.5 billion that can be used to expand crisis services through the Mental Health Block Grant and the American Rescue Plan (ARP), plus nearly \$300 million in additional funds for states to transition to 988. With these new funding and programmatic changes, it is critical that SBHAs use a data-driven approach to monitor their crisis continuums to ensure that crisis services are of high quality, are accessible, and that service transitions are seamless so that no one in need falls through the cracks. Based on a review of the literature and a series of interviews with 12 SBHAs, this paper discusses the critical data elements SBHAs collect to monitor the effectiveness of their crisis services continuum, and which data elements are meaningful and realistic for SBHAs to report to the Substance Abuse and Mental Health Services Administration (SAMHSA). This report also discusses how SBHAs present their crisis services data in the forms of reports and data dashboards, and how these reporting mechanisms can be used to inform key stakeholders about crisis service successes, needs, and trends.

## **Highlights:**

- States are expanding their crisis services systems to reduce reliance on law enforcement and the use of emergency departments for individuals in need, and 988 promises to significantly increase the number of persons contacting a behavioral health call center (“Someone to Talk To”), instead of 911 to respond to behavioral health crises. The estimated doubling of demand for hotline services will provide an opportunity to connect individuals needing additional care to other crisis services, “Someone to Respond” and “Some Place to Go.” This increase in service demand also increases the need for SBHAs to closely monitor the effectiveness of their services through the use of data, dashboards, and reports.
- The majority of SBHAs offer crisis services, but are at varying levels of implementation, with some SBHAs offering these services statewide, and others making them available in specific regions of the state. Eighty-eight percent offer 24/7 crisis hotlines, 88% offer mobile crisis response, 65% offer crisis stabilization units (<24 hours), and 83% offer crisis residential services (>24 hours).
- The varying levels of implementation across states, and the decentralized nature of crisis services within states, make it difficult for SBHAs to report standardized outcome measures at the national level.
- Collecting and synthesizing data about the availability and delivery of crisis services can help SBHAs make informed decisions about programmatic changes, find solutions to problems, identify barriers to accessing needed patient care, determine return on investment, and develop efficiencies for providers.
- Lessons learned from SBHAs, non-profits, and similar industries (e.g., EMS and 911) can help identify which data measures are most useful to collect, and how data can be showcased to inform stakeholders.

## **Recommendations:**

1. The increase in accessibility resulting from the launch of 988 will increase demand for supportive services, including mobile crisis and crisis residential services. Expanded access to these services will be critical to support the diversion of callers from law enforcement involvement and emergency department visits. Data can be helpful to SBHAs in determining level of need.
2. To determine which data elements are critical to collect at the state level, and to reduce resistance among providers in data reporting, it is critical that the SBHA bring all stakeholders in on the process up front. Collaboration is a must.
3. As SBHAs are at varying levels of implementation and are using federal funds for a variety of initiatives, qualitative data reporting at the national level may prove to be the most meaningful to show impact.



**O**n July 16, 2022, 988, the new dialing code for the National Suicide Prevention Lifeline (“Lifeline”) will be operational, increasing accessibility to behavioral health crisis services for more than 332 million Americans. It is estimated that the implementation of 988 will double demand for Lifeline services, which in turn will increase demand for ancillary crisis services such as mobile crisis response and crisis stabilization units.<sup>1</sup> Because of this anticipated increase in demand, it is critical that states augment their crisis continuums so that law enforcement does not become or continue to be the default responder to crisis calls that require an in-person response.<sup>2</sup> To meet this anticipated demand, state behavioral health authorities (SBHAs) are leveraging up to \$1.467 billion in new federal funds from the Mental Health Block Grant (MHBG) and the American Rescue Plan (ARP), plus an additional \$282 million to bolster their crisis continuums and transition to 988.<sup>3,4</sup> These significant programmatic and funding changes make it necessary for SBHAs to understand how well their own crisis continuums work and how effective SBHAs are at providing seamless, high-quality crisis care to individuals in need.

The goals of this paper are: 1) to identify which data and outcome measures are most important for SBHAs and other stakeholders to understand to ensure the effectiveness and continuity of behavioral health crisis services, 2) to determine which data and outcome measures SBHAs are feasible and meaningful for all SBHAs to report to the Substance Abuse and Mental Health Services Administration (SAMHSA); and 3) to see how SBHAs analyze and present crisis data in the forms of dashboards and reports to monitor their systems and share important trends with key stakeholders (e.g. policymakers and constituents).

## **Methodology**

An internet search for grey and white literature was conducted between December 2021 and February 2022. The goal of the internet search is to understand the importance of and identify best practices related to data collection, evaluation, and dissemination, specifically within the behavioral health service continuum. To ensure the most relevant and timely information is included, peer-reviewed journal articles and publications from nationally recognized associations published within the last five years are prioritized.

During October and November of 2021, the authors and other colleagues from the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) conducted a series of virtual interviews with representatives from the following twelve SBHAs: Alabama, Alaska, Colorado, Delaware, Georgia, Nebraska, North Carolina, Ohio, Oklahoma, Tennessee, Utah, and Vermont. These states were selected to participate in interviews based on the researchers’ knowledge about their mental health data systems, and/or the presence of a data dashboard on the SBHA’s website (in October 2021, NRI staff reviewed each SBHA’s website to identify those with robust data reporting systems). During these semi-structured interviews, researchers asked SBHA representatives about their use of data dashboards and reports, how the SBHA came to use data dashboards and reports for crisis services, and which data measures are most useful in monitoring the effectiveness and outcomes of crisis services. Interviewees were given the opportunity to review and provide feedback on the notes from their interviews and on a draft of this paper.

\*The \$1.467 billion is inclusive of the five percent MHBG set aside for crisis services (\$42.25 million), as well as the total base allocation of ARP funds (\$1.424 billion) to SBHAs. For FY 2021, SBHAs received an increase of five percent to their MHBG to be used for the development or enhancement of evidence-based crisis care programs for individuals with a serious mental illness, including the development or expansion of mobile crisis response teams and crisis stabilization units. Although SAMHSA did not include specific guidance about the ARP funds and their use on crisis services, SAMHSA did emphasize that states were free to use any or all of the ARP allotment to support the enhancement of crisis services. In addition to these funds that are directly allocated to the SBHAs, in December 2021, HHS announced \$282 million in new funds to SAMHSA to help transition the National Suicide Prevention Lifeline from its current 10-digit number to the three-digit dialing code 988. It is important to note that though the ARP funds are available to be used to enhance crisis services, it is possible that few funds are allocated for this purpose. One state noted that this influx of funds from the federal government may make it appear that the systems are flush with resources to enhance their crisis services system, when the reality is that the SBHA is largely trying to stabilize a fractured service delivery system.



A list of all measures and their definitions can be found in the Appendices: **Appendix A** contains metrics for call centers, **Appendix B** contains metrics for mobile crisis response, and **Appendix C** contains metrics for Crisis Stabilization Units and Residential Facilities.

## Defining the Crisis Continuum

SAMHSA's [National Guidelines for Behavioral Health Crisis Care](#) ("*National Guidelines*") outlines the necessary services and best practices to deliver an effective crisis continuum. According to SAMHSA, a comprehensive crisis service array includes three essential types of services, including centralized crisis lines that assess a caller's needs and dispatch support; mobile crisis teams dispatched as needed in the community; and crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime."<sup>5</sup>

According to NRI's 2021 State Profiles, of the 48 responding SBHAs, 98 percent offer at least one of the crisis services recommended in the *National Guidelines*.<sup>6</sup> Of those, 88 percent fund or operate 24-hour crisis hotline services, 88 percent fund or operate mobile crisis response, 65 percent fund or operate crisis stabilization units (<24-hour facilities), and 83 percent fund or operate crisis residential units (>24-hour facilities).<sup>7</sup> In addition to the SBHA-sponsored crisis services, SAMHSA's Lifeline, administered by Vibrant Emotional Health, is available via phone, chat, or text, 24-hours-a-day, seven-days-a-week in all 50 states and the District of Columbia. The U.S. territories are also working to implement 988 across their jurisdictions; American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands are all leveraging [Cooperative Agreements](#) from SAMHSA to build local 988 capacity. However, the U.S. territories, especially the Pacific Jurisdictions face unique challenges of a small population often spread across multiple islands, and a limited provider workforce, which create obstacles for the provision of mobile crisis response teams and the implementation of crisis stabilization units. Tribal organizations are also working to implement 988. Given their sovereign nature, tribal organizations are required to support their own 988 call centers and crisis continuums. 988 presents an opportunity for state and tribal partners to come together to reduce health disparities for Native Americans. Washington State is one example where this is being put into action. Currently, Lifeline calls are routed to call centers based on area code. In Washington State, callers are given the option to press a button to be immediately directed to the 988 tribal behavioral health and suicide prevention hotline.<sup>7</sup>

The Lifeline has operated as an 800 number (1-800-273-TALK) that individuals can call to receive "free and confidential support" when experiencing "suicidal crisis or emotional distress."<sup>8</sup> As of July 16, 2022, callers are also able to access the Lifeline by dialing 988, a simple, easy-to-remember, three-digit-code. In addition to a more accessible number, the focus of the Lifeline is expected to broaden to become a resource for all behavioral health crises, not just those that involve suicidal ideation. The easy-to-remember number combined with the expanded Lifeline focus are expected to significantly increase demand for Lifeline calls, which will require an increase in capacity at the Lifeline call centers across the U.S., as well as increased coordination between Lifeline call centers and the SBHA-supported crisis services that respond to the needs of callers that cannot be resolved over the phone.<sup>9</sup>

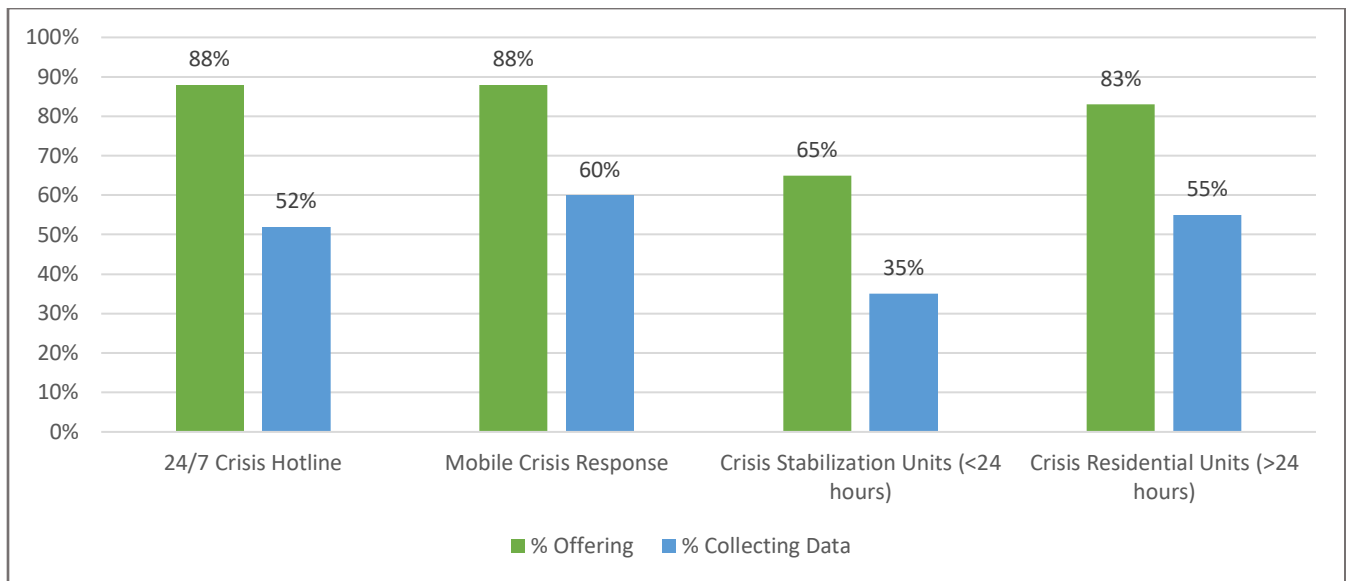
To ensure that these services work together in a continuum, and that individuals in need of care do not "fall through the cracks," especially as more individuals begin to engage with the behavioral health system through 988, it is critical that SBHAs work with Lifeline call centers and their crisis providers to collect data, monitor outcomes, and implement continuous quality improvement plans.

## Collecting Data Across the Crisis Continuum

Data from the 2021 State Profiles indicate that the majority of SBHAs collect at least some data about their crisis continuums. Slightly more than half of SBHAs with crisis hotlines, mobile crisis teams, and crisis residential facilities (>24 hour) collect data about their operations; and just more than one-third of SBHAs with crisis stabilization units (<24 hour) collect data about their operations (Figure 1).<sup>10</sup> Compared to the number of SBHAs

that operate and/or fund these services, there is still significant room for states to enhance their data collection activities around crisis services.

Figure 1: Percentage of SBHAs Offering Specific Services and Collecting Data about those Crisis Services (n=48), 2021<sup>6</sup>



### Metrics for Behavioral Health Crisis Hotlines

This section explores the types of measures recommended by industry leaders and accrediting bodies, as well as the key performance indicators collected and recommended by SBHAs for each service along the crisis continuum, including crisis hotlines, mobile crisis, crisis stabilization units, and crisis residential facilities, and measures that monitor transitions between each service to ensure that individuals in need are not overlooked or neglected.

Behavioral health crisis hotlines are an important component of the crisis continuum because they are and will increasingly be the point-of-entry for many individuals with a pressing need for behavioral health care. In the current landscape, a multitude of behavioral health crisis hotlines are often available to individuals in need, including centralized and regional hotlines supported by SBHAs, local crisis numbers made available by providers that offer telephonic crisis services after regular working hours, and Lifeline services through the current 800 number, and soon to be 988 when it rolls out in July 2022. Some states have decades of state support for non-Lifeline local call centers that are much more heavily used when compared to Lifeline call centers. For example, the Georgia Crisis Access Line receives 14 times more calls per year than the Lifeline call centers operated in the state; and Arizona’s local call centers receive 10 times more calls than Lifeline call centers. Often these well-established call centers are integrated into their larger crisis continuums and are able to more easily refer callers to Mobile Crisis Response and Crisis Stabilization Units. Data about the quality, availability, and demand for these crisis hotline services are critical to understanding the overall need for crisis services along the continuum. Because multiple

*To understand their influence on the crisis continuum, it is critical to collect data about the use and effectiveness of all three types of crisis call systems:*

- *State & Regional Crisis Hotlines*
- *Local Provider Crisis Numbers*
- *National Suicide Prevention Lifeline, including 988*

service systems are available for behavioral health crisis hotlines, it is critical to collect data about all three types of crisis call systems (Text Box) to understand their influence on the crisis continuum, especially as states will continue to operate their own local crisis numbers after 988 goes live, and many existing non-Lifeline call

centers will continue outside of 988 and will still receive calls from individuals experiencing a crisis. Recommendations from the National Suicide Prevention Lifeline and Crisis Now, measures collected by accrediting bodies and industries with similar hotlines, and the experience of SBHAs provide insight into which measures provide the most meaningful insight into the operations of these crisis hotline systems.

*National Suicide Prevention Lifeline Crisis Call Center Metrics*

In 2019, the National Suicide Prevention Lifeline published the guide, [Crisis Call Center Metrics](#), to help the behavioral health crisis hotline industry standardize data definitions to facilitate data sharing and improve service quality.<sup>11</sup> The recommendations contained in the guide were developed by a workgroup consisting of Lifeline crisis center directors and other experts in the behavioral health field. The guide is intended to “be used as a point of reference in the establishment of realistic performance measures” for behavioral health crisis call centers.<sup>12</sup>

The *Crisis Call Center Metrics* guide (*Guide*) divides measures into three categories: 1) Service Measures, which measure the accessibility and speed of service; 2) Efficiency Measures, which measure contact handling, resource utilization, and cost efficiency; and 3) Quality Measures, which measure the demeanor, acumen, and adherence to protocol by call takers. Many measures identified in the Guide rely on reports from an Automatic Call Distribution (ACD) system, which “distribute[s] incoming calls based on pre-defined rules.” ACDs are able to queue and route calls; offer auto-attendant services; create data reports; supervise calls for quality assurance; route emails, texts, chats, and videos; and offer voice-over internet protocol, allowing call takers to respond to the calls remotely.<sup>13</sup> The *Guide* acknowledges that only 55 percent of Lifeline call centers use an ACD, and this is likely attributed to the varying size of crisis call centers across the U.S., with the smaller centers not requiring an ACD to manage their smaller call volumes.<sup>14</sup> The *Guide* recommends behavioral health crisis call centers collect the metrics identified in **Table 1** below.

*Table 1: Measures Recommended by the Call Center Metrics Guide<sup>15</sup>*

Service Measures	Efficiency Measures	Quality Measures
<p><b>Accessibility</b></p> <ul style="list-style-type: none"> <li>• <b>Blockage:</b> % of callers unable to access call center due to an insufficient number of phone lines. Callers receive busy signal</li> <li>• <b>Hours of Operation:</b> Time of day call center can receive crisis calls.</li> <li>• <b>Self-Service Availability:</b> Pre-recorded menu that greeting that provides information to callers without involvement of crisis counselor.</li> <li>• <b>Call Abandonment Rate:</b> % of calls that disconnect after 30 seconds or two rings.</li> </ul>	<p><b>Contact Handling</b></p> <ul style="list-style-type: none"> <li>• <b>Average Handle Time:</b> Total talk time plus total after-call work time, divided by number of calls.</li> <li>• <b>After Call Work Time:</b> Total time it takes counselor to complete all tasks associated with one call.</li> <li>• <b>On-Hold Time:</b> Amount of time callers spend on hold.</li> </ul>	<p><b>Call-Handling Process</b></p> <ul style="list-style-type: none"> <li>• <b>Telephone Etiquette:</b> How a crisis counselor interacts with an individual (manners).</li> <li>• <b>Knowledge/Competency:</b> How adept a counselor is at providing services.</li> <li>• <b>Error/Rework Rate:</b> How frequently errors need to be corrected and work needs to be redone.</li> <li>• <b>Adherence to Protocol:</b> How well a crisis counselor follows standard procedures.</li> </ul>
<p><b>Speed of Service</b></p> <ul style="list-style-type: none"> <li>• <b>Service Level:</b> % of calls answered within a certain amount of time.</li> <li>• <b>Average Speed of Answer:</b> Total waiting time for answered calls divided by the number of total answered calls.</li> <li>• <b>Longest Delay in Queue:</b> Longest period of time that a caller waits to connect with a crisis counselor</li> </ul>	<p><b>Resource Utilization</b></p> <ul style="list-style-type: none"> <li>• <b>Staff Occupancy:</b> Time crisis counselors spend handling calls compared to time waiting for calls.</li> <li>• <b>Staff Shrinkage:</b> % of paid time crisis counselors are unavailable to answer calls.</li> <li>• <b>Schedule Efficiency:</b> Amount of overstaffing and understaffing that exists as a result of scheduling design.</li> <li>• <b>Schedule Adherence:</b> How much time a counselor is actively working compared to their paid time.</li> </ul>	<p><b>Resolution</b></p> <ul style="list-style-type: none"> <li>• <b>First-Call Resolution Rate:</b> Number of calls resolved during initial interaction.</li> <li>• <b>Transfer Rate:</b> % of calls that counselors transfer to another counselor within the call center, or to another entity.</li> </ul>

- **Availability:** How often counselors are available to take calls and how long it takes to resolve calls.
- **Cost Efficiency:** Uses cost per call measure to determine how efficiently resources are being used.
- **Cost Per Call:** May be calculated as strictly labor cost, or a cost that includes all overhead.

### *Metrics Collected by the Crisis Now Scoring Tool for Call Center Hubs*

Crisis Now, a collaboration between The National Association of State Mental Health Program Directors (NASMHPD), The National Action Alliance for Suicide Prevention, The National Suicide Prevention Lifeline, the National Council for Mental Wellbeing, and RI International, an organization that designs and delivers behavioral health crisis services offers a [Scoring Tool](#) that behavioral health call centers can use to see how well they are doing at meeting the criteria of Crisis Now model, recommended by SAMHSA in the *National Guidelines*. The Scoring Tool provides a series of metrics and criteria along a continuum that allows call centers to rate themselves and assign themselves a score based on the measures included in the tool. Scores help call centers determine how well integrated they are in the overall crisis continuum, as well as within the behavioral health system in the region, with level 1 being minimal integration, and level 5 being fully integrated where crisis services are “equal partners with first responders.”<sup>16</sup> The more integrated a crisis call center is with the overall crisis continuum and behavioral health system, the better able it is to ensure care coordination and seamless transitions of care.<sup>5</sup> Measures included in the Crisis Now Scoring Tool for call centers are provided in **Table 2**.<sup>17</sup>

*Table 2: Metrics Included in the Crisis Now Scoring Tool for Call Centers<sup>18</sup>*

<b>Crisis Now Scoring Tool (Call Center Hub)</b>				
<b>Level 1 (Minimal)</b>	<b>Level 2 (Basic)</b>	<b>Level 3 (Progressing)</b>	<b>Level 4 (Close)</b>	<b>Level 5 (Full)</b>
<input type="checkbox"/> Call Center Exists	<input type="checkbox"/> Meets Level 1 Criteria	<input type="checkbox"/> Meets Level 2 Criteria	<input type="checkbox"/> Meets Level 3 Criteria	<input type="checkbox"/> Meets Level 4 Criteria
<input type="checkbox"/> 24/7 Call Center in Place to Receive Behavioral Health Crisis Calls	<input type="checkbox"/> Locally Operated 24/7 Call Center in Place to Receive Calls	<input type="checkbox"/> Hub for Effective Deployment of Mobile Teams	<input type="checkbox"/> Formal Data Sharing in Place Between Crisis Providers	<input type="checkbox"/> Integrated Data that Offers Real-Time Air Traffic Control Functioning
<input type="checkbox"/> Answer Calls within 30 Seconds	<input type="checkbox"/> Answer Calls within 25 Seconds	<input type="checkbox"/> Answer Calls within 20 Seconds	<input type="checkbox"/> Answer Calls within 15 Seconds	<input type="checkbox"/> GPS-Enabled Mobile Team Dispatch by Crisis Line
<input type="checkbox"/> Cold Referral to Community Resources or Better Connection to Care	<input type="checkbox"/> Warm Hand-off to Behavioral Health Crisis Providers	<input type="checkbox"/> Directly Connects to Facility-based Crisis Providers	<input type="checkbox"/> Coordinates Access to Available Crisis Beds	<input type="checkbox"/> Shared Bed Inventory and Connection to Available Crisis and Acute Beds
<input type="checkbox"/> Meets Lifeline Standards and Participates in National Network	<input type="checkbox"/> Staff Trained in Zero Suicide/Suicide Safer Care and Behavioral Health Services <input type="checkbox"/> Call Abandonment Rate Under 20% <input type="checkbox"/> Shared MOUs/Protocols with Crisis Providers <input type="checkbox"/> Priority Focus on Safety/Security	<input type="checkbox"/> URAC Call Center or Similar Accreditation <input type="checkbox"/> Call Abandonment Rate Under 15% <input type="checkbox"/> Some Call Center Access to Person-Specific Health Data <input type="checkbox"/> Some Peer Staffing within Call Center	<input type="checkbox"/> Single Point of Crisis Contact for the Region <input type="checkbox"/> Call Abandonment Rate Under 10% <input type="checkbox"/> Some Access to Person-Specific Data for All Crisis Providers <input type="checkbox"/> Shares Documentation of Crisis with Providers	<input type="checkbox"/> 24/7 Outpatient Scheduling with Same-Day Appointment Availability <input type="checkbox"/> Call Abandonment Rate Under 5% <input type="checkbox"/> Real-Time Performance Outcomes Dashboard throughout the Crisis System

Crisis Now Scoring Tool (Call Center Hub)				
Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
			<input type="checkbox"/> Peer Option Made Available to All Callers Based on Need <input type="checkbox"/> Systematic Suicide Screening and Safety Planning	<input type="checkbox"/> Shared Status Disposition of Intensive Referrals <input type="checkbox"/> Trauma-Informed Recovery Model Applied <input type="checkbox"/> Suicide Care Best Practices that Include Follow-up Support <input type="checkbox"/> Full Implementation of all Four Crisis Now Modern Principles (Required)

### *Metrics Collected by Related Accrediting Bodies and Industries*

In addition to the metrics identified in *Crisis Call Center Metrics* and recommended by Crisis Now, measures used by related industries that maintain 24/7 hotlines (e.g., poison control and 911) and relevant accrediting bodies for health care call centers can provide insight into important indicators for behavioral health crisis call centers. The following organizations recommend call center metrics that may be helpful when determining which data points to collect for behavioral health crisis hotlines:

- The [National Emergency Number Association \(NENA\)](#) “works with 911 professionals nationwide, public policy leaders, emergency services and telecommunications industry partners, like-minded public safety associations, and other stakeholder groups to develop and carry out critical programs and initiatives, to facilitate the creation of an IP-based Next Generation 911 system, and to establish industry-leading standards, training, and certifications.”<sup>19</sup>
- The [American Association of Poison Control Centers \(AAPCC\)](#) “supports the nation’s 55 poison centers in their efforts to prevent and treat poison exposures.” These call centers “offer free, confidential, expert medical advice, 24-hours-a-day, seven-days-a-week” through a helpline and online chat.<sup>20</sup>
- The [Utilization Review Accreditation Commission \(URAC\)](#) is a non-profit that promotes improvement in healthcare through accreditation, education, and measurement. The URAC sets minimum key performance indicator targets for accreditation.<sup>21</sup>
- The [Alliance of Information and Referral Systems \(AIRS\)](#) is the professional association for community Information and Referral and Information and Referral/Assistance providers. AIRS sets standards, accredits, and certifies in the community information and referral sector.<sup>22</sup>
- The [Commission on Accreditation of Rehabilitation Facilities \(CARF\)](#) “assists health and human services providers in improving the quality of their services, demonstrating value, and meeting internationally recognized organizational and program standards.”<sup>23</sup>

Crisis hotline measures identified most frequently by the accrediting bodies, related industries, and the Lifeline (NSPL) as being useful include:

- Speed of Answer: NSPL, AAPCC, URAC, AIRS, NENA
- Abandonment Rate: NSPL, AAPCC, URAC, AIRS
- Blockage: NSPL, URAC
- Hours of Operation: NSPL, CARF
- Average Talk/Handle Time: NSPL, AIRS
- Staff Occupancy: NSPL, AIRS

*Metrics Collected by State Behavioral Health Authorities for Behavioral Health Crisis Hotlines*

Each of the 12 SBHAs interviewed for this report collect data related to their behavioral health crisis hotlines. During the interviews, SBHA staff were asked about the measures they collect, and which measures they find most useful in understanding how well their crisis hotline is performing. (Note: because this information was gathered during the interview, it is possible that interviewed SBHAs may collect additional measures related to their crisis hotlines not identified during the interviews.) Measures collected by the 12 SBHAs noted in the interviews, and identified as being most important by at least one SBHA, include (in alphabetical order):

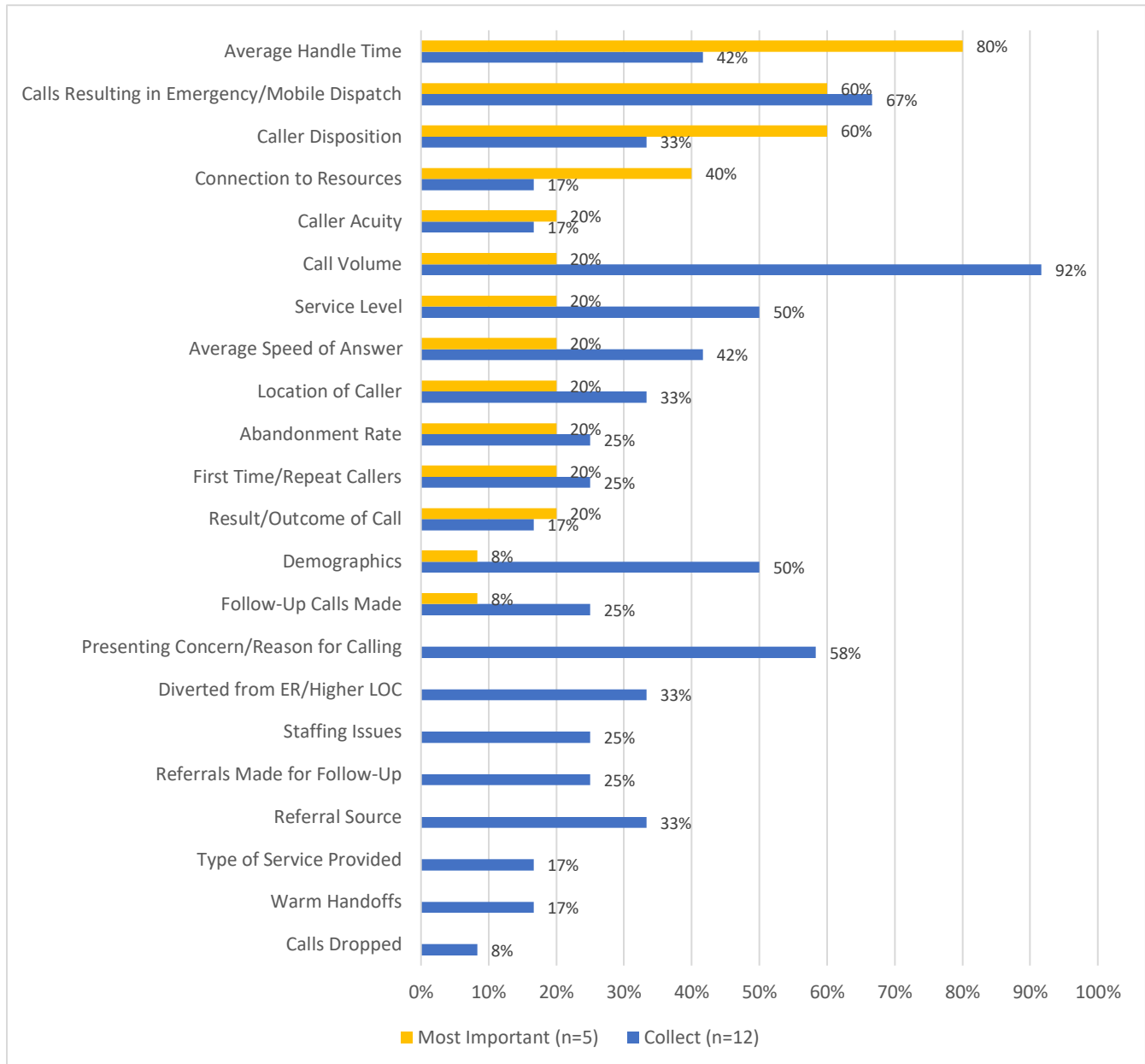
- Abandonment Rate
- Answer Rates
- Average Handle Time
- Average Speed of Answer
- Caller Acuity
- Caller Disposition
- Call Volume
- Connection to Resources
- Demographic Information
- First Time/Repeat Callers
- Location of Caller
- Number of Calls Resulting in Emergency/Mobile Dispatch, Active Rescues
- Number of Follow-Up Calls Made (including chats and texts)
- Result/Outcome of Call
- Service Level

Other measures collected by SBHAs, but not identified as most important, include:

- Reason for Calling/Presenting Concern
- Calls Diverted from ER/Higher Level of Care
- Call Source/Referral Source
- Number of Referrals Made for Follow-Up
- Staffing Issues
- Percentage of Calls Dropped
- Number of Warm Handoffs Made/Declined
- Type of Service Provided

**Figure 2** provides a breakdown of the percentage of SBHAs interviewed collecting or planning to collect<sup>†</sup> each measure (n=12), and the percentage of these SBHAs that identify each measure as most important (n=5).

*Figure 2: Measures Collected by SBHAs and those Identified as Most Important by SBHAs Interviewed for this Report*



Metrics for behavioral health call centers identified in *Crisis Call Center Metrics*, *Crisis Now*, and by the accrediting bodies listed above are included in the table in [Appendix A](#). The table provides definitions and considerations for each measure, and highlights which of the 12 SBHAs interviewed for this report are collecting the measures, and which of these SBHAs indicated the measure to be most important.

### *Collecting Demographic Information of Callers to Behavioral Health Crisis Hotlines*

While half of the SBHAs interviewed for this report collecting demographic information during crisis calls, and one SBHA identifies it as one of the most important metrics, collecting demographic information during crisis

<sup>†</sup> Alaska is planning to collect service level and average speed of answer but has not yet implemented a data collection process for these measures.

calls is extremely challenging. Many callers to a crisis hotline prefer to remain anonymous, and most SBHAs interviewed for this report indicate that they are successful at obtaining demographic information only approximately half the time.

Colorado's Crisis Service System receives many inquiries about who uses the crisis hotline from the state legislature, as this information is especially useful with the "alarming increase" in suicide attempts and completions by youth and young adults during the pandemic (Lee, M., Personal Communication, November 16, 2022). However, as noted callers often prefer to remain anonymous. If callers do give information, it is most likely that they provide date of birth and name, but not much beyond that. The state estimates that they receive more thorough demographic information 35 to 50 percent of the time (Lee, M., Personal Communication, November 16, 2021). The crisis line is able to cross reference with previous callers see if they have had prior contact with the crisis line and can retroactively fill in demographic information.

Georgia is also able to crosswalk caller data with information provided on prior calls. The call center is also able, in real time, to gather information through a reverse look up with its Medicaid records or prior call records if it is determined that mobile crisis needs to be dispatched or an active rescue needs to occur. Georgia's DBHDD provides training information to crisis counselors on how to collect demographic information. They train crisis counselors to mingle questions about demographic information throughout the natural conversation. However, for urgent calls, demographic information is less likely to be collected.

Delaware's crisis hotline attempts to collect demographic information but finds it extremely challenging to compassionately collect these data during an active crisis. The SBHA indicates that it "is impossible to ask about race;" however, crisis call operators are usually able to determine where a caller is calling from during the course of the crisis call, which can provide valuable information about a client's cultural and linguistic needs, especially in a small state like Delaware. The SBHA notes that it is important to collect demographic information to determine if a lack of cultural and linguistic competence is a factor in dropped calls. (Wang, C., Personal Communication, November 10, 2021).

The SBHAs in Oklahoma, Tennessee, and Vermont indicate that they do not yet collect demographic data during crisis calls but are working to integrate this measure as 988 becomes a reality.

#### *Limitations for Data Collection and Monitoring for Behavioral Health Crisis Hotlines*

There are several important limitations to consider when establishing a data collection and monitoring system that are applicable to all types of behavioral health crisis call centers. Crisis call centers are complex and dynamic; therefore, no standard operating procedure applies universally to, or is appropriate for all behavioral health crisis call centers. The authors of *Crisis Call Center Metrics* note that, "crisis hotlines... experience significant variability in terms of call volume, caller needs, and potential interventions, making staffing (and therefore cost) projections challenging."<sup>24</sup> Variability in caller needs and interventions can range from the need for basic information and referrals, to crisis counseling, to conducting an active rescue to help an individual at imminent risk of harm to self or others. More acute calls may require multiple staff members to provide a variety of services simultaneously, (e.g., crisis counseling, coordinating emergency services, and conducting follow-up) which can impact the call center's capacity to respond to additional incoming calls, thereby affecting their service metrics. The availability of resources also affects the accessibility of a call center, and there is no industry standard for what is considered an excessively long wait for service. While many SBHAs and call center managers set desirable metrics for answer time (e.g., answer calls within 30 seconds), the needs of the callers, costs of the crisis center, and funding resources significantly influence the attainability of these goals.<sup>25</sup>



## Metrics for Mobile Crisis Response

Mobile Crisis Response is a critical component of a state’s behavioral health crisis continuum. While it is estimated that 80 percent of crisis calls can be resolved over the phone, the remaining 20 percent of callers require additional level of care. Mobile Crisis Teams provide this higher level of care in the community, reducing the reliance on and involvement of law enforcement, and divert many individuals experiencing a crisis away from emergency rooms, jails, or inpatient hospitalization. Coordination between crisis call centers, law enforcement, crisis stabilization units, and community providers is critical to ensuring seamless transitions between services, so that no individual is denied the care they need. Mobile Crisis Response measures recommended by Crisis Now and industries with similar services, as well as the experience of SBHAs provide insight into which measures provide the most meaningful insight into the operations of Mobile Crisis Teams within the larger crisis continuum. *(Note that some states and localities offer mobile crisis response specifically for children, and that these services may necessitate collecting different metrics to monitor outcomes; for the purposes of this report, only metrics for adult services are included.)*

### *Metrics Collected by the Crisis Now Scoring Tool for Mobile Outreach*

Similar to its metrics for Crisis Hubs, Crisis Now makes available a [Scoring Tool](#) that Mobile Outreach teams can use to see how well they are doing at meeting the criteria of Crisis Now model, recommended by SAMHSA in the *National Guidelines*. The Scoring Tool provides a series of metrics and criteria along a continuum that Mobile Outreach Teams to rate themselves and assign themselves a score based on the measures included in the tool. Scores help Mobile Outreach Teams objectively understand how well integrated they are in the overall crisis continuum, as well as within the behavioral health system in the region, with level 1 being minimal integration, and level 5 being fully integrated where crisis services are “equal partners with first responders.”<sup>26</sup> The more integrated Mobile Outreach Team is with the overall crisis continuum and behavioral health system, the better able it is to ensure care coordination and seamless transitions of care.<sup>27</sup> Measures included in the Crisis Now Scoring Tool for Mobile Outreach Teams are provided in **Table 3**.<sup>28</sup>

*Table 3: Metrics Included in the Crisis Now Scoring Tool for Mobile Outreach<sup>29</sup>*

Crisis Now Scoring Tool (Mobile Outreach)				
Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
<input type="checkbox"/> Mobile Teams are in Place for Part of the Region	<input type="checkbox"/> Meets Level 1 Criteria	<input type="checkbox"/> Meets Level 2 Criteria	<input type="checkbox"/> Meets Level 3 Criteria	<input type="checkbox"/> Meets Level 4 Criteria
<input type="checkbox"/> Mobile Teams are Operating at Least 8 Hours per Day in at Least Part of the Region	<input type="checkbox"/> Mobile Teams are Available Throughout the Region at Least 8 Hours per Day	<input type="checkbox"/> Mobile Teams are Available Throughout the Region at Least 16 Hours per Day	<input type="checkbox"/> Formal Data Sharing in Place Between Mobile Teams and All Crisis Providers	<input type="checkbox"/> Real-Time Performance Outcome Dashboards Throughout Crisis System
<input type="checkbox"/> Mobile Teams Respond to Calls within 2 Hours Where in Operation	<input type="checkbox"/> Mobile Teams Respond to Calls within 2 Hours Throughout the Region	<input type="checkbox"/> Mobile Teams Respond to Calls within 1.5 Hours Throughout the Region	<input type="checkbox"/> Mobile Teams Respond to Calls within 1 Hour Throughout the Region	<input type="checkbox"/> GPS-Enabled Mobile Team Dispatch by Crisis Line
<input type="checkbox"/> Mobile Teams Complete Community-Based Assessments	<input type="checkbox"/> Mobile Team Assessments include All Essential Crisis Now Defined Elements	<input type="checkbox"/> Directly Connect to Facility-Based Crisis Providers as Needed	<input type="checkbox"/> Support Diversion Through Services to Resolve Crisis with Rate Over 60%	<input type="checkbox"/> Support Diversion Through Services to Resolve Crisis with Rate Over 75%
<input type="checkbox"/> Mobile Teams Connect to Additional Crisis Services as Needed	<input type="checkbox"/> Staff Trained in Zero Suicide/Suicide Safer Care and Behavioral Health Services	<input type="checkbox"/> Some Mobile Team Access to Person-Specific Health Data	<input type="checkbox"/> Mobile Teams Receive Electronic Access to Some Health Information	<input type="checkbox"/> All Mobile Teams Include Peers

Crisis Now Scoring Tool (Mobile Outreach)				
Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
	<input type="checkbox"/> Shared MOUs/ Protocols with Call Center Hub <input type="checkbox"/> Priority Focus on Safety/Security	<input type="checkbox"/> Shared MOUs/ Protocols with Call Center and Crisis Facility-Based Providers <input type="checkbox"/> Trauma-Informed Recovery Model Applied	<input type="checkbox"/> Shares Documentation of Crisis with Providers <input type="checkbox"/> Some Peer Staffing within Mobile Teams <input type="checkbox"/> Systematic Suicide Screening and Safety Planning	<input type="checkbox"/> Shared Status Disposition of Intensive Referrals <input type="checkbox"/> Meets Person Wherever they are – Home, Park, Street, Shelter, etc. <input type="checkbox"/> Real-Time Access to Electronic Health Records <input type="checkbox"/> Suicide Care Best Practices that Include Follow-up Support <input type="checkbox"/> Full Implementation of all Four Crisis Now Modern Principles (Required)

### *Metrics Collected by Related Industries*

In addition to the key performance indicators identified by Crisis Now, measures used by related industries that dispatch clinical teams can provide insight into important indicators for behavioral health Mobile Crisis Teams. Metrics used by Emergency Medical Services' (EMS) teams can be especially helpful for Mobile Crisis Teams. The National EMS Advisory Council and the National EMS Information System (NEMSIS) are two organizations that make recommendations for quality improvement for EMS teams for the information system:

- [National Emergency Medical Services \(EMS\) Advisory Council \(NEMSAC\)](#) was established by Congress in 2007 and is a “nationally recognized council of EMS representatives and consumers [that] provides advice and recommendations regarding EMS to NHTSA (the National Highway Traffic Safety Administration) in the Department of Transportation and to the members of the Federal Interagency Committee on EMS. [It] provides a forum for the development, consideration, and communication of information from a knowledgeable and independent perspective.”<sup>30</sup>
- [National EMS Information System \(NEMSIS\)](#) “is the national database that is used to store EMS data from the United States and territories. NEMSIS is a universal standard for how patient care information resulting from an emergency 911 call for assistance is collected.”<sup>31</sup> NEMSIS recommends EMS teams to collect the following measures that are relevant to Mobile Crisis Teams:<sup>32</sup>
  - Demographics, including County, State, Zip Code, Gender, Race, and Age
  - Type of Service Requested/Type of Service Provided/Type of Service Denied
  - Type of Delays:
    - Dispatch delays are any time delays that occur from the referring public safety entity to the time EMS receives notification to dispatch.
    - Response delays are any time delays that occur from when the unit is notified to dispatch to the time the unit arrives on scene. May include poor directions/unable to locate, excessive distance, route obstruction (e.g., train or construction), vehicle failure, weather, etc.
    - Scene delays occur from the time the EMS unit arrives on scene to the time the unit leaves the scene. Scene delays may be caused by crowds, language barriers, weather, etc.
    - Turn-around delays are the amount of time it takes to resolve on scene to when the EMS team can go back into service.

- Insurance Status/Primary Method of Payment
- Service Location
- Primary Concern/Reason for Calling
- Secondary Concerns
- Length of Field Assessment
- Initial Patient Acuity/Final Patient Acuity
- Barriers to Patient Care. May include cultural, custom, religious barriers; language barriers; physical barriers; uncooperative patient; suspected drug or alcohol use; etc.
- Medication Administered, including Narcan for suspected opioid overdoses
- Patient Disposition
- Destination After EMS Intervention
- Reason for Choosing Destination
- Level of Service

*Metrics Collected by State Behavioral Health Authorities for Mobile Crisis Response*

Of the 12 SBHAs interviewed for this report, 10 have mobile crisis teams available statewide, and each monitors data about the operation of these teams. Alabama has mobile crisis teams available in a few regions of the state and does not collect data about these teams. Alaska’s SBHA does not offer mobile crisis services due to the remote nature of the state but is exploring how to implement these services in urban areas.

During the interviews, SBHA staff were asked about the measures they collect, and which measures they find most useful in understanding how well their mobile crisis teams are performing. (Note: because this information was gathered during the interview, it is possible that SBHAs collect additional measures related to their mobile crisis teams; Oklahoma did not provide details about the metrics it collects). Four SBHAs provided feedback on which metrics they identify as most important. Measures collected by the nine SBHAs that provided details, and identified as being most important by at least one SBHA, include (in alphabetical order):

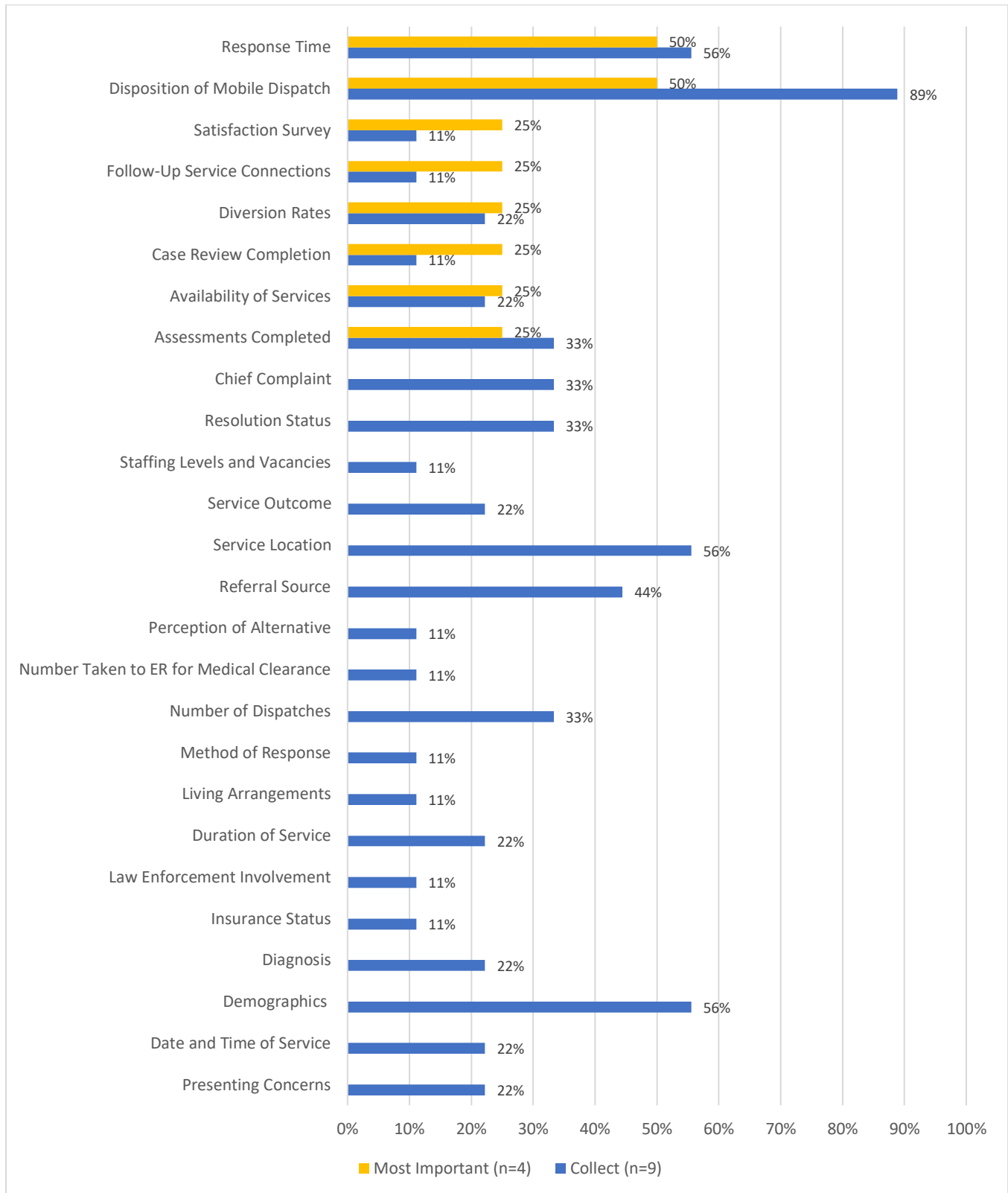
- |   |  |
|---|--|
| • Assessments Completed                 | • Diversion Rates (from jails, EDs, inpatient) |
| • Availability of Services              | • Follow-Up Service Connections                |
| • Case Review Completion within 30 Days | • Response Time                                |
| • Disposition of Mobile Dispatch        | • Satisfaction Survey                          |

Other measures collected by SBHAs, but not identified as most important, include:

- |                               |                                 |
|-------------------------------|---------------------------------|
| • Date and Time of Service    | • Method of Response            |
| • Demographics                | • Number of Dispatches          |
| • Diagnosis                   | • Presenting Concerns           |
| • Duration of Service         | • Service Location              |
| • Insurance Status            | • Service Outcome               |
| • Law Enforcement Involvement | • Staffing Levels and Vacancies |
| • Living Arrangements         |                                 |

**Figure 3** on the following page provides a breakdown of the percentage of interviewed SBHAs collecting each measure (n=10), and the percentage of interviewed SBHAs that identify each measure as most important (n=4).

Figure 3: Measures Collected and Identified as Most Important by the Interviewed SBHAs for Mobile Crisis Response



Metrics for mobile crisis response identified by Crisis Now, NEMIS, and the SBHAs are included in the table in [Appendix B](#). The table provides definitions and considerations for each measure, and highlights which of the 12

SBHAs interviewed for this report are collecting the measures, and which SBHAs indicate the measure to be most important.

## Metrics for Crisis Stabilization Units (<24 hours) and Crisis Residential Facilities (>24 hours)

Crisis stabilization units and crisis residential facilities provide short-and-medium-term services to individuals experiencing a behavioral health crisis. Crisis stabilization units provide short-term (less-than-24-hours) services in a home-like, non-hospital environment.<sup>3</sup> Crisis residential facilities provide greater-than-24-hour care, with services usually available to individuals for up to three to five days and offer care more similar to inpatient services. Of the SBHAs interviewed for this report, all but one offer both types of services. The services are similar in nature, with individuals being admitted and discharged from a unit, so many of the measures SBHAs use to evaluate these services are the same. Measures recommended by Crisis Now for sub-acute stabilization facilities, as well as the experience of SBHAs provide insight into which measures provide the most meaningful insight into the operations of crisis stabilization units and crisis residential facilities within the larger crisis continuum.

### *Metrics Collected by Crisis Now Scoring Tool for Sub-Acute Stabilization (<24 hours)*

The [Crisis Now Scoring Tool](#) also contains a section for sub-acute stabilization services, or crisis stabilization programs that provide less-than-24-hour-care. The Crisis Now model does not include crisis residential facilities that provide greater-than-24-hour-care; therefore, Crisis Now does not recommend metrics to analyze these services. The Scoring Tool provides a series of metrics and criteria along a continuum that sub-acute stabilization units can use to rate themselves and assign themselves a score based on the measures included in the tool. Scores help these facilities objectively understand how well integrated they are in the overall crisis continuum, as well as within the behavioral health system in the region, with level 1 being minimal integration, and level 5 being fully integrated where crisis services are “equal partners with first responders.”<sup>33</sup> The more integrated sub-acute facilities are with the overall crisis continuum and behavioral health system, the better able they are to ensure care coordination and seamless transitions of care.<sup>34</sup> Measures included in the Crisis Now Scoring Tool for sub-acute stabilization facilities are provided in **Table 4**.<sup>35</sup>

Table 4: Metrics Included in the Crisis Now Scoring Tool for Sub-Acute Stabilization Units<sup>36</sup>

Crisis Now Scoring Tool (Sub-Acute Stabilization)				
Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
<input type="checkbox"/> Sub-Acute Stabilization is in Place for Part of the Region	<input type="checkbox"/> Meets Level 1 Criteria	<input type="checkbox"/> Meets Level 2 Criteria	<input type="checkbox"/> Meets Level 3 Criteria	<input type="checkbox"/> Meets Level 4 Criteria
<input type="checkbox"/> Have 24/7 Access to Psychiatrists or Master’s-Level Clinicians	<input type="checkbox"/> Some Form of Facility-Based Crisis is Available throughout the Region	<input type="checkbox"/> Crisis Beds/Chairs Available at a Ratio of at Least 3 per 100,000 Census	<input type="checkbox"/> Formal Data Sharing with Sub-Acute Stabilization and All Crisis Providers	<input type="checkbox"/> Real-Time Performance Outcome Dashboards Throughout Crisis System
<input type="checkbox"/> In Counties with Sub-Acute Stabilization, at Least 1 Bed/Chair per 100,000 Census	<input type="checkbox"/> Crisis Beds/Chairs Available at a Ratio of at Least 2 per 100,000 Census <input type="checkbox"/> Shared MOUs/Protocols with Other Crisis Providers <input type="checkbox"/> Staff Trained in Zero Suicide/Suicide Safer Care and Behavioral Health Services	<input type="checkbox"/> Offers Crisis Stabilization/Observation Chairs as well as Sub-Acute/Residential <input type="checkbox"/> Multiple Providers Offering Facility-Based Crisis Services <input type="checkbox"/> Some Crisis Facility Access to Person-Specific Health Data	<input type="checkbox"/> Crisis Beds/Chairs Available at a Ratio of at Least 4 per 100,000 Census <input type="checkbox"/> Support Diversion from Acute Inpatient at Rate over 60% <input type="checkbox"/> Incorporates Crisis Respite Services into Facility-Based Crisis Continuum	<input type="checkbox"/> Crisis Beds/Chairs Available at a Ratio of at Least 5 per 100,000 Census <input type="checkbox"/> Support Diversion from Acute Inpatient at Rate over 70% <input type="checkbox"/> No Refusal to First Responder Drop Offs as Primary Service Location

Crisis Now Scoring Tool (Sub-Acute Stabilization)				
Level 1 (Minimal)	Level 2 (Basic)	Level 3 (Progressing)	Level 4 (Close)	Level 5 (Full)
	<input type="checkbox"/> Priority Focus on Safety/Security	<input type="checkbox"/> Trauma-Informed Recovery Model Applied <input type="checkbox"/> Direct Law Enforcement Drop Offs Accepted <input type="checkbox"/> Least Restrictive Intervention and No-Force First Model	<input type="checkbox"/> Operates in a Home-Like Environment <input type="checkbox"/> Systematic Suicide Screening and Safety Planning <input type="checkbox"/> Some Peer Staffing within the Crisis Facility <input type="checkbox"/> Sub-Acute Stabilization Receive Electronic Access to Some Health Information <input type="checkbox"/> Shares Documentation of Crisis with Providers	<input type="checkbox"/> Bed Inventory and Referral Centralized through Crisis Line <input type="checkbox"/> Suicide Care Best Practices that Include Follow-Up Support <input type="checkbox"/> Utilize Peers as Integral Staff Members <input type="checkbox"/> Shared Status Disposition of Intensive Referrals <input type="checkbox"/> Law Enforcement Drop-Off Time Less than 10 Minutes <input type="checkbox"/> Full Implementation of all 4 Crisis Now Modern Principles (Required)

*Metrics Collected by State Behavioral Health Authorities for Crisis Stabilization and Residential Facilities*

Of the 12 SBHAs interviewed for this report, 11 operate both crisis stabilization units and crisis residential facilities, and each monitors data about the operation of these services. Alaska’s SBHA does not yet offer these services but is standing these services up.

During the interviews, SBHA staff were asked about the measures they collect, and which measures they find most useful in understanding how well crisis stabilization units and crisis residential facilities are performing (Note: because this information was gathered during the interview, it is possible that SBHAs collect additional measures related to these services.) Ten SBHAs provided insight into the measures they collect for these services, and five SBHAs provided feedback on which metrics they identify as most important. Measures collected by the 10 SBHAs that provided details, and identified as being most important by at least one SBHA, include (in alphabetical order):

- Admissions/Discharges
- Change in Acuity
- Community Referrals
- Diagnoses
- Disposition at Discharge
- Diversion Rate
- ED Utilization
- Length of Stay
- Occupancy Rate
- Readmission Rate
- Referral Source
- Response Time
- Satisfaction with Services
- Treatment Follow-Up
- Triage Assessment
- Waitlist

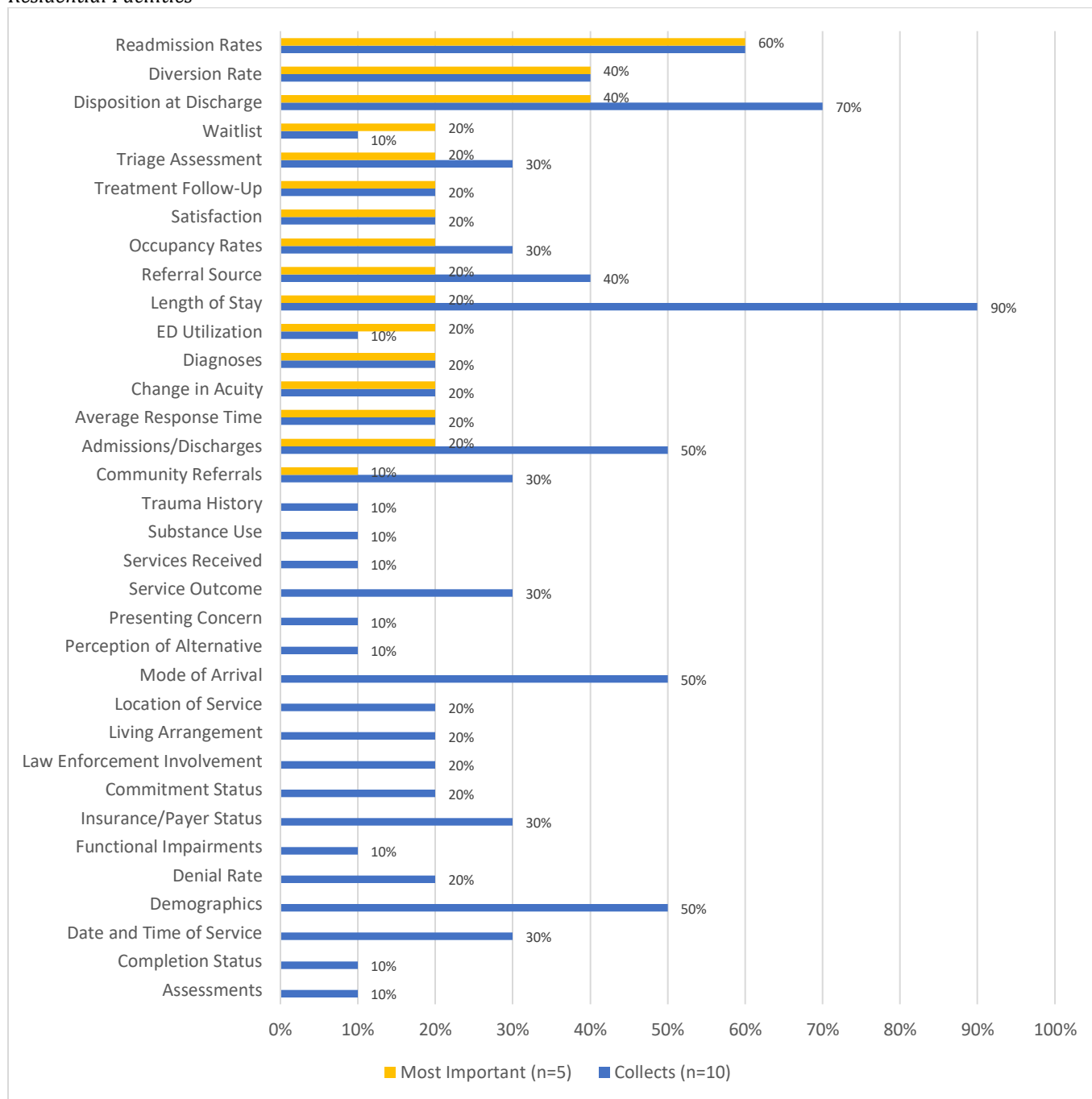
Other measures collected by SBHAs, but not identified as being most important, include:

- Assessments
- Commitment Status
- Completion Status
- Date and Time of Service
- Demographics
- Denial Rate
- Functional Impairments
- Insurance/Payer Status
- Law Enforcement Involvement
- Living Arrangement

- Location of Service
- Mode of Arrival
- Perception of Alternative
- Presenting Concern
- Service Outcome
- Services Received
- Substance Use
- Trauma History

Figure 4 provides a breakdown of the percentage of interviewed SBHAs collecting each measure (n=10), and the percentage of interviewed SBHAs that identify each measure as most important (n=5).

Figure 4: Measures Collected and Identified as Most Important by Interviewed SBHAs for Crisis Receiving Units and Crisis Residential Facilities



## Metrics that Monitor Service Transitions and Diversion

While many metrics help individual SBHAs and providers understand the quality of their specific services, few measures are available and collected by SBHAs that show how well individuals navigate through the behavioral health crisis continuum, and how effective crisis services are at diverting individuals from higher levels of care, including emergency departments (ED), jails and correctional facilities, and inpatient hospitalizations. The Crisis Now scoring tool for stabilization units does ask for a reflection on whether the least restrictive and non-coercive intervention was used, but this metric could also be relevant for mobile responses to track when police are called to help maximize appropriate use of law enforcement and minimize inappropriate use of them and other coercive techniques in crisis response. In *Lending Hands*,<sup>37</sup> some of these dynamics are articulated. Nonetheless, SBHAs interviewed for this report did not distinguish between diversion from EDs, jails, other correctional facilities, and inpatient settings; however, understanding which settings individuals are diverted from, and the frequency of use of less restrictive interventions, can be helpful to SBHAs in monitoring outcomes and determining cost savings to the overall system due to improved crisis services.<sup>‡</sup> Measures in **Table 5** are identified as being helpful by SBHAs to monitor service transitions and diversion.

Table 5: Measures that Monitor Service Transitions and Diversion

Measure	Definition and Notes	SBHAs Collecting for at Least One Crisis Setting
<b>Answer Rates, Abandonment Rate, Blockage, Calls Dropped</b>	<b>These measures show how efficiently the crisis call center is at responding to calls to reduce the likelihood that individuals give up on reaching out for help.</b> Poor outcomes for these measures may indicate issues with staffing resources or technology challenges.	AL, AK, CO, GA, NC, NE, OH, OH, TN, UT, VT
<b>Availability of Services</b>	<b>Both geographic availability and the hours services are available.</b> A measure of how accessible services are.	OH, TN
<b>Barriers to Care</b>	<b>Any obstacle to providing crisis care.</b> May include cultural, customs, or religious barriers; physical barriers; uncooperative patient; suspected drug or alcohol use; etc. Helps understand why services are not rendered, why they may be declined, and/or why they may not produce desired outcomes.	None
<b>Case Review Completion Status for Individuals with More than 3 Crisis Contacts in 30 Days</b>	<b>Measure of the number of case reviews that have been completed for individuals who have had three or more contacts with the crisis system within 30 days.</b> Allows providers and SBHA to understand why individuals may seek out repeat contacts and ensure that all potential services have been offered to the client and why those services may not have been effective or accepted by client.	TN
<b>Connection to Resources</b>	<b>Documentation of which community and crisis resources individuals are connected to during services.</b> An indication of which additional resources were offered as options to the caller. Allows crisis service providers and other stakeholders to determine if all supportive resources were provided to prevent higher levels of care/institutionalization. Similar to Type of Services Provided.	AL, AK, OH, OK, TN
<b>Demographic Information</b>	<b>Age, race, gender, ethnicity, and county of location.</b> Helps SBHAs identify need by population groups and focus outreach and services to these populations.	AK, CO, GA, NE, OH, TN, UT
<b>Denial Rate</b>	<b>Number of individuals denied services by mobile crisis teams, crisis stabilization units, or residential facilities.</b>	AL, GA
<b>Disposition of Care</b>	<b>Destination of individual receiving crisis services.</b> Helps SBHAs and providers understand where an individual goes after receiving services. This may include back to the community with follow-up services scheduled, other crisis services, emergency rooms, or other inpatient units. This data point is critical as it captures the connection point between crisis services within the continuum.	AL, GA, CO, GA, NE, NC, OH, TN, UT, VT

<sup>‡</sup> As noted above, the metric monitoring least restrictive intervention and no-force first is valuable in a variety of settings, including mobile crisis response and sub-acute stabilization to help optimize positive responses to behavioral health crises.



Measure	Definition and Notes	SBHAs Collecting for at Least One Crisis Setting
Diversion Rates	<b>Number of individuals that would have required emergency room or inpatient care, or law enforcement involvement had they not received the crisis intervention.</b> Measure demonstrates that services are effective at keeping individuals in the community.	AL, GA, NC, TN, UT, VT
First-Call Resolution Rate	<b>Number of crisis calls resolved on the first interaction.</b> Helps understand the effectiveness of crisis call centers to ensure they are meeting the needs of the community. Goal 70-75% is desirable.	AK, NE, TN
Follow-Up Calls Made/ Number of Referrals Made for Follow-up	<b>The number of calls, chats, or texts crisis services providers (from all settings) make post-intervention. Typically required within 24-36 hours of service provision.</b> Measure ensures that individuals are doing well, and crisis has resolved; also helps ensure individuals successfully connect with community resources, and any issues connecting with resources can be resolved.	AL, OH, OH, NC, TN, UT, VT
Living Arrangement	<b>Living situation of individual served.</b> Can help SBHAs and providers identify challenges in the availability of community services (e.g., housing supports)	TN, UT
Number and Status of Warm Handoffs	<b>Number of warm handoffs made by the crisis line, including a distinction of those that were declined.</b> Helps ensure continuity along the continuum.	TN, UT
Number of Calls Resulting in Emergency Dispatch/Mobile Dispatch/Active Rescue	<b>Operationalized as the number of callers expressing suicidal thoughts/at imminent risk of harm to self or others, and the number of active rescues through emergency dispatches and mobile crisis dispatch.</b> An indication of the number of calls that cannot be diverted from higher levels of care (even along the continuum).	AK, DE, GA, NE, NC, TN, UT, VT
Number of Repeat Callers	<b>Number of callers that call the crisis line more than once.</b> Similar to first-call resolution rate. Helps the SBHA understand where additional resources may be needed in the community.	AK, NE
Readmission Rates	<b>Number of individuals readmitted to crisis residential facilities within 30 calendar days.</b> Measure may indicate a lack of effective supports in the community.	AL, CO, GA, NC, OH, TN
Referral Source	<b>Source of crisis call/mobile dispatch/check-in to crisis stabilization/residential.</b> Helps to understand that the crisis system is working effectively and other agencies and behavioral health providers understand that crisis services are available. For crisis providers, can help increase understanding of quality (e.g., if a crisis operator refers a significant number of individuals for mobile crisis or law enforcement involvement/active rescue, targeted training can occur to ensure the operator is following best practices and offering effective services). Ohio indicates this represents the connection to the entire crisis continuum and is critical for understanding linkages between services.	GA, NE, OH, TN, UT
Response Time	<b>The amount of time between dispatch of mobile crisis team and the arrival of mobile crisis team.</b> Crisis Now goals range from response within one hour to two hours. Response times in rural areas will likely be longer than in urban corridors. Longer response times may be associated with individuals giving up and not receiving services in a timely manner to address their crisis.	CO, GA, OH, TN, UT
Result/Outcome of Service/ Resolution Status/ Completion Status	<b>Outcome of crisis service.</b> Helps determine if crisis was resolved or acuity lessened during crisis intervention. Shows that services result in positive outcomes.	CO, OH, TN, UT, VT
Type of Services Provided/ Offered/Declined	<b>A count of the services provided, services offered, and services declined by individual during the course of crisis care.</b> This enables SBHAs with client-level information to retroactively review client records to ensure that all potential services were exhausted prior to an individual being admitted to higher levels of care.	DE, OH, TN
Waitlist	<b>Number of individuals waiting for beds/chairs to become available at crisis stabilization units and residential facilities.</b> A measure that shows capacity for services is not meeting community demand.	NE

## Availability of Data to Understand the Relationship Between Crisis Services and Suicide Rates

SAMHSA’s National Guidelines recommends that behavioral health crisis staff at call centers and on mobile crisis teams be trained in suicide screening, safety planning, and suicide care best practices. One of the primary goals of crisis services is to reduce suicide attempts and completions; however, according to the SBHAs interviewed in this report, few have access to suicide data to make any meaningful comparisons between the implementation and enhancement of crisis services and changes in suicide rate. While all states maintain vital statistics, including suicide death rates, SBHAs typically do not maintain the data internally, and must often work with their State Department of Health to collect suicide data. While this is possible in the majority of SBHAs interviewed for this report, the data they receive is often delayed by as much as a year. Oklahoma’s SBHA accesses suicide data through a relationship with the State’s Medical Examiner and can manipulate data on an internal dashboard by demographics to identify trends across the state. **Table 6** provides an overview of how the SBHAs interviewed for this report access and use suicide data (Note: the accessibility and use of North Carolina, Tennessee, and Utah’s suicide data were not discussed during the interviews; therefore, information is unavailable).

*Table 6: Examples of Availability and Accessibility of Suicide Data by SBHAs of those SBHAs Interviewed*

State	Agency that Collects Suicide Data	Accessibility of Data by SBHA
<b>Alabama</b>	Alabama Department of Public Health, Vital Statistics	SBHA receives reports for state suicide and death rates. Able to analyze by age, race, and sex.
<b>Alaska</b>	Alaska Department of Health and Social Services, Health Analytics and Vital Records	SBHA receives reports about suicide attempts and deaths; however, data are delayed approximately one year. Working to get more real-time information to increase response rates. Anecdotal information is helpful, when the agency hears of suicide rates spiking in individual communities, the SBHA is able to mobilize to respond.
<b>Colorado</b>	Colorado Department of Public Health	SBHA interacts with DPH as needed; usually to develop targeted marketing campaigns
<b>Delaware</b>	State Law Enforcement Agency and Department of Health and Social Service Data	Data systems are siloed, would be helpful if connected. SBHA can access Law Enforcement data for suicide to understand the incidence rates and identify “hot spots” of attempts that are registered. Suicide data for children and youth are difficult for the adult SBHA to access because the system is bifurcated; only can access data in the MHBG.
<b>Georgia</b>	Department of Public Health	Behavioral Health Prevention Office uses data. DBHDD reviews where suicides happen, and age ranges of suicide attempts/completions. These data inform programming and training, but SBHA is not able to determine relationships between increased crisis care and decreases in suicides. Suicide data lag, making real-time analysis impossible. SBHA is hiring an epidemiologist to explore the data to identify trends and develop strategies.
<b>Nebraska</b>	Department of Public Health	Suicidal ideation and attempt data are collected through the statewide call center. More robust suicide data are available through the Department of Public Health, which tracks suicides through the vital statistics record system.
<b>Ohio</b>	Ohio Hospital Association (OHA)	OHA collects data from emergency rooms related to suicide attempts. The Office of Mental Health is working with OHA to try to obtain the data. The SBHA is interested in understanding the number of psychiatric admissions to the ER, and how many are suicide related.
<b>Oklahoma</b>	Office of the Medical Examiner	Oklahoma’s Department of Mental Health and Substance Abuse Services (ODMHSAS) downloads the Medical Examiner’s suicide and death data once per month. Internal dashboards have been developed that sort suicides and other deaths in the state by demographics.
<b>Vermont</b>	State Law Enforcement Agency and Vermont Department of Health	SBHA works with the State Police to capture suicide data. Suicide data reporting are delayed, and it is difficult to identify connections between service availability/provision and suicide rates. The state does retroactive analyses to determine when an individual’s last point of contact was with the behavioral health system before attempting/completing suicide. The SBHA is also working to analyze the available suicide data by demographics and occupation.

## Metrics for Understanding the Behavioral Health Crisis Workforce

The behavioral health workforce shortage has been exacerbated by the COVID-19 pandemic. According to the Office of the Assistant Secretary for Planning and Evaluation (ASPE), “many people who require behavioral health services do not receive care, potentially due in part to behavioral health workforce shortages.”<sup>38</sup> These workforce shortages are expected to continue through the foreseeable future, due to funding limitations and burn-out caused by working in high-stress environments. SBHAs that collect robust data about the demand for crisis services, as well as data about staffing trends can better manage their systems to maximize efficiency while minimizing burnout for crisis providers. This will be especially helpful when 988 launches and the demand for crisis services increases, allowing SBHAs to plan for the demand and be able to provide the workforce capacity necessary to provide high-quality crisis care.

Of the SBHAs interviewed for this report, strategies to collect workforce data were discussed with six (Alabama, Colorado, Delaware, Ohio, Tennessee, and Vermont). Each of these six SBHAs collect data on staffing shortages and vacancies. Tennessee noted that it has no systematic way to collect these data, but it would be helpful to understand. Colorado and Alabama each collect data on staff trainings, staff turnover, and cultural and linguistic competency; however, these data are not used in a systematic way to identify shortfalls and make improvements to the system. In the fall of 2021, Ohio released a [forecasting report](#) it conducted in partnership with Deloitte that alerts the SBHA about needs by provider credential and county. The report also provides projections for the workforce and anticipated demand for services over the next five, ten years, and makes recommendations on strategies to enhance the workforce to meet anticipated need. Delaware’s SBHA suggested incorporating service volume and peak-time information with the staffing model to more efficiently staff call centers, mobile crisis teams, and crisis stabilization/residential units.

Specific measures collected by SBHAs that increase understanding of needs for the behavioral health crisis workforce are provided in **Table 7**.

*Table 7: Measures Collected by SBHAs to Increase Understanding of Staffing Needs*

Measure	Definition	SBHAs Collecting
Average Handle Time	Total talk time plus after-call work time, divided by the number of calls. Helps SBHAs and call centers develop staffing plans to meet the needs of callers.	AL, NE, NC, OH, TN
Demographic Information – specifically, Location	Location information (county of residence) helps identify regional demand so SBHAs can effectively assign resources to areas with greater need.	AK, CO, GA, NE, OH, TN
Service Location/Setting	Where intervention occurs. Measure helps determine hotspots for need to understand staffing and programmatic requirements.	GA, OH, TN, UT, VT
Staffing Levels for Call Centers	SBHAs monitor staffing levels at call centers that can be analyzed with call volume to identify best times for staffing surges.	CO, DE, GA, UT, VT
Staffing Service Level	An indication of which providers are used and needed to provide services (e.g., social workers, peers, etc.).	None
Waitlist	An indication that the amount of available services do not meet community demand.	NE

## Considerations for National Reporting

SBHAs identified a handful of measures that they find to be most meaningful to understanding the performance of their crisis service continuums. These measures are identified in **Table 8**.

*Table 8: Meaningful Measures Identified by Interviewed SBHAs to Monitor Crisis Services Continuum*

Crisis Setting	Measures (Alphabetical Order)
Crisis Hotlines	<ul style="list-style-type: none"> <li>Abandonment Rate</li> <li>Answer Rate</li> <li>Average Handle Time</li> <li>Average Speed of Answer</li> <li>Caller Acuity</li> </ul>

Crisis Setting	Measures (Alphabetical Order)
	<ul style="list-style-type: none"> <li>• Caller Disposition</li> <li>• Call Volume</li> <li>• Connection to Resources</li> <li>• Demographic Information</li> <li>• First Time/Repeat Callers</li> <li>• Location of Callers</li> <li>• Number of Calls Resulting in Emergency/Mobile Dispatch, Active Rescue</li> <li>• Number of Follow-Up Calls Made (including chat and text)</li> <li>• Result/Outcome of Call</li> <li>• Service Level</li> </ul>
Mobile Crisis Teams	<ul style="list-style-type: none"> <li>• Assessments Completed</li> <li>• Availability of Services</li> <li>• Case Review Completion within 30 Days</li> <li>• Disposition of Mobile Dispatch</li> <li>• Diversion Rates (from jails, EDs, inpatient settings)</li> <li>• Follow-up Service Connections</li> <li>• Response Time</li> <li>• Satisfaction Survey</li> </ul>
Crisis Stabilization/Residential Units	<ul style="list-style-type: none"> <li>• Admissions/Discharges</li> <li>• Change in Acuity</li> <li>• Community Referrals</li> <li>• Diagnoses</li> <li>• Disposition at Discharge</li> <li>• Diversion Rate</li> <li>• ED Utilization</li> <li>• Length of Stay</li> <li>• Occupancy Rate</li> <li>• Readmission Rate</li> <li>• Referral Source</li> <li>• Response Time</li> <li>• Satisfaction with Services</li> <li>• Treatment Follow-Up</li> <li>• Triage Assessment</li> <li>• Waitlist</li> </ul>

It is important to note that many of these measures are challenging to collect due to the de-centralized nature of crisis systems throughout the state, varied data infrastructure and reporting capabilities, and resource limitations to develop robust reporting abilities. The lack of standardized service definitions even within states, let alone across the country make it difficult to compare outcomes across regions and states. When asked which measures SAMHSA might consider collecting from SBHAs about their crisis services systems to inform Congress about the effectiveness of the MHBG Set Aside, the SBHAs interviewed recommend measures that are clearly defined, not overly burdensome to collect, of high value, and that allow for meaningful comparisons across states, SBHAs recommend that SAMHSA collect the penetration rate of crisis services across the state. The penetration rate is a metric that shows how readily available crisis services are in a state. In addition, the SBHAs interviewed for this report also suggest reporting the amount of MHBG funds allocated to each service component, qualitative information on how MHBG funds are used for crisis services, and the impact of the funding on the state’s crisis continuum. It is also critical that all aspects of the crisis continuum, not just 988 call centers, are reflected in the data collected. Solely focusing on metrics related to 988 call centers will result in missing hundreds of thousands of calls that state and local crisis hotlines respond to each year.

Note that standardization of data definitions is necessary to make meaningful comparisons across the country. Any measures requested at the national level should be explicitly defined to ease burden on providers and the SBHA, as well as to create meaningful state comparisons and identify national trends. Specific recommendations

and concerns about data collection for the MHBG Crisis Set Aside raised by eight of the SBHAs interviewed include (Source: SBHA Interviews):

- “SAMHSA-required data collection and reporting should be limited to just the five percent set aside for crisis services. There would be concerns if any required data reporting expanded that would have a negative impact on the current SAMHSA Block Grant funds and their currently approved expenditure areas. The SBHA utilizes the funds to ensure the safety net foundation recovery services are in place as part of the mental health continuum of care. Also, for the new 5% set aside programs, providers should be given a warning and a period of time to implement newly required data reporting and to correct shortfalls before claw-backs are implemented.”
- “Providers and plan administrators complain about widget counting (i.e., the number of people who use a service); however, this is what the legislature is interested in and it is not too burdensome to report. While it is ideal to collect and track outcomes, the SBHA’s data system does not support this robust level of data collection.”
- “While meaningful and interesting, data related to demographics, de-escalation and diversion rates, suicide attempts resolved, and other outcomes are nearly impossible to collect at the state level.”
- “Crisis services vary in their sophistication and level of implementation across the states. Data about these services will be meaningless to SAMHSA, since the data do not allow for ‘apple-to-apple’ comparisons. Basic volume data is what SAMHSA can get from states that is meaningful, including how many are served. Simple metrics will serve states best for now, since so much about data outcomes are dependent on the state’s context (e.g., are CCBHCs available, etc.).”
- “Recognizing that not all states have all elements of the crisis services continuum available statewide, the SBHA recommends that SAMHSA track the availability of those services in states.”
- “Our crisis system is brand new, so what our state can report specific to crisis services is limited. Measures reported to SAMHSA should not be so complicated that states who are not at the same level of implementation are penalized. Our SBHA provides a lot of information about the system as a whole in URS reporting; therefore, it is important that any measures requested by SAMHSA are not duplicative. It would be my dream if SAMHSA just asked open-ended questions!”
- “Our state allocated the entire 5% Set Aside to the National Suicide Prevention Lifeline. Providing data about the entire crisis system in the state will not be an accurate indication of how effective the MHBG funds are in our state. Recognizing that our state has more sophisticated data collection capacities, it would be useful to report data on diversion rates.”
- “If we had all the money in the world, we could get into infinite metrics. But given that so many states are relatively elementary in their build outs, it is not realistic to ask for sophisticated data points. All SBHAs could provide information about how the MHBG funds are allocated (e.g., how much to each service), and what are the funds used for (e.g., hire people or build out data infrastructure). Most SBHAs do not have the continuum to report back on, or the ability to report complex metrics. But they can report on the number of contacts in each element of the system.”

## Displaying and Reporting Data on the Crisis Continuum

Data dashboards are useful management tools that allow SBHAs and providers to track the overall performance of their crisis continuum and quickly convey important information about how well crisis services are working across the state, within a region, or even within or between specific providers. “Data dashboards display real-time key metrics and performance indicators that are essential for guiding decisions.”<sup>39</sup> Data dashboards are easily accessible, and results and outcomes are easily shared with key stakeholders, including the general public, individuals and families in need of services, state and local agencies, policy makers, and others.

Dashboards, when used by SBHAs, can be used for oversight reporting and management reporting. Dashboards may be publicly available, or only available to specific stakeholders. Oversight reports, which may be part of a state’s requirement or tradition of government transparency, are a way for the SBHA to tell other stakeholders, such as the legislature, governor’s office, or others how the system is working. SBHAs seeking support or additional funding may use reports produced by data dashboards to display their successes. Although data dashboards are useful at telling the story about how well the crisis continuum is working, they require significant investment in data infrastructure and reporting commitments to be meaningful. Because of this significant commitment, few SBHAs manage data dashboards for their crisis continuums.

An internet search in the fall of 2021 of all SBHA websites in the U.S. identified only three SBHAs that operate publicly facing data dashboards for any services within their crisis continuum. Of the SBHAs interviewed, three more operate internal data dashboards. Only two of these SBHAs, Tennessee and Vermont, maintain a dashboard for all services across their crisis continuums, including crisis hotlines, mobile crisis teams, crisis stabilization units, and/or crisis residential facilities (Vermont does not offer crisis stabilization units). Colorado’s SBHA maintains a publicly facing dashboard for its behavioral health crisis hotline; Georgia and Utah maintain internal dashboards for their mobile crisis teams; and Utah maintains an internal dashboard for its crisis stabilization and crisis residential units. **Table 9** below provides an overview of dashboard usage within the SBHAs interviewed for this report.

*Table 9: Dashboard Usage Among Interviewed SBHAs*

State	Any Dashboard for Crisis Services?	Dashboard for Call Centers?	Dashboards for Mobile Crisis?	Dashboards for Crisis Stabilization?	Dashboards for Crisis Residential?
Alabama	No*	Collects Data	Collects Data	Collects Data	Collects Data
Alaska	No	Collects Data	N/A – Service Level Does Not Exist	N/A – Service Level Does Not Exist	N/A – Service Level Does Not Exist
Colorado	Yes	Dashboard	Collects Data	Collects Data	Collects Data
Delaware	No	Collects Data	Dashboard	Collects Data	No Data
Georgia	Yes	Collects Data	Dashboard	Collects Data	Collects Data
Nebraska	No	Collects Data	Collects Data	Collects Data	Collects Data
North Carolina	No	Collects Data	Collects Data	Collects Data	Collects Data
Ohio	No	Collects Data	Collects Data	Collects Data	Collects Data
Oklahoma	No	Collects Data	Collects Data	Collects Data	Collects Data
Tennessee	Yes	Dashboard	Dashboard	Dashboard	Dashboard
Utah	Yes	Collects Data*	Dashboard	Dashboard	Dashboard
Vermont	Yes	Dashboard	Dashboard	N/A – Service Level Does Not Exist	Dashboard

\*Indicates SBHA is planning to develop a data dashboard for this level of service.

## Use of Data Dashboards and Reports by SBHAs

SBHAs are at varying stages of dashboard implementation for their crisis service continuums. Five of the SBHAs interviewed for this report indicated that they operate dashboards related to their crisis service continuum. The data dashboards across these five states range in complexity. One SBHA maintains dynamic data dashboards that allow SBHA staff to track services at an individual level, while other SBHAs maintain static databases that help tell the story of crisis services in the state at the provider, regional, or state level. This section provides an overview of each of five SBHA's dashboards and discusses how each SBHA uses them to monitor and understand the strengths and weaknesses of their crisis service continuums.

### *Tennessee Department of Mental Health and Substance Abuse Services' Crisis Services Dashboard*

Tennessee's Department of Mental Health and Substance Abuse Services' (TDMHSAS) maintains a public-facing crisis services [dashboard](#) that is designed "to provide more transparency to the general public around the services they fund." (M. Yancey, personal communication, November 15, 2022). Built with Tableau, the dashboard allows the public to understand how many crisis assessments have been completed, either in-person or through the crisis hotline, since 2018 in each of the state's 95 counties. **Figure 5** is a snapshot of the interactive dashboard available through Tennessee's [Open Data Portal](#). The dashboard is "helpful in terms of planning and policy because it allows [the SBHA] to home in on the areas of the state with the greatest needs related to crisis call assessments." (M. Yancey, personal communication, November 15, 2022). The dashboard, in tandem with promotional videos and pamphlets, helps the public understand how they can access crisis services, and what to expect once they do.

TDMHSAS collects vast amounts of data beyond what are available on the public-facing dashboard and manages the crisis system through internally facing dashboards.

Tennessee's crisis services data are so robust that TDMHSAS is able to monitor an individual's journey through the crisis services system to ensure they receive the highest quality care and do not "fall through the cracks" when receiving services along the continuum. Weekly, the SBHA compiles data in a report for the Commissioner that shows how many individuals in the past week were referred to a higher level of care, the number of individuals waiting for a bed in a crisis stabilization unit (compared to the census), and which resources and

Figure 5: Screenshot of Tennessee's Crisis Services Dashboard





services were offered to try to prevent diversion. If an individual’s crisis does result in inpatient hospitalization, TDMHSAS is able to look back at the services and resources they were offered to ensure that every opportunity to divert the individual from inpatient hospitalization was exhausted. This ability is especially valuable in the wake of the isolation and added stressors of the COVID-19 pandemic, which is increasing the acuity of crises across the state.

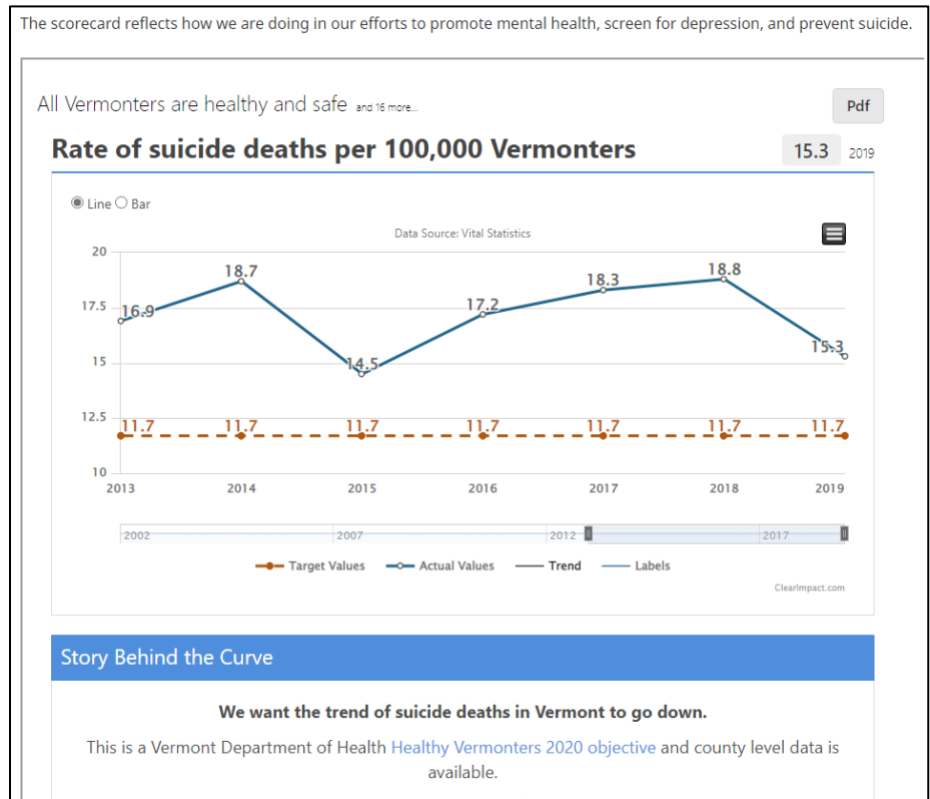
TDMHSAS implemented this system approximately one year ago in response to providers speaking up about the areas they feel are underfunded within the crisis continuum. This was the catalyst for TDMHSAS to thoroughly examine the data they had to see if they could truly understand where gaps existed in the crisis system. At the time, TDMHSAS realized that the data they had available were not enough to identify the strengths and weaknesses within the system. The old system captured information about callers, and outcomes related to face-to-face service encounters, but did not allow them to track how people moved through the system. Strong leadership from the commissioner enabled TDMHSAS to significantly enhance their crisis management data system. TDMHSAS brought together a variety of stakeholders, including internal IT partners, hospital services, TDMHSAS staff, TennCare (Medicaid) and providers to ensure that the best data possible are collected through this new endeavor. Providers expressed a strong desire for as much standardization in service definitions as possible to make it easier to compare outcomes across the state; although state staff noted that “even when standardized, it is hard to compare apples to apples,” noting that service experiences vary from provider to provider, service to service, and individual to individual. In addition to enhancing the data management system for crisis services, it also presented the state with an opportunity to better align services across agencies.

*Vermont Department of Mental Health’s Online Scorecards*

Vermont’s Department of Mental Health (DMH) maintains publicly facing, static, online [scorecards](#) that allow individuals to see annual values and trends over time for a variety of indicators. In addition to the static scorecards, individuals can

download PDF versions of the output reports, with minimal customization actions available (e.g., users can change formatting and display choices). Scorecards on the DMH website address suicide rates, use of emergency departments for self-harm, percentage of individuals with a suicide plan, and percentage of individuals receiving non-emergency services within seven days of emergency services. Each scorecard also provides a “Story Behind the Curve,” which other agencies DMH is working with to address challenges, and a strategy for improving outcomes. **Figure 6** provides an example of the suicide deaths scorecard presented by DMH.

*Figure 6: Screenshot of Vermont’s Public-Facing Crisis Services’ Data Scorecard*





Vermont’s DMH relies on the scorecards to share information with the state legislature and other state agencies with a stake in behavioral health. They are also helpful in establishing provider agreements. The scorecards, and all data collection activities, help for DMH to hold themselves accountable for the quality of services provided, and help the agency remain transparent in its efforts. DMH is improving its data dashboards by increasing the availability of both quantitative and qualitative data so that leadership can “see the story behind the curve to give a narrative around why measures are in place.” (S. DeVoe, Personal Communication, January 24, 2022).

### *Colorado Crisis Services Data Dashboard*

Colorado Crisis Services, run by the Office of Behavioral Health (OBH), maintains a public-facing [dashboard](#) with information about its statewide crisis hotline, warmline, and text line. Built with Tableau, a premium data visualization tool, the dashboard was created in response to COVID-19 to address the “unprecedented increase in volume” the crisis hotline received during the start of the pandemic. (Lee, M., Personal Communication, November 16, 2021). OBH receives Excel files containing data from the crisis hotline provider weekly to populate the dashboard. Data visualizations for the dashboard can be manipulated to show the number of calls to the crisis hotline by month, year, and activity by county. Crisis line data are broken down into average call per day by each service, and the percentage of requests for each service type (e.g., hotline, warm line, and text). County-level activity data are displayed in an interactive map where users can see the average calls per month by county. See **Figure 7** and **Figure 8** on the following pages.

In addition to the data displayed on the dashboard, OBH also receives data about speed of answer, demographics, presenting concern of caller, abandonment rate, and staffing patterns, among other data points. OBH receives many inquiries for crisis hotline data, especially for demographic data to determine the number of callers under the age of 18 as there has been an alarming increase in youth suicides in the state since the start of the pandemic.

The data dashboards for the crisis hotline also help OBH determine staffing needs. The dashboards help OBH determine where the highest level of service need is in the state so they can better target training resources and monitor contracts to ensure staffing are at the appropriate levels. For instance, if there is an increased call volume from a certain region of the state, OBH can rework its provider contracts to provide more funding to accommodate for the increased demand.

The data dashboards are also used to respond to media requests and state legislature inquiries. OBH staff lament that rarely does anyone from other state agencies use the crisis services data, noting that greater participation and use of the dashboards by other stakeholders would help all stakeholders across the state to better understand the systemwide impact of crisis services and the influence of external events, such as the pandemic, on demand for services (Lee, M., Personal Communication, November 16, 2021).

Figure 7: Screenshot of Colorado Crisis Services' Hotline Data Dashboard

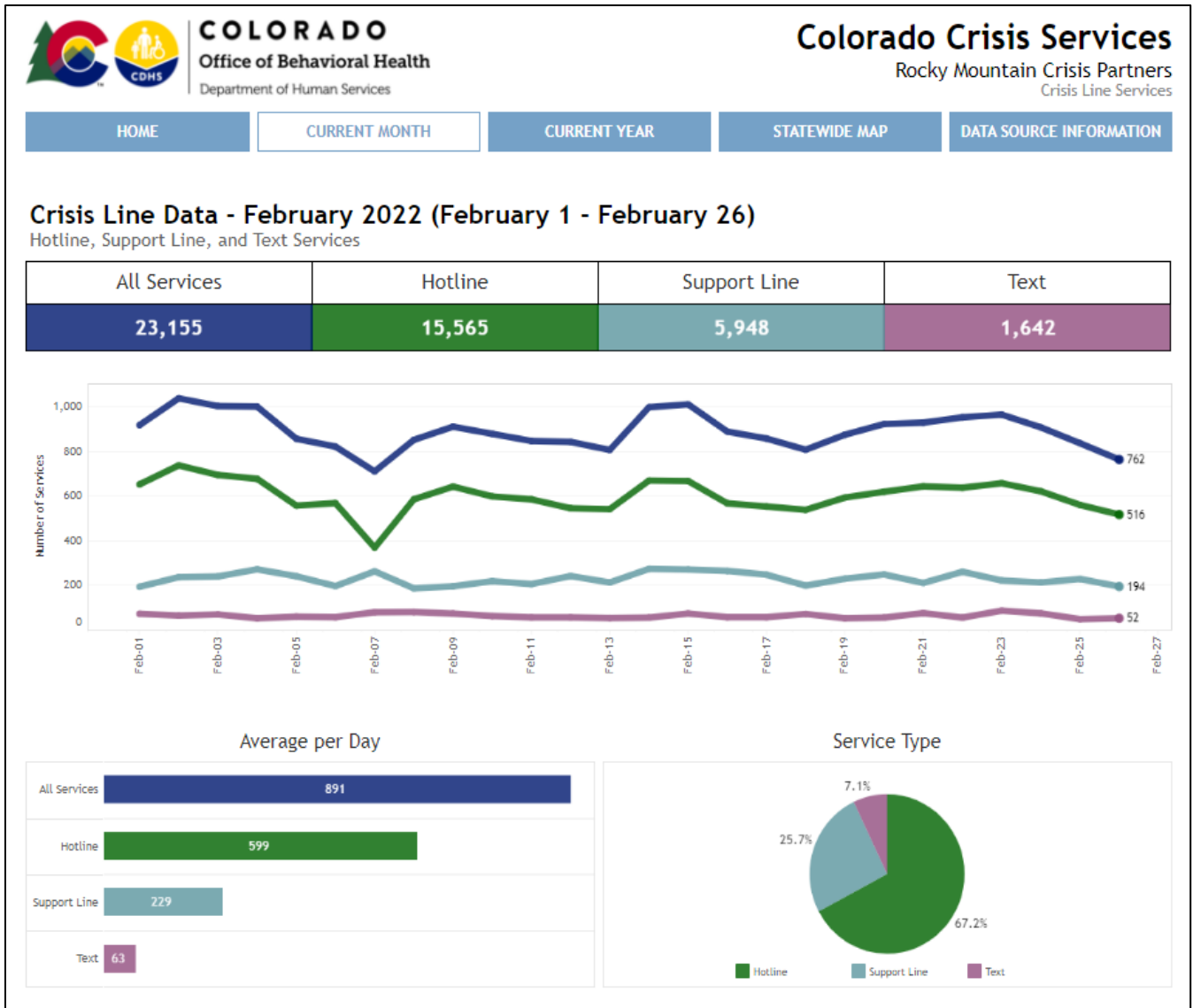
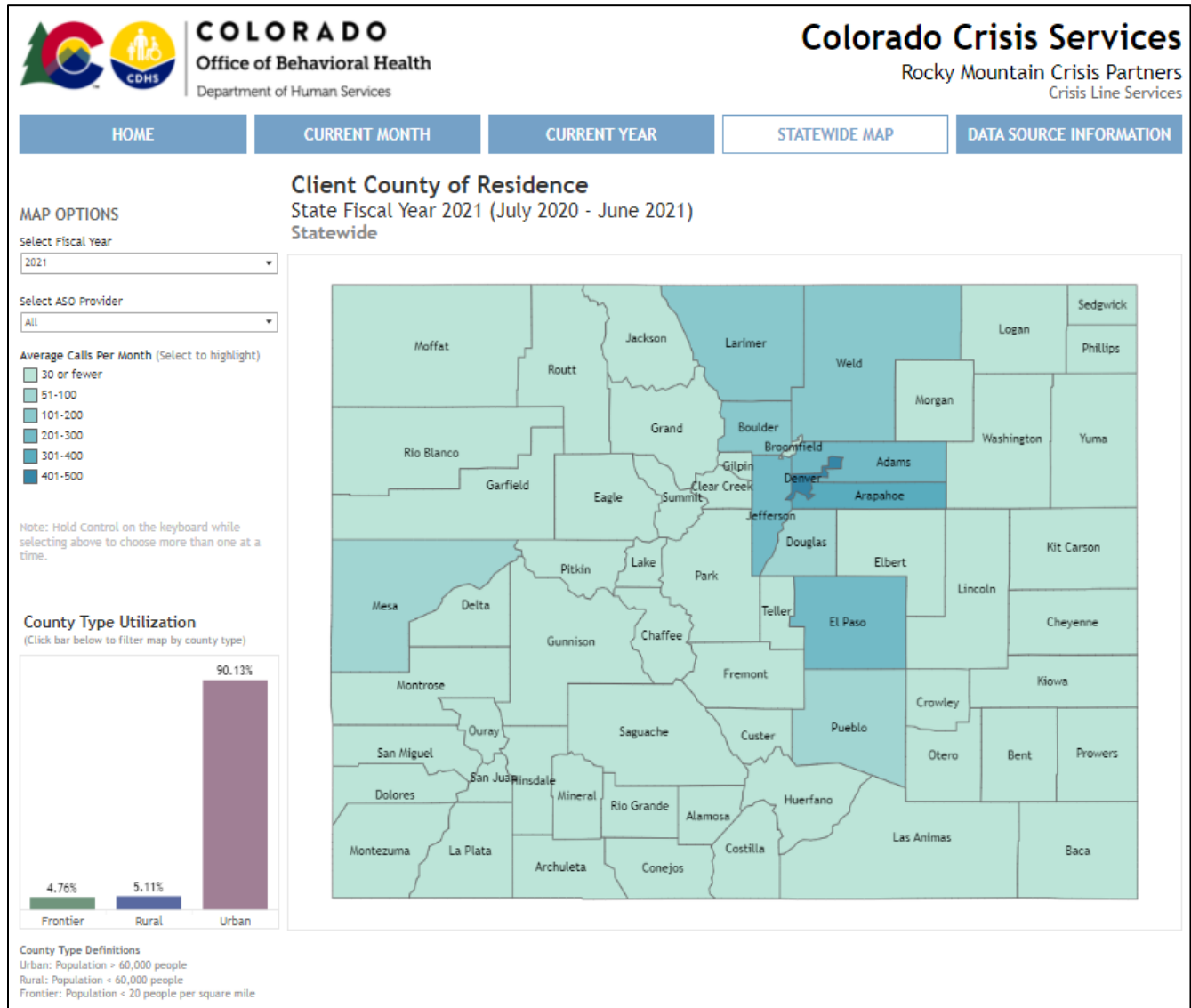


Figure 8: Screenshot of Colorado Crisis Services' Hotline Interactive Map



## *Georgia*

Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) receives crisis services data daily, weekly, monthly, and quarterly. These data generate reports and internal dashboards that are shared with stakeholders, including the Lifeline (for Lifeline call centers), DBHDD program managers, providers, the state legislature, and the governor's office. The type of data and service setting determines how often they are reported to DBHDD.

DBHDD crisis call centers report the following data that are used to generate static reports for stakeholders:

- Daily: Call volume, including calls related to COVID-19
- Weekly:
  - Abandonment rate
  - Speed to answer
- Monthly:
  - Trends of call volume, abandonment rate, and speed to answer
  - Staffing patterns
  - Percentage of call originating from the Lifeline
  - Answer rate
  - Number of active rescues

While DBHDD does not utilize a dynamic dashboard for its call centers, the call centers do have dynamic dashboards that display real-time information. These dashboards are not yet accessible by DBHDD staff, but they are working with the call centers to enable access for DBHDD staff so that data are customizable based on role and permission.

Georgia's DBHDD has dashboards for mobile crisis response. Data are provided daily and monthly by region and statewide. Both dashboards are internal facing. Dashboard data include the following:

- Number of counties served (statewide reports only)
- Number of Individuals served by age
- Response time
- Number of assessments
- Length of time for assessment (goal is to keep assessments within one hour)
- Number of individuals referred to the emergency room for medical clearance
- Location of service (e.g., street, social services agency, hospital, residence, etc.)
- Disability diagnoses, specifically for populations under the purview of the ADA Settlement Agreement
- Law enforcement involvement

Georgia's DBHDD also does not maintain data dashboards for crisis stabilization units or crisis residential facilities, however, they are in the process of exploring how to operationalize a dashboard for these services. Should DBHDD develop a dashboard for these services, the key performance indicators that would be included are:

- Occupancy rates
- Number of admissions (volume)
- Diversion rates
- Average length of stay: Seven days for adult units, and 10 days for child and adolescent units
- Destination at discharge
- Readmission rates
- Denial rates: goal is fewer than 10% per year

Although DBHDD does not have dashboards for crisis stabilization or residential facilities, they are able to use their live bed board to determine bed availability across the state.

### *Utah*

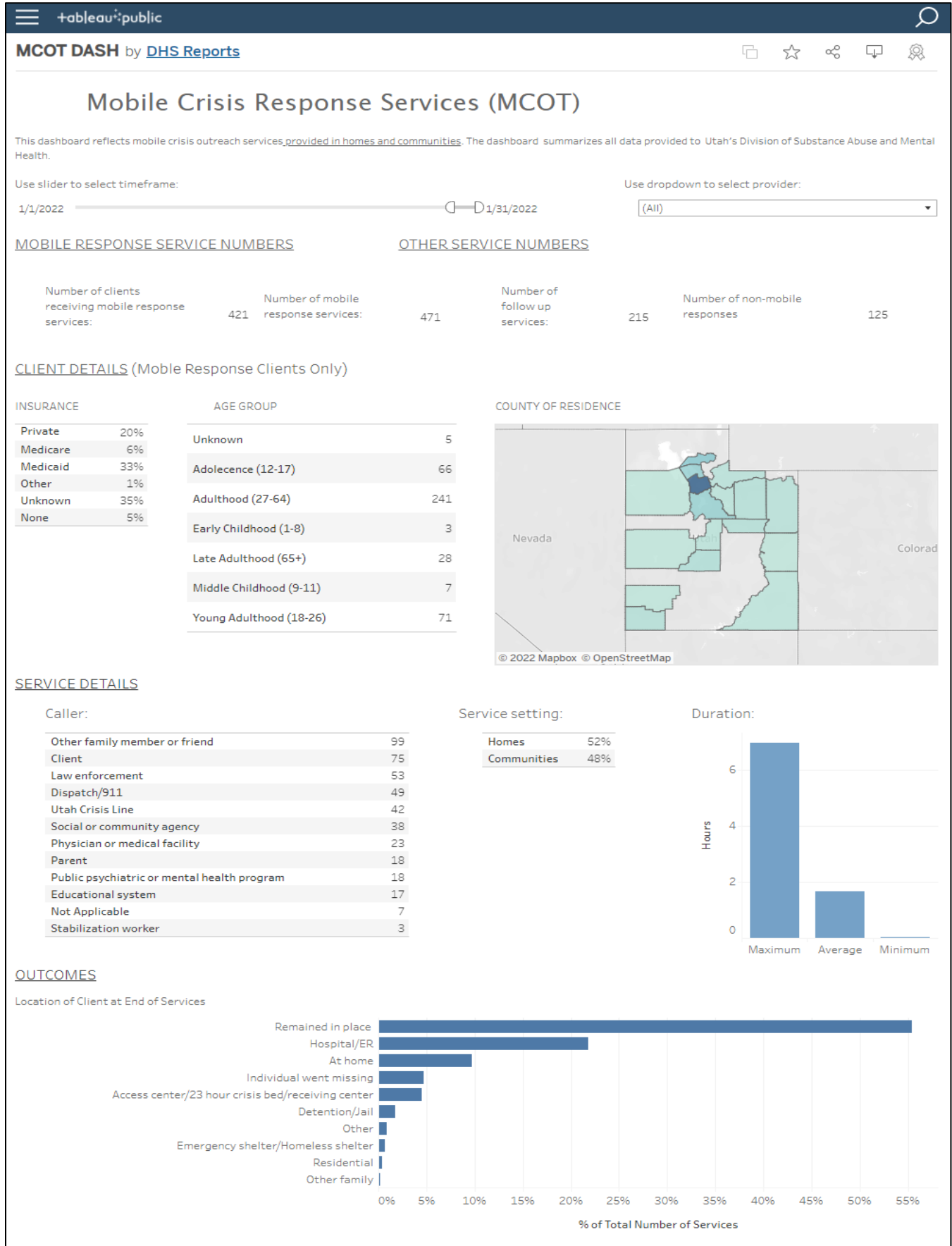
Utah's Division of Substance Abuse and Mental Health (DSAMH) maintains a public-facing [dashboard](#) that monitors the state's mobile crisis response services (MCOT). Built with Tableau, the dashboard allows users to see the number of mobile crisis response services provided throughout the state, the number of follow-up services provided, location of services by county, age of individuals receiving services, insurance status of individuals receiving services, referral source, service setting, duration of service, and outcomes of mobile crisis response. See **Figure 9** on the following page for a screenshot of Utah's data dashboard for mobile crisis response services.

DSAMH also maintains an internally facing dashboard for its crisis stabilization units. This dashboard is not maintained in Tableau, but does contain protected patient information, as well as information about type of service (substance use or mental health); demographics; county of residence; language spoken; insurance status; living situation (prior to intake); primary and secondary presenting concerns; provider ID; date, time, and duration of service; initiator of service episode (e.g., who prompts the call or who brings the client into the receiving center), law enforcement involvement, length of time law enforcement (if involved) spends dropping an individual off, end of service location (e.g., where the client goes upon discharge), and client perception of alternative (e.g., where an individual perceives they would end up if crisis services are not available). DSAMH relies on individual mobile crisis teams and crisis stabilization providers to submit data.

The MCOT dashboard and internal dashboard for crisis stabilization units enable DSAMH to manage contracts, identify service gaps, understand service volumes, and help keep key stakeholders, including the state legislature and governor's office, informed about the use and efficacy of state general funds allocated to DSAMH.

Similar to Tennessee, the eventual goal of Utah's DSAMH is to align data components across the crisis service continuum and connect services to unique identifiers for each individual served by the system. This would enable the SBHA to determine how many times an individual accesses the system, which services are offered, which services they use, which services are declined, and the outcome of each service. DSAMH is in the process of refining its data collection and reporting systems to improve oversight and the management of the crisis service continuum.

Figure 9: Screenshot of Utah's Mobile Crisis Response Services Dashboard



## Conclusion

The implementation of 988 in July of 2022 promises to significantly increase the number of persons contacting a behavioral health call center (SAMHSA's "Someone to talk to") instead of 911 to respond to behavioral health crises. The estimated doubling of demand for Lifeline services will provide an opportunity to connect individuals experiencing behavioral health crises needing additional care into ancillary crisis services: Someone to Respond to (e.g., mobile crisis response) and Some Place to Go for adults (e.g., crisis stabilization units) to effectively and efficiently respond to their needs and minimize contacts with law enforcement and emergency departments. The ability of these services to respond will determine whether crisis call centers (especially the new 988 system) are effective at meeting the needs of individuals in crisis with appropriate and effective behavioral health services, or whether 988 have to default to contacting 911 and dispatch law enforcement because the "Someone to Respond" and "Some Place to go" set of services are not available. For SBHAs to determine how well their crisis service systems are meeting this increased demand and providing quality behavioral health crisis services where behavioral health professionals respond and no one "falls through the cracks," it is necessary for them to collect and monitor data across their entire behavioral health crisis services continuum. Lessons from other SBHAs, national crisis organizations, and national associations in similar industries offer insight into which outcome measures are most critical for SBHAs to collect and monitor, at both the state and national reporting levels.

At the state level, the most important metrics for behavioral health crisis services are those that indicate volume (demand for services), speed of service, disposition of individual in need, repeat users of service, need for active rescue/law enforcement response/mobile dispatch, and diversion rates. Each of these metrics are useful in determining demand for services, how well individuals transition through the continuum, and effectiveness of services provided. The use of data dashboards and reports help SBHAs share how well the crisis service system, as well as individual components of the crisis continuum are working with stakeholders, including other state agencies, the state legislature, and the governors' offices. While these metrics are useful at the state level, they are less feasible, and therefore less meaningful for national reporting.

Understanding how states are leveraging federal funds to improve their crisis service continuums is challenging to operationalize at a national level due to the de-centralized nature of crisis service systems within each state, variations in data infrastructure and reporting capabilities across the states, and the resource limitations SBHAs face in developing robust reporting abilities. Because of these challenges, the interviewed states recommend that initial national reporting should focus on the penetration rate for crisis services, the amount of funds allocated to each crisis service component, and qualitative information about how the additional funds are used in each state for crisis services. States recommended this type of information will provide the most meaningful national assessment of the impact of these additional funds and allow for better comparisons of impact across the states.

Collecting and reporting data about crisis services provides invaluable insight into how well a state's crisis continuum is working, and allows SBHAs to adjust resources and change strategies to address any weaknesses in the system and to meet the increased demand associated with the implementation of 988. SBHAs can use interactive data dashboards and static reports to monitor the operations of their crisis services systems, share information with stakeholders, and make the case for additional resources to the state legislature and the governor's office. More general, qualitative reporting of data at the national level will provide Congress and SAMHSA meaningful, much-needed information to understand how well their investments in state crisis services systems are working.

Appendix A: Table of Key Performance Indicators for Behavioral Health Crisis Hotlines (Alphabetical Order)

Measure	Definition	Notes	SBHAs Collecting (n=12)/Identifying as Most Important (n=5)	
Behavioral Health Crisis Hotline Measures	<b>Adherence to Protocol</b>	Requires telephone monitoring/recording of crisis counselors.	<ul style="list-style-type: none"> <li>Lifeline Quality/Call-Handling Process Measure</li> </ul>	None indicated.
	<b>After-Call Work Time</b>	The amount of time a crisis counselor takes to finish all tasks associated with the call. May include updating database, helpdesk, or customer relationship management; completing paperwork; collaborating with colleagues; sending emails; and updating calendars.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Contact Handling Measure</li> </ul>	None indicated.
	<b>Answer Rates</b>	Number of calls answered compared to the number of calls received by the hotline. Includes breakdown of in-state answer rates. For Lifeline, calls not answered by the original center are directed to other centers and count against a center's answer rate.	<ul style="list-style-type: none"> <li>The goal for the new 988 Lifeline is 90% in-state answer rate</li> </ul>	<ul style="list-style-type: none"> <li>9 SBHAs Collect: AK, GA, NC, NE, OH, OK, TN, UT, VT</li> <li>4 SBHAs Indicate Most Important: AK, NE, OH, TN</li> </ul>
	<b>Average Handle Time</b>	Total talk time plus total after-call work time, divided by the total number of calls.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Contact Handling Measure</li> <li>Tracked by AIRS.</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: AL, NE, NC, OH, TN</li> <li>4 SBHAs Indicate Most Important: NE, NC, OH, TN</li> </ul>
	<b>Average Speed of Answer</b>	Calculated as total waiting time for answered calls divided by the number of total answered calls.	<ul style="list-style-type: none"> <li>Lifeline Service/Speed Measure</li> <li>Tracked by American Association of Poison Control Centers</li> <li>URAC Goal: average speed of answer by live person within 30 seconds.</li> <li>Tracked by AIRS. Target of &lt;90 seconds.</li> <li>Tracked by NENA. Target, 90% of 911 calls answered within 10 seconds.</li> <li>Crisis Now Goal: Answer within 15 to 30 seconds.</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: AL, CO, DE, GA, NC</li> <li>1 SBHA Planning to Collect: AK</li> <li>1 SBHA Indicates Most Important: NC</li> </ul>
	<b>Blockage</b>	% of callers unable to access call center due to an insufficient number of phone lines. Callers receive busy signal. To measure, review ACD reports.	<ul style="list-style-type: none"> <li>Lifeline Service/Accessibility Measure</li> <li>URAC Goal for Monthly Minimum Performance: &lt;5%</li> </ul>	None indicated.
	<b>Call Abandonment Rate</b>	% of calls that disconnect after 30 seconds. If pre-recorded greeting answers, time begins after the greeting has ended. On ACD reports, identified as calls that drop after 30 seconds. For call centers without ACD reports, abandonment rate can be measured as the number of calls that hang up prior to the second ring.	<ul style="list-style-type: none"> <li>Lifeline Service/Accessibility Measure</li> <li>Tracked by AAPCC, excluding short abandons of less than 12 seconds. Also tracks average delay before abandon.</li> <li>URAC Goal for Monthly Minimum Performance: &lt;5%</li> <li>Tracked by AIRS</li> <li>Crisis Now Goal: Abandonment rate between 5% (level 5) and 20% (level 2).</li> </ul>	<ul style="list-style-type: none"> <li>3 SBHAs Collecting: CO, GA, NC</li> <li>1 SBHA Indicates Most Important: NC</li> </ul>
	<b>Caller Acuity</b>	Assesses severity of individual's crisis.	None	<ul style="list-style-type: none"> <li>2 SBHAs collect: NE, OH</li> <li>1 SBHA Indicates Most Important: OH</li> </ul>



Measure	Definition	Notes	SBHAs Collecting (n=12)/Identifying as Most Important (n=5)	
Behavioral Health Crisis Hotline Measures	<b>Caller Disposition</b>	Recommendation for post-crisis intervention. Assists with evaluating diversionary efforts/scopes of triage and intervention services.	None	<ul style="list-style-type: none"> <li>• 4 SBHAs Collect: NE, OH, TN, UT</li> <li>• 3 SBHAs Indicate Most Important: OH, TN, UT</li> </ul>
	<b>Calls Diverted from Emergency Room/ Higher Level of Care</b>	Count of the number of callers that would have required emergency room or inpatient care had crisis call not occurred. Documented as “imminent risk reduced” in Vermont. Can be a sub-category of the measure Result of Call.	None	<ul style="list-style-type: none"> <li>• 4 SBHAs Collect: NC, TN, UT, VT</li> </ul>
	<b>Calls Dropped</b>	Number of calls that are inadvertently disconnected by the call center, usually due to technical error.	None	<ul style="list-style-type: none"> <li>• 1 SBHA collects: AL</li> </ul>
	<b>Call Source/ Referral Source</b>	Source of call referral. May include calls initiated by individuals or family, those initiated by Law Enforcement, referrals from the National Suicide Prevention Lifeline, etc.	None	<ul style="list-style-type: none"> <li>• 3 SBHAs Collect: GA, NE, OH</li> </ul>
	<b>Call Volume</b>	Number of calls that come into the crisis call center in a given period. Changes in call volume can be used to make the case for adjusting funding levels for services. Can be analyzed hourly, daily, monthly, quarterly, and annually.	<ul style="list-style-type: none"> <li>• Tracked by AIRS</li> </ul>	<ul style="list-style-type: none"> <li>• 11 SBHAs Collecting: AL, AK, CO, DE, GA, NE, NC, OH, OK, TN, UT</li> <li>• 1 SBHA Indicates Most Important: NC</li> </ul>
	<b>Connection to Resources</b>	An indication of which additional resources were offered as options to the caller. Allows the call center and other stakeholders to determine if all supportive resources were provided to prevent higher levels of care and institutionalization.	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: AK, TN</li> <li>• 2 SBHAs Indicate Most Important: AK, TN</li> </ul>
	<b>Cost Per Call</b>	Used to evaluate how efficiently resources are being used and to gauge return on investment. Cost per call may be calculated as either strictly a labor cost, or a “fully loaded cost” that includes all overhead, including telecom, facilities, and other service costs.	<ul style="list-style-type: none"> <li>• Lifeline Efficiency/Resource Utilization Measure</li> </ul>	None indicated.
	<b>Demographic Information</b>	Enables SBHAs to identify need by population groups (e.g., age, race, ethnicity, gender) and focus outreach and services to these groups.	None	<ul style="list-style-type: none"> <li>• 6 SBHAs Collect: AK, CO, GA, NE, OH, TN</li> <li>• 1 SBHA Indicates Most Important: AK</li> </ul>
	<b>Error/Rework Rate</b>	The % and types of rework that occur. Typically captured by ACD systems. Changes in processes can significantly reduce and/or increase the error and rework rate.	<ul style="list-style-type: none"> <li>• Lifeline Quality/Call-Handling Process Measure</li> </ul>	None indicated.
	<b>First-Call Resolution Rate</b>	Definitions vary across call centers whether call is resolved during initial interaction. Goal of 70 to 75% is desirable. Can be a sub-category of the measure Result of Call.	<ul style="list-style-type: none"> <li>• Lifeline Quality/Resolution Measure</li> </ul>	<ul style="list-style-type: none"> <li>• 1 SBHA Collects: TN</li> <li>• 2 SBHAs monitor the number of first-time/unique callers: AK, NE.</li> </ul>
<b>First Time and Repeat Callers</b>	Allows call centers and SBHAs to understand if there is a relationship between the rate of new callers and other events affecting the community (e.g., pandemic, natural disasters, terrorist attacks, shootings, etc.). For repeat callers, measure allows ABHA to work with other behavioral health organizations to provide coordinated services to high utilizers.	None	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: AK, NE</li> <li>• 1 SBHA Indicates Most Important: AK</li> </ul>	

Measure	Definition	Notes	SBHAs Collecting (n=12)/Identifying as Most Important (n=5)	
Behavioral Health Crisis Hotline Measures	<b>Follow-Up Calls Made</b>	The number of calls, chats, or texts that crisis operators make following-up with past callers. Typically required within 24-36 hours of initial call.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: OH</li> </ul>
	<b>Hours of Operation</b>	For SBHAs without centralized 24/7 hotlines, it is important to understand which hours should be fully staffed at local call centers based on demand. Assess number of calls that arrive outside of business hours as well as the number of individuals that call back during business hours and conduct cost-benefit analysis of staffing.	<ul style="list-style-type: none"> <li>Lifeline Service/Accessibility Measure</li> <li>CARF Standard</li> <li>Crisis Now Goal: Services Available 24/7/365</li> </ul>	None indicated.
	<b>Insurance Status</b>	Type of insurance caller has, or does not have.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: NE</li> </ul>
	<b>Location of Caller</b>	Often collected by caller zip code or area code. Measure is helpful to understand regional utilization, allowing SBHA to conduct targeted outreach and expand capacity to meet community needs.	None	<ul style="list-style-type: none"> <li>4 SBHAs collect: AK, GA, NE, OK</li> <li>1 SBHA Indicates Most Important: AK</li> </ul>
	<b>Longest Delay in Queue</b>	The longest period of time that a caller in a queue before connecting with a crisis counselor or hanging up.	<ul style="list-style-type: none"> <li>Lifeline Service/Speed Measure</li> </ul>	None indicated.
	<b>Mental Health Diagnosis of Caller</b>	Documentation of the mental health diagnosis of a caller, if provided.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: NE</li> </ul>
	<b>Number of Calls Resulting in Emergency Dispatch/Mobile Dispatch/Active Rescue</b>	Operationalized as the number of callers expressing suicidal thoughts/at imminent risk of harm to self or others, and the number of active rescues through emergency dispatches (law enforcement) and mobile crisis dispatch. Can be a sub-category of the measure Result of Call.	None	<ul style="list-style-type: none"> <li>8 SBHAs Collect: AK, DE, GA, NE, NC, TN, UT, VT</li> <li>3 SBHAs Indicate Most Important: AK, NE, UT</li> </ul>
	<b>Number of Referrals Made for Follow-Up</b>	Number of referrals for community-based services made by a crisis call operator.	<ul style="list-style-type: none"> <li>Crisis Now offers a spectrum of goals: minimal goal is to have cold referrals to community resources or better connection of care (level 1), warm handoff to behavioral health crisis providers (level 2), direct connection to facility-based crisis providers (level 3), coordinate access to available crisis beds (level 4), shared bed inventory and connection to available crisis and acute beds through an integrated bed registry (level 5).</li> </ul>	<ul style="list-style-type: none"> <li>3 SBHAs Collect: TN, UT, VT</li> </ul>
	<b>Number and Status of Warm Handoffs</b>	Number of warm handoffs made by the crisis line, including a distinction of those that were declined.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: UT</li> </ul>
	<b>On-Hold Time</b>	Amount of time callers spend on hold. Used as a gauge for individual counselors and can indicate insufficient knowledge or confidence in handling calls independently.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Contact Handling Measure</li> </ul>	None indicated.

Measure	Definition	Notes	SBHAs Collecting (n=12)/Identifying as Most Important (n=5)	
Behavioral Health Crisis Hotline Measures	<b>Presenting Concern</b>	Measure documents the reason an individual calls the crisis hotline. It is helpful in understanding the needs of a specific community. It has allowed states to monitor calls related to COVID, suicide, and the opioid crisis. Call centers may also document secondary and tertiary concerns.	None	<ul style="list-style-type: none"> <li>7 SBHAs Collect: AK, CO, GA, NE, OH, TN, UT</li> </ul>
	<b>Result/Outcome of Call</b>	Outcome of call to the call center.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, UT</li> </ul>
	<b>Schedule Adherence</b>	How much time a counselor is actively working compared to their paid time. Measured by total time crisis counselor is available and dividing it by the time they are scheduled to work. Takes into account breaks and non-call-related work.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Resource Utilization Measure</li> </ul>	<ul style="list-style-type: none"> <li>None indicated.</li> </ul>
	<b>Schedule Efficiency</b>	Measure of productivity that refers to the amount of overstaffing and understaffing that exists as a result of scheduling design. Most effective measured in intervals over the course of a day. Depending on the size of the call center, acceptable over or understaffing can range from plus/minus 1 or 2 to 5 staff.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Resource Utilization Measure</li> </ul>	<ul style="list-style-type: none"> <li>None, although 3 SBHAs monitor staffing measures: CO, GA, UT.</li> </ul>
	<b>Service Level</b>	% of calls answered within a certain amount of time. Used to calculate Average Speed of Answer. There is no industry standard for ideal service level. Productivity may decline when service levels improve as more staff are available and waiting to quickly answer high volumes of calls.	<ul style="list-style-type: none"> <li>Tracked by AIRS. Target is 80% of calls answered within 90 seconds.</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: AL, CO, DE, GA, NC</li> <li>1 SBHA Planning to Collect: AK</li> <li>1 SBHA Indicates Most Important: NC</li> </ul>
	<b>Staff Occupancy</b>	Time crisis counselors spend handling calls compared to waiting for calls. A measure of productivity and resource utilization.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Resource Utilization Measure</li> <li>Tracked by AIRS. Target between 65% and 80%</li> </ul>	<ul style="list-style-type: none"> <li>None, although 3 SBHAs monitor staffing measures: CO, GA, UT.</li> </ul>
	<b>Staff Shrinkage</b>	% of paid time that crisis counselors are unavailable to answer calls. There is no industry standard for staff shrinkage, and percentages can vary significantly day-to-day.	<ul style="list-style-type: none"> <li>Lifeline Efficiency/Resource Utilization Measure</li> </ul>	<ul style="list-style-type: none"> <li>None, although 3 SBHAs monitor staffing measures: CO, GA, UT.</li> </ul>
	<b>Type of Service Provided</b>	A count of the types of services provided during crisis calls, including case management, counseling, psychiatric evaluations, well-being checks, etc.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: DE, TN</li> </ul>

## Appendix B: Table of Key Performance Indicators for Mobile Crisis Response (Alphabetical Order)

Measure	Definition & Notes	Notes	SBHAs Collecting (n=9; no mobile crisis services in AK, data not collected in AL, and OK did not provide data points)/Identifying as Most Important (n=4)	
Mobile Crisis Response Measures	<b>Assessments Completed</b>	Number of community-based assessments completed by the mobile crisis team, including telehealth.	<ul style="list-style-type: none"> <li>Crisis Now Measure</li> </ul>	<ul style="list-style-type: none"> <li>3 SBHAs Collect: GA, TN, VT</li> <li>1 SBHA Indicates Most Important: VT</li> </ul>
	<b>Availability of Services</b>	Both geographic availability and hours mobile crisis teams are available to respond.	<ul style="list-style-type: none"> <li>Goal is 24/7/365.</li> <li>Crisis Now Goal: minimum goal of availability 8 hours per day in at least part of the region, to 24/7/365 availability with real-time performance outcome dashboards showing location, occupancy, and outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>2 SBHAs Collect: OH, TN</li> <li>1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Barriers to Care</b>	May include cultural, customs, or religious barriers; language barriers; physical barriers; uncooperative patient; suspected drug or alcohol use; etc. Helps mobile crisis teams and SBHAs understand why services are not rendered, why they may be declined, or why they are not effective.	<ul style="list-style-type: none"> <li>Collected by NEMSIS</li> </ul>	None indicated.
	<b>Case Review Completion Status for Individuals with 3 or More Crisis Contacts in 30 Days</b>	Measure of the number of case reviews that have been completed for individuals who have had three or more contacts with the crisis system (including hotline, mobile crisis, crisis stabilization) within 30 days.	<ul style="list-style-type: none"> <li>Tennessee's goal is 100%</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: TN</li> <li>1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Chief Complaint of Individual (Reason for Mobile Crisis Response/Primary Concern)</b>	Measure documents the reason an individual requires mobile crisis response. It is helpful in understanding the needs of a specific community. It has allowed states to monitor dispatches related to COVID, suicide, and the opioid crisis. Mobile crisis teams may also document secondary and tertiary concerns.	<ul style="list-style-type: none"> <li>Collected by NEMSIS</li> <li>Utah collects primary and secondary concerns and documents if suicidal risk, harm to self, harm to others, substance use, psychosis or grave disability concern, situational stress, informational, other.</li> </ul>	<ul style="list-style-type: none"> <li>3 SBHAs Collect: GA, TN, UT</li> </ul>
	<b>Date and Time of Service</b>	Allows SBHA and providers to identify usage trends to assist with staffing.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, UT</li> </ul>

Measure	Definition & Notes	Notes	SBHAs Collecting (n=9; no mobile crisis services in AK, data not collected in AL, and OK did not provide data points)/Identifying as Most Important (n=4)
<b>Mobile Crisis Response Measures</b>	<b>Delays</b> May include dispatch, response, scene, or turnaround delays. Dispatch delays are any time delays that occur from the referring public safety entity to the time the mobile crisis team receives notification to dispatch. Response delays are time delays that occur between when the unit is notified to dispatch to the time the unit arrives on scene; delays may be attributable to poor directions, unable to locate, excessive distance, route obstruction, vehicle failure, weather, etc. Scene delays occur from the time the unit arrives on scene to the time they leave the scene; may be caused by crowds, language barriers, weather, etc. Turnaround delays are the amount of time it takes to resolve one crisis to when the team can return back to service.	<ul style="list-style-type: none"> <li>Collected by NEMSIS</li> </ul>	None indicated.
	<b>Demographic Information</b>	<ul style="list-style-type: none"> <li>Collected by NEMSIS</li> <li>Utah also collects language information.</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: GA, NE, OH, TN, UT</li> </ul>
	<b>Diagnosis</b>	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: GA, TN</li> </ul>
	<b>Disposition of Mobile Dispatch/ Destination at End of Service.</b>	<ul style="list-style-type: none"> <li>Crisis Now Measure: Documents which services the individual is connected to post intervention.</li> <li>Collected by NEMSIS</li> <li>North Carolina monitors if mobile crisis response is connected to a decrease in ER use through the evaluation of claims data.</li> </ul>	<ul style="list-style-type: none"> <li>8 SBHAs Collect: CO, GA, NE, NC, OH, TN, UT, VT</li> <li>2 SBHAs Indicate Most Important: NE, OH</li> </ul>
	<b>Diversion Rate</b>	<ul style="list-style-type: none"> <li>Crisis Now Goal: Resolve between 60 and 75% of all mobile crisis interventions</li> <li>Tennessee's goal is that inpatient psychiatric hospitalization remain within 2% of the three previous fiscal years.</li> </ul>	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, VT</li> <li>1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Follow-Up Service Connections</b>	<ul style="list-style-type: none"> <li>Crisis Now Measure</li> <li>Tennessee measures number completed within 24 hours.</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: TN</li> <li>1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Geographic Availability</b>	<ul style="list-style-type: none"> <li>Crisis Now Goal: Available in all regions throughout the state.</li> </ul>	None

Measure	Definition & Notes	Notes	SBHAs Collecting (n=9; no mobile crisis services in AK, data not collected in AL, and OK did not provide data points)/Identifying as Most Important (n=4)	
Mobile Crisis Response Measures	<b>Insurance Status</b>	The type of insurance/method of payment an individual has, or does not have, to pay for services.	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> </ul>	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, UT</li> </ul>
	<b>Law Enforcement Involvement</b>	Notes if law enforcement was involved in episode.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, UT</li> </ul>
	<b>Length of Field Assessment/ Duration of Service</b>	The amount of time the mobile crisis team is spent working with an individual in the field. Time of arrival to time of departure/resolution.	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> <li>Georgia's goal is one hour.</li> </ul>	<ul style="list-style-type: none"> <li>2 SBHAs Collect: GA, UT</li> </ul>
	<b>Level of Acuity</b>	Level of acuity of individual receiving services. Monitor both initial acuity and final acuity to determine change in acuity attributable to services.	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> </ul>	None
	<b>Level of Service</b>	A documentation of the level of service an individual receives in mobile crisis response, and which type of professional provides the service (e.g., peers, nurses, social workers, clinicians, etc.).	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> <li>Crisis Now Goal: All mobile teams include peers.</li> </ul>	None
	<b>Living Arrangement</b>	Living situation of individual served. May include homeless/shelter, private residence, jail/correctional facility, institutional setting (nursing home, IMD, psychiatric hospital, etc.).	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, UT</li> </ul>
	<b>Medication Administered</b>	A documentation of which medications are administered during mobile crisis response, including Narcan for suspected opioid overdoses.	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> </ul>	None indicated.
	<b>Method of Response</b>	A count of how the service is provided, either face-to-face or via telehealth services.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: NE, TN</li> </ul>
	<b>Number of Follow-Ups Made within a Specific Timeframe</b>	Post-intervention, mobile crisis teams make follow-up calls to individuals who received services to ensure they are connected with appropriate community-based supports.	<ul style="list-style-type: none"> <li>North Carolina's goal is to complete follow-ups within three days of mobile crisis response.</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: NC</li> </ul>
	<b>Number of Mobile Crisis Team Dispatches</b>	Number of times the mobile crisis team is dispatched.	None	<ul style="list-style-type: none"> <li>4 SBHAs Collect: GA, NC, TN, VT</li> </ul>
	<b>Number Taken to ER for Medical Clearance</b>	Some states require that individuals experiencing a behavioral health crisis be taken to the ER for medical clearance before they can be admitted to a crisis stabilization unit or crisis residential facility.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: GA, TN</li> </ul>

Measure	Definition & Notes	Notes	SBHAs Collecting (n=9; no mobile crisis services in AK, data not collected in AL, and OK did not provide data points)/Identifying as Most Important (n=4)	
Mobile Crisis Response Measures	<b>Perception of Alternative</b>	Utah asks individuals who receive mobile crisis services what they think the outcome of their crisis would have been had mobile crisis not intervened.	<ul style="list-style-type: none"> <li>Utah asks, "If this service were not available, what do you think the most likely result would have been?" Potential responses include remain at home, call law enforcement, hospital/ER, detention/jail, emergency shelter/homeless shelter, foster or proctor home, youth run away, other, went to access center/23 hour, went to detox (outside ER), remained in place.</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: UT</li> </ul>
	<b>Reason for Choosing Destination</b>	Documentation of an individual's reason for choosing a specific destination at end of service, including a residence (back to the community), shelter, crisis stabilization unit, ER, etc.	<ul style="list-style-type: none"> <li>Collected by NEMSIS</li> </ul>	None indicated.
	<b>Referral Source/Initiator of Episode</b>	Who refers an individual for mobile crisis response. May be crisis call center, 211, 911, law enforcement, individual, family, provider, etc. Ohio indicates this measure represents the connection to the entire crisis continuum and is critical for understanding linkages between services.	None	<ul style="list-style-type: none"> <li>4 SBHAs Collect: NE, OH, TN, UT</li> </ul>
	<b>Resolution Status</b>	Percentage of mental health crises resolved/not resolved during mobile crisis intervention.	<ul style="list-style-type: none"> <li>Crisis Now goal ranges between 60% and greater than 75% for crises to be resolved in the field.</li> </ul>	<ul style="list-style-type: none"> <li>3 SBHAs Collect: CO, TN, VT</li> </ul>
	<b>Response Time</b>	The amount of time between dispatch of mobile crisis team and the arrival of mobile crisis team. Crisis Now goals range from response within one hour to two hours. Response times in rural areas will likely be longer than in urban corridors.	<ul style="list-style-type: none"> <li>Crisis Now Measure within 1 to 2 hours.</li> <li>Collected by NEMSIS by monitoring dispatch time, dispatch arrival, and dispatch delays.</li> <li>Colorado's goal is one hour for urban calls, two hours for rural calls.</li> <li>Tennessee's goal is within 2 hours or less 90% of the time; 1 hour or less for youth when assessment location is a school or outpatient provider</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: CO, GA, OH, TN, UT</li> <li>2 Indicate Most Important: OH, TN</li> </ul>
	<b>Satisfaction Survey</b>	Results of satisfaction survey administered by the mobile crisis team.	<ul style="list-style-type: none"> <li>Tennessee administers satisfaction surveys to individuals post-care. Goal is 80% or more indicating services were helpful during follow-up.</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: TN</li> <li>1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Service Level</b>	Credentials of Mobile Crisis Team, including nurses, clinicians, social workers, peers, others.	<ul style="list-style-type: none"> <li>Crisis Now Measure: Goal for all mobile crisis teams to include peers.</li> <li>Collected by NEMSIS</li> </ul>	None indicated.
<b>Service Location/Setting</b>	May be street, residence, community building (e.g., schools), shelter, or through video conference/telehealth. Measure helps determine hotspots for need to understand staffing and programmatic requirements.	<ul style="list-style-type: none"> <li>Crisis Now Measure</li> <li>Collected by NEMSIS</li> </ul>	<ul style="list-style-type: none"> <li>5 SBHAs Collect: GA, OH, TN, UT, VT</li> </ul>	

Measure		Definition & Notes	Notes	SBHAs Collecting (n=9; no mobile crisis services in AK, data not collected in AL, and OK did not provide data points)/Identifying as Most Important (n=4)
Mobile Crisis Response Measures	<b>Services Declined</b>	Count of the services declined by individual experiencing crisis. Also track reason for decline. Helps SBHAs understand why services are refused (e.g., cultural objection or issue with quality of service).	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> </ul>	None indicated.
	<b>Services Offered</b>	Count of services offered. When compared with services provided and services declined provides clearer picture of service demand and community need.	<ul style="list-style-type: none"> <li>Collected by NEMESIS</li> </ul>	None indicated.
	<b>Service Outcome</b>	Outcome of service, may include diversion rate from hospitals, ER, law enforcement; also the number involuntarily held; number of safety plans made.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: TN, VT</li> </ul>
	<b>Services Provided</b>	Count of services provided. When compared with services offered and services declined provides clearer picture of service demand and community need.	None	None indicated.
	<b>Staffing Levels and Vacancies</b>	Number of staff available for mobile crisis response and how many mobile crisis positions need to be filled.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: VT</li> </ul>



## Appendix C: Table of Metrics for Crisis Stabilization Units & Crisis Residential Facilities (Alphabetical Order)

Measure	Definition & Notes	Notes	SBHAs Collecting (n=10)/Identifying as Most Important (n=5)	
Crisis Stabilization/Crisis Residential Measures	<b>Admissions/Discharges</b>	Number of individuals admitted for services.	None	<ul style="list-style-type: none"> <li>• 5 SBHAs Collect: AL, CO, GA, OH, TN</li> <li>• 1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Assessments</b>	Number of crisis assessments made	None	<ul style="list-style-type: none"> <li>• 1 SBHA Collects: AL</li> </ul>
	<b>Average Response Time (&lt;24 hour services)</b>	Response time is the amount of time that occurs between when an individual presents in a crisis stabilization unit to when they receive the crisis assessment.	<ul style="list-style-type: none"> <li>• In Tennessee, the crisis assessment must occur within one hour of arrival 90% of the time.</li> </ul>	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: NC, TN</li> <li>• 1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Change in Acuity with Treatment</b>	Helps providers determine if the individual is better off than when they arrived, and if there was a reduction in distress/suicidality.	<ul style="list-style-type: none"> <li>• Vermont administers a survey that asks individuals to self-report if they feel they are better off compared to when they arrived.</li> </ul>	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: OH, VT</li> <li>• 1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Community Connections Made/Community Referrals</b>	Number of individuals who connect with community providers upon discharge.	<ul style="list-style-type: none"> <li>• Oklahoma is able to follow-up with individuals post discharge to ensure they receive outpatient services in the community. This is done through data matching. Integration with Medicaid is extremely helpful to make this happen.</li> </ul>	<ul style="list-style-type: none"> <li>• 3 SBHAs Collect: AL, OH, OK</li> <li>• 1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Completion Status</b>	Whether services are successful or unsuccessful.	None	<ul style="list-style-type: none"> <li>• 1 SBHA Collects: OH</li> </ul>
	<b>Date and Time of Service</b>	Allows SBHA and providers to identify usage trends to assist with staffing. Time begins with arrival.	None	<ul style="list-style-type: none"> <li>• 3 SBHAs Collect: NC, TN, UT</li> </ul>
	<b>Demographics</b>	Include age/date of birth, gender, race, ethnicity, county of residence, and language spoken.	<ul style="list-style-type: none"> <li>• Utah and Nebraska collect information about preferred language.</li> </ul>	<ul style="list-style-type: none"> <li>• 5 SBHAs Collect: CO, NE, NC, TN, UT</li> </ul>
	<b>Denial Rate</b>	Percentage of individuals turned away from crisis stabilization/residential services.	<ul style="list-style-type: none"> <li>• In Georgia, fewer than 10% of denials are allowed per year.</li> </ul>	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: AL, GA</li> </ul>
	<b>Diagnosis</b>	Diagnosis of individual receiving services.	None	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: AL, NE</li> <li>• 1 SBHA Indicates Most Important: NE</li> </ul>
	<b>Disposition at Discharge</b>	Location where client is being discharged to.	None	<ul style="list-style-type: none"> <li>• 7 SBHAs Collect: AL, GA, NE, NC, OH, TN, UT</li> <li>• 2 SBHAs Indicate Most Important: NE, OH</li> </ul>
<b>Diversion Rate</b>	Number of individuals diverted from a higher level of care, including hospital, ER, and law enforcement.	<ul style="list-style-type: none"> <li>• Tennessee's goal is for the percentage of individuals who are admitted for 23-hour observation and who are referred for inpatient psychiatric hospitalization to not exceed 30%.</li> <li>• Tennessee's goal is for the percentage of individuals who are admitted for &gt;24-hour care and who are referred for inpatient psychiatric hospitalization to not exceed 7.5% of admissions.</li> <li>• Georgia's goal is 50% diversion for individuals admitted to 23-hour stabilization.</li> </ul>	<ul style="list-style-type: none"> <li>• 4 SBHAs Collect: AL, GA, TN, VT</li> <li>• 2 SBHAs Indicate Most Important: OH, TN</li> </ul>	

Measure	Definition & Notes	Notes	SBHAs Collecting (n=10)/Identifying as Most Important (n=5)	
Crisis Stabilization/Crisis Residential Measures	<b>Emergency Department Utilization</b>	Number of individuals that need to be seen at the emergency department.	None	<ul style="list-style-type: none"> <li>• 1 SBHA Collects: OH</li> <li>• 1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Event Duration/Length of Stay</b>	Length of time an individual receives services at the crisis stabilization/residential unit.	None	<ul style="list-style-type: none"> <li>• 9 SBHAs Collect: AL, CO, GA, NE, NC, OH, OK, TN, UT</li> <li>• 1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Functional Impairments</b>	Whether an individual has reduced functioning.	None	<ul style="list-style-type: none"> <li>• 1 SBHA Collects: NE (&gt;24-hour)</li> </ul>
	<b>Initiator of Episode/Referral Source</b>	Person who made the initial call for service or who brought client to the receiving center. May be parent, individual, other family member or friend, physician or medical facility, social or community agency, educational system, law enforcement, courts or corrections, private psychiatric/mental health program, public psychiatric/mental health program, clergy, private practice mental health professional, stabilization worker, crisis hotline, dispatch/911, other.	None	<ul style="list-style-type: none"> <li>• 4 SBHAs Collect: NE, OH, TN, UT</li> <li>• 1 SBHA Indicates Most Important: NE</li> </ul>
	<b>Insurance/Payer Status</b>	The type of insurance/method of payment an individual has, or does not have, to pay for services.	None	<ul style="list-style-type: none"> <li>• 3 SBHAs Collect: NE, TN, UT</li> </ul>
	<b>Involuntary/Voluntary Commitment Status</b>	A measure of the number of individuals who are involuntarily committed.	None	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: NE, NC</li> </ul>
	<b>Law Enforcement Involvement</b>	Count of the number of individuals presenting at facility with law enforcement involvement in admission.	None	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: NE, OH</li> </ul>
	<b>Living Arrangement</b>	Living situation of individual served. May include homeless/shelter, private residence, jail/correctional facility, institutional setting (nursing home, IMD, psychiatric hospital, etc.).	None	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: NE, UT</li> </ul>
	<b>Location of Service</b>	Location of crisis stabilization or crisis residential facility. Often categorized by county.	<ul style="list-style-type: none"> <li>• Helps inform the legislature where services are provided and where greatest needs are in the state.</li> </ul>	<ul style="list-style-type: none"> <li>• 2 SBHAs Collect: OH, TN</li> </ul>
	<b>Mode of Arrival</b>	How an individual transported to the facility (e.g., walked in, EMS, law enforcement, etc.)	None	<ul style="list-style-type: none"> <li>• 5 SBHAs Collect: AL, CO, GA, NC, TN</li> </ul>
	<b>Occupancy Rates</b>	Percentage of beds filled. Helps determine bed availability and utilization rates.	None	<ul style="list-style-type: none"> <li>• 3 SBHAs Collect: GA, TN, VT</li> <li>• 1 SBHA Indicates Most Important: VT</li> </ul>

Measure	Definition & Notes	Notes	SBHAs Collecting (n=10)/Identifying as Most Important (n=5)	
Crisis Stabilization/Crisis Residential Measures	<b>Perception of Alternative</b>	Utah asks individuals who receive crisis stabilization services what they think the outcome of their crisis would have been had the service not been provided.	<ul style="list-style-type: none"> <li>Utah asks, "If this service were not available, what do you think the most likely result would have been?" Potential responses include remain at home, call law enforcement, hospital/ER, detention/jail, emergency shelter/homeless shelter, foster or proctor home, youth run away, other, went to access center/23 hour, went to detox (outside ER), remained in place.</li> </ul>	<ul style="list-style-type: none"> <li>1 SBHA Collects: UT</li> </ul>
	<b>Presenting Concern</b>	Reason individual presents to crisis stabilization/residential unit. May include primary and secondary concerns. It is helpful in understanding the needs of a specific community. It has allowed states to monitor needs related to COVID, suicide, and the opioid crisis.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: UT</li> </ul>
	<b>Readmission Rates (Unscheduled)</b>	The number of individuals readmitted within 30 calendar days.	<ul style="list-style-type: none"> <li>In Tennessee, the goal is that this figure not be greater than 2% above the statewide average of readmissions completed during the last completed fiscal year.</li> </ul>	<ul style="list-style-type: none"> <li>6 SBHAs Collect: AL, CO, GA, NC, OH, TN</li> <li>3 SBHAs Indicate Most Important: NC, OH, TN (all for &gt;24 hour services)</li> </ul>
	<b>Satisfaction Survey</b>	Self-report of individuals who report services are useful during follow-up.	<ul style="list-style-type: none"> <li>Tennessee's goal is for 80% or more of survey respondents to indicate services were helpful. Used in both &lt;24 hour, and &gt;24 hour services.</li> <li>Ohio distributes survey every six months to gauge satisfaction and collect other data.</li> </ul>	<ul style="list-style-type: none"> <li>2 SBHAs Collect: OH, TN</li> <li>1 SBHA Indicates Most Important: TN</li> </ul>
	<b>Service Outcome</b>	At the end of the event, was the case resolved, or were further actions expected?	None	<ul style="list-style-type: none"> <li>3 SBHAs Collect: OH, TN, UT</li> </ul>
	<b>Services Received</b>	Count of services an individual receives.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: OH</li> </ul>
	<b>Substance Use</b>	Individual's use of substances, including tobacco products.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: NE (&gt;24-hour)</li> </ul>
	<b>Trauma History</b>	If an individual has history of trauma, and if trauma occurred when they were youth or adults, and the type of trauma experienced	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: NE (&gt;24-hour)</li> </ul>
	<b>Treatment Follow-up</b>	Number of follow-ups with discharged individuals completed by staff.	None	<ul style="list-style-type: none"> <li>2 SBHAs Collect: AL, OH</li> <li>1 SBHA Indicates Most Important: OH</li> </ul>
	<b>Triage Assessment/Type of Crisis</b>	Assessment of crisis severity and individual need, including 911 emergency, emergent crisis, urgent response, routine response, stabilization only, information only.	None	<ul style="list-style-type: none"> <li>3 SBHAs Collect: NC, OH, UT</li> <li>1 SBHA Indicates Most Important: OH</li> </ul>
<b>Waitlist</b>	Number of individuals waiting for beds/chairs to become available.	None	<ul style="list-style-type: none"> <li>1 SBHA Collects: NE</li> <li>1 SBHA Indicates Most Important: NE</li> </ul>	

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# A SAFE PLACE TO BE

Crisis Stabilization Services and Other Supports for Children and Youth

**NASMHPD**

Paper No. 4 in the *From Crisis to Care* Series

# **A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth**

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*Fourth in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs Focused on Building from 988 and Beyond for Better Mental Health Outcomes*



**National Association of State Mental Health Program Directors**  
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## **Abstract:**

The developmental, social, and clinical needs of youth are different from those of adults. A robust crisis continuum of care is needed that specifically can meet the needs of youth and families in their homes and communities whenever possible. The essential elements of a community-based crisis service array are *someone to contact* (crisis call lines), *someone to respond* (mobile response teams), and a *safe place to be* (this includes a system to support the youth and family including home- and community-based stabilization services as well as acute care such as inpatient care). Although ideally a youth can be cared for at home, the important element is that they have a *safe place to be*, and this might include a crisis stabilization location or inpatient care. Still, stabilization services at home should not be considered an alternative to a robust continuum of care (including acute care) but rather are critically necessary services nested within a service array. While mobile response can and should be designed to *respond* to an immediate incident, de-escalate the situation, and begin the process of stabilization, states and localities must ensure they also have sufficient capacity to refer for and deliver stabilization services. Stabilization components must be provided to the youth and family as soon as practicable and may continue for up to six to eight weeks, depending on youth and/or family preferences, and clinical and functional needs of the family system. This paper reviews the need for and components of crisis stabilization services for children, youth, young adults, and their families.

## **Highlights:**

- Amending or attempting to retrofit an adult crisis response system to serve the needs of youth and families is insufficient.
- 988 provides the opportunity to streamline the process for youth and families experiencing a crisis to obtain timely, necessary services and supports, reduce unnecessary use of emergency departments and police response, and provide equitable response and access for diverse populations.
- Crisis stabilization services include an array of services and supports for youth and families focused on de-escalation and stabilization within the home and community.
- Stabilization services are grounded in Systems of Care values and principles.

## **Recommendations for Policy Makers, Practitioners and Thought Leaders:**

1. Ensure that child- and family-serving system partners, including youth and families with lived experience, are included in 988 and crisis system design and implementation efforts.
2. Use data to inform the development of a children's crisis continuum that addresses historic use of emergency rooms and police response as well the needs of diverse populations.
3. Develop capacity within a robust crisis continuum to provide stabilization services in homes and communities for up to six to eight weeks to meet the needs of youth and families who require ongoing stabilization after initial mobile response.
4. Consider funding and system design mechanisms to allow youth and families to access appropriate crisis service interventions regardless of where they enter the system of care, their ability to pay, or their diagnostic condition.

**W**hen children, youth, and young adults (hereinafter “youth”) experience a behavioral health crisis, they and their caregivers often have had limited options apart from calling 911 or going to the emergency department (ED), where they can face extended waits for care. A robust crisis service array is needed specifically to meet the needs of youth and families in their homes and communities. The essential elements of this community-based crisis continuum are **someone to call** (crisis call lines, which include text and chat options), **someone to respond** (mobile response teams), and a **safe place to be** within a system to support youth (home- and community-based stabilization services, as well as acute care services including inpatient care). This customized crisis continuum serves youth and families and offers 24/7 interventions to de-escalate, treat, and stabilize behavioral health needs while improving functional and clinical outcomes. Such services are instrumental in averting unnecessary ED visits in which youth are likely to be “boarded” – the practice of caring for people, including youth, in the ED for a prolonged length of stay after a determination that the person needs inpatient care but until an inpatient bed becomes available (which can take hours, weeks or more than a month at times).<sup>1,2</sup> A continuum of services is also critical to minimize out-of-home placement, and placement disruption - while reducing overall costs.

“Someone to call” means that there is an easily identifiable, single point of access contact line available 24/7, regardless of previous or current system involvement or payer source, available to address crises as defined by the caller. “Someone to respond” indicates that 24/7 mobile response teams are ready to respond in the home or community and are staffed by appropriately licensed, certified, trained, and/or credentialed providers with expertise and experience in child and adolescent behavioral health and family systems.

Adult systems are evolving to facilitate de-escalation and response that can be managed in a natural setting, yet there is also a focus for adults to have “somewhere to go” as a default for a crisis intervention. For youth dealing with a behavioral health crisis, recognizing the importance of security and stability for their development, every effort is made to maintain them in their current living environment and in a family-based setting, ideally with active engagement from family members and other natural supports. The frame of reference is therefore labeled a “safe place to be,” which emphasizes safety, and infers making available an array of supports within a system of care that are delivered as home- and community-based services following the initial crisis response. These can include home-based stabilization services when needed for up to six to eight weeks in some instances. Ideally the youth’s crisis supports can be met through these services offered in the youth’s natural environment but can include services youth would receive when needed within crisis stabilization units or even inpatient psychiatric units in some instances. Ongoing supports can include a range of interventions, such as stabilization services provided in the home, substance use treatment, access to a child psychiatrist or other clinical approaches.<sup>3</sup>

As noted, the developmental, social, and clinical needs of youth are different from those of adults. Amending or attempting to retrofit an existing adult crisis response system to serve the needs of youth and families is insufficient. A dedicated, customized response system, including mobile response, *a safe place to be* including the availability of in-home stabilization services, is therefore necessary to fully meet the needs of youth and families. These crisis services should be well coordinated with other adult-, family- and youth-serving system partners, including those that serve youth of transition age.<sup>4</sup> Youth experiencing behavioral health crises often are involved with multiple entities (e.g., primary care physicians, medical homes, schools, behavioral health providers, child welfare organizations, juvenile justice, law enforcement, community-based organizations, etc.). Existing and new system partners must work together to maximize the availability and accessibility of services – particularly when fiscal

resources and human capital are scarce – and minimize re-traumatization and unnecessary duplication of assessments, plans of care, and direct service provision.

Recognizing the importance of fostering “a safe place to be”, this paper focuses on one aspect of the third element of a robust crisis continuum, the system needed to support the youth, and the customizations required to best serve youth and families. As with other elements, stabilization services must be trauma-responsive, developmentally appropriate, culturally humble, and focused on de-escalating and preventing future crises in the least restrictive setting required to appropriately meet the needs of the youth and family.

## **Framing the Crisis Continuum**

### *Front Door: 988 and Crisis lines*

As noted in *From Crisis to Care*,<sup>5</sup> Congress recently enacted laws<sup>6</sup> to establish 988, a three-digit number analogous to 911, designed to assist individuals in crisis. Beginning in July 2022, 988 will operate 24/7. In April 2022, the U.S. Department of Health and Human Services awarded \$105 million to states and territories to “improve response rates, increase capacity to meet future demand, and ensure calls initiated in their states or territories are first routed to local, regional, or state crisis call centers...[R]ecipients may also use the funds to build the workforce necessary for enhancing local text and chat response.”<sup>7</sup>

The federal enabling legislation permitted states to impose a fee to administer their respective 988 hotlines. By April 1, 2022, 14 states (Colorado, Connecticut, Illinois, Indiana, Maryland, Mississippi, Nebraska, Nevada, New York, Oregon, Utah, Virginia, Washington, and West Virginia) enacted legislation to begin implementing 988, of which four states (Colorado, Nevada, Virginia, and Washington) had authorized or imposed a fee. Of the original 14 states, four (Connecticut, Nevada, Oregon, and Washington) had one or more child- or youth-specific implementation planning provisions included in the enacted legislation.<sup>8,9,10,11</sup>

Creating a single point of access, as is intended with 988, streamlines the process and removes barriers to obtaining timely, necessary services and supports for youth and families experiencing a behavioral health crisis. An easy-to-remember single phone number available to the community and family- and youth-serving partners (e.g., child welfare, juvenile justice, schools, medical providers, etc.) to contact with a “no wrong door” approach simplifies what has historically been a time-consuming, complex, and sometimes dispiriting process.<sup>12</sup> “No wrong door” is an approach that provides all youth and families with access to appropriate service interventions regardless of where they enter the system of care, their ability to pay, or their diagnostic condition.

### *Mobile Response*

According to the Substance Abuse and Mental Health Services Administration and the Center for Medicaid and CHIP [Children’s Health Insurance Program] Services (CMCS), mobile response and stabilization services are “instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements, particularly hospitalization.”<sup>13</sup> Mobile response is a child-, youth-, and family-specific crisis intervention model for home- and community-based response. It is designed to meet a youth and caregiver’s sense of urgency when children and youth begin to demonstrate behavioral changes associated with the early phase of a crisis, commonly understood as pre-crisis.<sup>14</sup> Caregivers are involved intricately in children’s crisis situations due to the nature of the caregiver-child relationship.

Mobile response teams provide needed assistance to youth and families in de-escalation; perform brief, initial safety assessments and assess immediate basic needs such as food, housing, and medical care; develop and begin implementing a crisis care plan; facilitate the youth and family's connection to natural supports; and engage the youth and family in care planning to identify triggers to prevent future crises, and avert and divert from restrictive levels of care (ED, residential treatment, etc.), out-home-placement, and unnecessary contact with law enforcement and juvenile justice.<sup>15</sup>

Although mobile response responds to immediate needs, states and localities must ensure there is sufficient capacity to provide ongoing stabilization services when these are warranted. When additional supports are indicated, they may be provided by the same or a different team. Such services should be provided to the youth and family as soon as practicable and may continue for several weeks, depending on preferences, clinical and functional needs, and the specific delivery model.

### ***Components of Stabilization Services***

- Parent/caregiver education
- Positive youth development and recreational programs
- Family and youth peer support
- In-home services
- Systems navigation, including identification of formal and natural supports
- Linkages to home-, school- and community-based services
- Linkages to psychiatric or primary care services for medication management or evaluations
- Clinical treatment
- Respite care
- Care coordination with other family and youth-serving systems, such as education, child welfare, housing, and economic supports, as applicable

## **The Need for Youth-Focused Crisis Services**

Behavioral health challenges are common: approximately 1 in every 11 children ages 3-17 has diagnoses of attention-deficit/hyperactivity disorder and anxiety, and 20% of youth ages 12-17 have experienced a major depressive disorder.<sup>16</sup> From 2009-2019, the number of high school students reporting persistent feelings of sadness or hopelessness increased to 1 in 3, a 40 percent increase from 2009.<sup>17</sup> Although female suicide rates have generally declined recently, they increased for female youth and young adults between the ages of 10 and 24. Suicide rates for males between the ages of 15 and 24 have remained stable from 2017 through 2020 after a significant increase from 2007-2017; there has been a significant increase in the rate of suicides for males ages 10-14, although the suicide rate for this population remains the lowest of all age groups.<sup>18</sup> Although more female youth attempt suicide than male youth, male youth have a “considerably higher risk” of dying by suicide, which may be explained by their use of more lethal means, particularly firearms.<sup>19</sup> These statistics highlight the importance of healthy emotional development for youth, including the ability to “perceive, assess, and manage emotions.”<sup>20</sup> From 2007 to 2016, the utilization rates of pediatric psychiatric ED increased for children ages 5-17.<sup>21</sup> During the COVID-19 pandemic, these rates increased even further.<sup>22,23</sup> Related data demonstrate that some racial and ethnic groups are disproportionately represented among youth who attempt or die by suicide. For example, suicide attempts among Black youth are rising faster than among any other racial or ethnic group.<sup>24</sup> The suicide rate for Black children and youth increased from 2.55 per 100,000 in 2007 to 4.82 per 100,000 in 2017.<sup>25</sup> Although the rate of deaths by suicide for children under 13 is smaller,

Black youth under 13 years are twice as likely to die by suicide as their White peers; Black males, five to 11 years old, are significantly more likely to die by suicide compared to their White peers.<sup>26</sup> In 2019, 40% of Hispanic high school students reported experiencing persistent feelings of sadness or hopelessness during the past year.<sup>27</sup>

Youth with intellectual and developmental disabilities (IDD), from underserved and historically marginalized populations; with diverse sexual orientation, gender identity, and gender expression; in rural areas; in immigrant households; and involved with juvenile justice or child welfare agencies faced higher risks of behavioral health challenges during the pandemic due to racism and discrimination;<sup>28</sup> intergenerational and communal trauma;<sup>29</sup> economic,<sup>30</sup> educational,<sup>31</sup> and social disruption;<sup>32</sup> accessibility and access to care;<sup>33</sup> and language barriers.<sup>34</sup>

## **Addressing Crisis Needs in Diverse Populations**

As noted in the 2020 NASMHPD Technical Assistance Collaborative series and throughout SAMHSA's guidelines, it is important that crisis services are built to address the needs of diverse populations.<sup>35</sup> Yet, racism continues to be a factor that must be considered in developing properly adept crisis services. Racism is an organized system by which the dominant group "devalues, disempowers, and differentially allocates desirable societal opportunities and resources to racial groups categorized as inferior."<sup>36</sup> Youth of color are aware of at least some of these biases and may experience racism as chronic stressors that affect their mental health. A comprehensive review of over 100 studies examined the association between discrimination and health and well-being of youth finding that "[e]xposure to discrimination predicted worse mental health (e.g., anxiety and depression symptoms) in 76 percent of the 127 associations examined. Similarly, discrimination was inversely associated with positive mental health (e.g., resilience, self-worth, self-esteem) in 62 percent of the 108 associations examined."<sup>37</sup> In addition, several studies found an association between parental racial discrimination and childhood anxiety and depression.<sup>38</sup>

The racial disparities in mental health care reflect ongoing and pervasive racism. An important indicator of acute and chronic unmet behavioral health needs are ED psychiatric visits for youth 6 to 24 years. These visits are increasing across the United States with the greatest increases occurring among Black and Hispanic youth even after adjusting for insurance status.<sup>39</sup>

### ***Disparities in Response***

A recent study found that even when Black youth access care in the ED, they are more likely to be physically restrained. In a sample of over 551,000 visits of patients 0 to 16 years old, in which physical restraints were used, Black youth were 1.8 times more likely to receive a physical restraint than White youth. Boys were more likely than girls to be restrained.<sup>40</sup>

In addition, Black youth are perceived as less "childlike" than their White peers and more likely to be the targets of police involvement. Such involvement is worrisome given that Black children are 18 times more likely than White children to be sentenced as adults and who represent 58 percent of children sentenced to adult facilities.<sup>41</sup>

Indigenous communities have striking higher suicide rates when compared to the U.S. as a whole. The Indian Health Service (IHS) Trends in Indian Health Report, which provides data on American Indians and Alaska Natives residing in IHS service areas identified suicide as the second leading cause of death for

children and youth aged 5 to 24.<sup>42</sup> In May 2022, agencies across the U.S. Department of Health and Human Services issued a joint letter urging states, tribes, and jurisdictions to prioritize and maximize efforts to strengthen children’s mental health and well-being:

“mental health challenges were a leading cause of disability and poor life outcomes in young people even before the COVID-19 pandemic. The COVID-19 pandemic exacerbated the unprecedented stressors young people already faced, as they have navigated pandemic-related deaths of family and friends, illness, economic instability, and fear and loneliness. At the same time, children and youth are remarkably resilient...It is imperative that we work together to implement meaningful and equitable approaches to identify and address mental health needs among children and expand access to high quality pediatric mental health care.”<sup>43</sup>

One in four youth in the U.S. resides in a family with at least one immigrant. Youth- and family-serving systems must be cognizant of the needs of immigrants, including mixed status families. Mixed status refers to a family with both citizen and non-citizen members, with any combination of legal status (asylees, refugees, lawful resident, and those who are undocumented). A common situation is one in which the youth was born in the U.S. and is a citizen with at least one non-citizen parent or caregiver. Immigrant youth and families are heterogeneous and have diverse strengths and needs that affect their behavioral health needs, as well as their access to care.<sup>44</sup>

Immigrants and refugees may experience harm as they depart from their country of origin or secondary location and travel to the U.S. Such harm might include “exposure to sexual assault, human trafficking, and other forms of violence, and from the ongoing stress from starting a new life away from family and culture, as well as prejudice and discrimination received from those in the United States.”<sup>45</sup> In addition, some youth may be traveling alone. Unaccompanied minors arrive in the U.S. or at its border without an adult caregiver or parent. These youth may be “may be exploited, abandoned, or abused on more than one occasion, from pre-migration throughout the journey.... The accumulation of traumatic stressors can extend to their postmigration lives here, where they may face substandard living conditions, social isolation, discrimination, and complicated unification with family members who are known to them only virtually.”<sup>46</sup>

Furthermore, providers of crisis response and stabilization services —especially those providing out-of-home services (e.g., 23-hour crisis stabilization units, respite care, treatment foster care), must ensure that they are utilizing best practices in serving youth who identify as transgender, non-binary, or have other diverse sexual orientation and gender identity and expression. This includes the adoption of non-discrimination policies, processes, and procedures; staff training; and use of preferred names and pronouns. A 2018 study found a strong relationship between mental health symptoms, suicidality, and insecure housing amongst youth who identify as lesbian, gay, bisexual, and transgender (LGBTQ+).<sup>47</sup> A recent survey of youth who identify as LGBTQ+ found that “42 percent...including more than half of transgender and nonbinary youth, seriously considered attempting suicide in the past year. Nearly half of respondents could not access the mental health care they desired.”<sup>48</sup> A 2020 survey by The Trevor Project found that LGBTQ+ youth face significant barriers to care due to inability to afford care, lack of confidentiality, fear of conversion therapy, and identity-related barriers stemming from a workforce unequipped to provide them the care they needed.<sup>49</sup> Such youth need LGBTQ+-affirming care at the point of crisis, and community crisis centers should consider developing LGBTQ+ resources<sup>50</sup> and forming partnerships with homeless prevention partners to protect these youth from housing instability if they must leave family home in the post-crisis stabilization<sup>51</sup> as youth who identify as LGBTQ+ are at increased risk of homelessness compared to their peers.<sup>52</sup> Parental or caregiver support for transgender youth, including the youth’s mental health concerns, is also important; transgender youth are at increased risk for mental health problems and suicide.<sup>53</sup>

Crisis systems should be designed in concert with youth and families with lived experience. The exact design should reflect the specific needs of the community to be served. As entities consider developing youth crisis systems, they should explore the [National Culturally and Linguistically Appropriate Standards \(CLAS\) Checklist and embrace cultural humility](#). Cultural humility is the recognition of power imbalances and implicit bias to avoid authoritative communication and treatment in favor of an open, youth- and family-centered approach that validates their respective lived experience. Like cultural responsiveness, cultural humility notes the importance of providers gaining familiarity with the populations they are likely to serve and emphasizes critical self-awareness and self-reflection to avoid making assumptions about youth and families. Instead, providers become immersed in learning from the youth's and families' perspectives.<sup>54</sup>

States and localities must utilize all available tools to ensure that all youth and families—including those who are LGBTQ+—feel safe and able to access quality services. This requires adoption of non-discrimination policies, development of processes and procedures for the physical safety of participants, workforce training and coaching, and using youth and family members' self-identified names and pronouns.

## **Beyond Beds**

Historically, the crisis response approach for youth has been limited largely to evaluation in a hospital ED. Numerous studies have documented the challenges associated with emergency psychiatric care, including lengthy “boarding” where children and youth remain in the ED – often for several days (or longer)<sup>55</sup> – until a suitable inpatient treatment setting can be located. Generally, ED staff

“are poorly prepared to respond to behavioral health crises beyond suicidality and psychosis... [D]espite efforts to route families to community providers after an initial ED visit, the ED often becomes the ongoing site for recurrent behavioral health crises. 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.”<sup>56</sup>

Some youth are placed in psychiatric residential treatment facilities, residential treatment centers, and group living environments. However, residential facilities are used all too often as a default, when they should only be used when it is the least restrictive setting available to provide the necessary intensity, clinical care and intervention, and supervision required by the child.<sup>57,58,59</sup> Additionally, improvement during a residential placement does not predict future functioning or the ability to sustain clinical and functional improvements after a youth is discharged<sup>60, 61, 62</sup> The most salient factors that sustain positive outcomes following discharge are family involvement and the availability of an array of home- and community-based services (HCBS).<sup>63</sup>

Rather than considering increasing ED and inpatient care as a single solution, NASMHPD has called on states and communities to develop additional HCBS. \* When such services and supports are available and accessible to youth and families, they reduce the need for inpatient and residential treatment beds. The U.S. Surgeon General urged states and localities to address the social drivers of health for youth and families and expand access to behavioral health services by:

“strengthening public and private insurance coverage...ensuring adequate payment for pediatric mental health services, investing in innovative payment models for integrated and team-based

\* For additional information, please see NASMHPD's [Beyond Beds: A Series of Working Papers](#)

care, increasing the participation of mental health professionals in insurance networks, and ensuring compliance with mental health parity laws.”<sup>64</sup>

as well as integrating screening and treatment with pediatric primary care and expanding telehealth, and school-based and crisis services.

The recommendation for additional HCBS is drawn, in part, from an evaluation of the Psychiatric Residential Treatment Facilities (PRTF) federal demonstration program. Nine states were awarded grants to develop and implement HCBS. The evaluation followed over 5,000 children for five years, finding that the HCBS in the demonstration resulted in improved clinical and functional outcomes, reduced suicide attempts, decreased contact with law enforcement, improved school attendance, and led to higher youth and familial satisfaction.<sup>65</sup>

## What is Crisis Stabilization?

Youth-centered crisis response incorporates the recognition that a youth needs a *safe place to be*. Where possible, this would be in the youth’s home setting. Thus, it is important for crisis stabilization to include and prioritize a treatment pathway that leads to a *system* of HCBS and supports. Stabilization services are not an alternative to a robust continuum of care (including acute care in settings such as crisis stabilization units, inpatient care or even residential care if needed) but rather **stabilization services are critically necessary services nested within such a continuum**.

While mobile response can and should be designed to *respond* to an immediate incident, de-escalate the situation, and begin the process of stabilization, states and localities must ensure they also have sufficient capacity to refer for and deliver stabilization services. Depending on the model, these stabilization components may be provided by the mobile response team or by a separate but well-coordinated crisis stabilization provider. No matter the model, stabilization components must be provided to the youth and family as soon as practicable and may continue beyond the immediate crisis needs, with some states providing them for up to six to eight weeks, depending on youth and/or family preferences, and clinical and functional needs of the family system.

A mobile response itself can take time and is often considered active even up to 72 hours to de-escalate a situation. After the immediate intervention, not every youth or family who requests mobile response will require stabilization services, depending on the nature of the crisis, existing relationships with service providers, the availability of natural supports, and the presence of other stressors on the family. Yet, stabilization services must be available to those families who need them as a transition following the mobile response that they received.

During the initial mobile response, the youth should receive a trauma-responsive, individualized assessment. Many states are incorporating the use of a validated, standardized tool (e.g., the [Crisis Assessment Tool](#)),<sup>66</sup> which is used to support the development of an Individualized Crisis Plan (ICP); both the assessment and the ICP are then able to be reviewed during the stabilization period, with the ICP updated to reflect goals and strategies to further address needs. Providers incorporating these steps are well-positioned to engage in a strengths discovery to ensure that strengths are incorporated into the ICP and should actively engage and empower youth and families as active partners in care planning and service delivery. One state, Oklahoma, for example, requires the development of a crisis safety plan in conjunction with the youth and family. The plan must be proactive; written in the youth’s own words; define appropriate and inappropriate behaviors; describe safety steps and supportive services to prevent or manage behavioral triggers; and include methods to manage “negative reactions to the

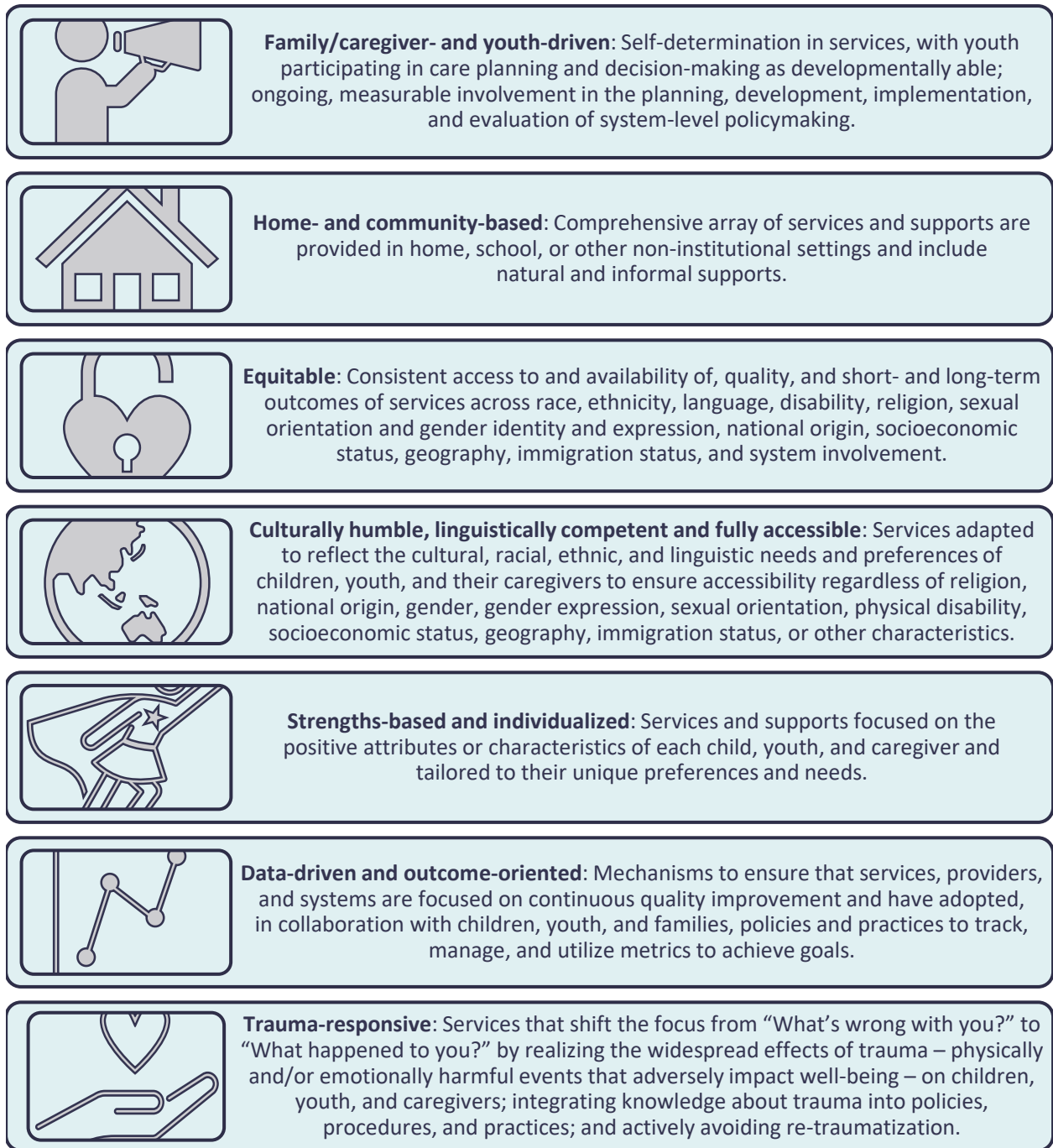


behavior or situation from authorities, peers, and members of the community that could cause further harm or shame to the youth or young adult.”<sup>67</sup> While it is difficult to attribute positive outcomes to any particular intervention, including mobile response, from January 2019 through January 2021, 79 percent of youth who received mobile crisis and crisis planning in Oklahoma were diverted from a change in placement.<sup>68</sup> Similar successes have been reported in Connecticut, with a reduction in ED use,<sup>69</sup> and New Jersey with placement stability.<sup>70</sup>

In systems that have leveraged these more rigorous and standardized models of mobile crisis response the youth, family, and stabilization service provider can work together to develop goals that are integrated into the ICP to address the factors contributing to or maintaining the presenting crisis or situation. Engaging and empowering youth and families often involves identifying unmet needs, communication challenges, and underlying concerns such as familial or other interpersonal conflict; behavioral problems; academic challenges, including special education needs; unmanaged anxiety, depression, or other mental health disorders; symptoms related to trauma exposure; social or peer problems; delayed skills acquisition; and/or housing or financial instability.<sup>71,72</sup>

The ICP typically includes the formal and informal or natural services that will address the factors that contributed to or maintain crises and to prevent further recurrence. The ICP is a living document and must be updated in response to the acuity level, youth and family’s progress and preferences, strengths, and needs. Stabilization services are grounded in Systems of Care (SOC) values and principles (Figure 1).

**Figure 1: Systems of Care Values in Service Planning and Provision. Adapted from Stroul, B.A., Blau, G.M., & Larsen, J. (2021). *The Evolution of the System of Care Approach*. Baltimore: The Institute for Innovation and Implementation.**



## Stabilization Supports and Services

The assessment process will help guide the provider, family, and youth to determine the type and volume of services that would be appropriate to address the identified goals. Examples of such services include parent/caregiver education; positive youth development and recreational programs; family and youth peer support; in-home services; systems navigation, including identification of formal, informal, and natural supports; linkage to home-, school- and community-based services; linkages to psychiatric or primary care services for medication management; psychological treatment; respite care; and care coordination with other family and youth-serving systems, such as education, child welfare, housing, and economic supports. Youth and families should have access to care coordination; parent, infant, and early childhood supports; peer support and natural supports; intensive in-home services; school-, community- and office-based services; and population-specific resources.

A percentage of families and youth will require continued support after the six- to eight-week period of stabilization services. For example, in 2021, 33% of the youth in Connecticut were referred to outpatient services, 8.3% to intensive in-home services, 1.3% to care coordination, and 0.6% to residential treatment.<sup>73</sup> For youth with moderate to complex behavioral health needs, states and localities will need to consider how to transition the roles and responsibilities from mobile response to stabilization providers to other HCBS providers, including other coordinating entities.

When considering, selecting, and referring a youth and family to services, including evidence-based practices<sup>†</sup>, providers should consider the cultural humility and linguistic competency of programming and the fit of the intervention with the strengths, needs, and goals of the youth and family. State and localities are encouraged to adopt consistent training for all providers serving children, youth, and families. In addition to training on child and youth development, the adolescent brain, and trauma-responsive systems, communities can provide training on how data can inform continuous quality improvement; workforce development to eliminate the use of seclusion and restraint; how to establish a performance improvement team with non-tokenized roles for youth and families; and the importance of youth- and family-centered care, respect, and dignity. Family, youth, and other team members should be active participants in making decisions about the transition from stabilization services to ongoing services.



**Figure 2: Key Components of Stabilization Service Array**

<sup>†</sup> See the California Evidence-Based Clearinghouse for Child Welfare (<https://www.cebc4cw.org/>), the Washington State Institute for Public Policy (<http://www.wsipp.wa.gov/>), the Title IV-E Prevention Clearinghouse (<https://preventionservices.acf.hhs.gov/>), the Blueprints for Healthy Youth Development (<https://www.blueprintsprograms.org/>), and the What Works Clearinghouse (<https://ies.ed.gov/ncee/wwc/>) for more information evidence-based and evidence-informed interventions.

### *Care Coordination*

During the stabilization service phase, providers may provide care coordination activities to assist youth and families in developing, implementing, and completing their care plan. Care coordination focused on initial and ongoing stabilization and youth and family resiliency includes, but is not limited to, attending school-based meetings, connecting or re-connecting to formal and informal services and supports, communicating with the medical home or primary care provider about follow-up plans, reviewing insurance and/or entitlement eligibility, and linking youth and families to resources in the community to meet basic needs that may be a barrier to receiving the appropriate level of treatment. In addition, it is critical to engage community partners and peer supports in offering services that align with the cultural, social, and linguistic needs of youth and families. Providers may also refer youth and families to receive additional supports after stabilization services have ended.

This may include, as an example, Intensive Care Coordination (ICC) with Wraparound, a structured model utilizing a child and family team to develop, implement, and monitor an individualized plan of care.<sup>‡</sup> Some states, for example, have developed intensive care coordination (ICC) entities.<sup>74</sup> Though not all states have ICC entities, where they exist, the model includes “assessment and service planning, accessing and arranging for services, coordinating multiple services, including access to crisis services....” The wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. This approach focuses on all life domains and includes clinical interventions and formal and informal supports.”<sup>75</sup> Likewise, for youth and families enrolled in a service like ICC, prior to contacting a crisis line, mobile response should be coordinated and there should be a hand-off to the ICC provider for stabilization services.

### *Parent, Infant, & Early Childhood Services*

Stabilization services are best designed to address children and families through the lifespan, including the early childhood period (generally considered to be infancy through ages 5-8). Children in this age range exhibit behaviors different than those of school-aged peers and specialized experience may be necessary to identify these behaviors as mental health concerns. Children can show characteristics of mental health disorders at a young age and young children process experiences and traumatic events differently than older children and adults.<sup>76</sup> Resources such as the updated *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3R)* supports clinicians to recognize mental health and developmental challenges in young children while understanding how relationships and environment impact health and development.<sup>77</sup> Nonetheless, “early interventions aimed at emotional and behavioral disturbances are more effective when done at preschool age rather than school age.”<sup>78</sup> Infant and early childhood mental health is “the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment and learn all in the context of family, community and culture.”<sup>79</sup>

Stabilization service providers must have the knowledge and skills to support family engagement for young children. Such skills and competencies include understanding “a child’s physical environment, experience of attachment, social relationships, culture, life circumstances (e.g., poverty and domestic violence), temperament, and developmental capacities all impact behavior and social and emotional

<sup>‡</sup> See the National Wraparound Initiative (<https://nwi.pdx.edu/>) for more information.

well-being.”<sup>80</sup> This includes an appreciation of how parents/caregivers experience with trauma, separation, physical and/or behavioral health conditions, loss, socioeconomic status, and cognitive functioning, affect caregiving and coping skills.

Creating positive outcomes for young children requires a two-generation approach that supports the caregivers in the child’s life. Stabilization supports for young children and their families may take the form of parent coaching, postpartum behavioral health treatment, stress management, wellness education, and referral to family-run<sup>81</sup> organizations. Families may benefit from evidence-based and promising practices, including home visiting approaches like Attachment and Biobehavioral Catch-up (ABC), Health Families America, Parents as Teachers, or Nurse-Family Partnership (NFP).<sup>82</sup> There are also evidence-based and promising practices that support improved caregiver-child interactions and address socio-emotional and behavioral health needs. These include Child-Parent Psychotherapy (CPP)<sup>83</sup> and Parent-Child Interaction Therapy (PCIT).<sup>84</sup>

If indicated through initial screening and assessments, stabilization providers should be prepared to refer families to receive Part C Infants & Toddlers Services for children under age 3 if the family and provider identify a possible developmental delay in the child. Part C is a section of the Individuals with Disabilities Education Act; it is a federal grant program that provides assistance to states for early intervention services.<sup>85</sup> Similarly, providers should be aware of infant and early childhood mental health consultation services that may be available to support young children and their caregivers, including in childcare settings, to support children’s social and emotional development;<sup>86</sup> address challenging behaviors in early learning and home environments; and reduce childcare or preschool suspensions and expulsions,<sup>87</sup> which was found to be triple the rate for school-aged peers.<sup>88,89</sup>

### *Family and Youth Peer Support, Natural Supports, and Other Support Models*

Natural supports are individuals who are connected to a youth or family and provide unpaid support. Natural supports include family members, friends, neighbors, after school programs, clergy, coaches, and others. In Wraparound,<sup>90</sup> natural supports “are integral team members” and, “when possible, strategies in the [individual care] plan are undertaken by natural supports within the youth’s and family’s community.”<sup>91</sup> One recent study found that higher percentages of natural supports on child and family teams were associated with better outcomes. These outcomes included decreased youth problematic behavior and impairment and improved child functioning.<sup>92</sup> Natural supports assist with building and maintaining family, friend, and community connections and can help to carry out and sustain interventions after formal services end.<sup>93</sup>

In terms of others who may have important roles in crisis response, in late 2021, the Centers for Medicaid and Medicare Services (CMS) and CHIP [Children’s Health Insurance Program] provided guidance on the scope and payments for community-based mobile crisis services. In a State Health Official Letter, they reinforced the use of peers in crisis services: “Best practices include incorporating trained peers who have lived experience in recovery from mental illness and/or SUD [substance use disorder] and formal training within the mobile crisis team; responding without law enforcement accompaniment, unless special circumstances warrant inclusion, in order to support justice system diversion...”<sup>94</sup> Over thirty states<sup>95</sup> currently permit Medicaid reimbursement for family and/or youth peer support services.

Two states recently included coordination with walk-in or peer-run crisis stabilization in their recently enacted 988 legislations:

- Colorado’s SB 21-154, which requires the non-profit organization operating the 988 hotline to “coordinate access to crisis walk-in centers” which includes peer-run centers.<sup>96</sup>
- Oregon’s HB 2417, which requires the crisis call center to triage calls and “link individuals to follow-up care [including] facilities offering short-term respite services, peer respite centers, and behavioral health urgent care walk-in centers.” The bill defines “peer respite center” as a “voluntary, nonclinical, short-term residential peer support” provided in a home-like setting by a peer-run organization, directed and delivered by individuals with lived experience.<sup>97</sup>

Family peer support providers “...deliver peer support through face-to-face support groups, phone calls, or individual meetings. They bring expertise based on their own experience parenting children or youth with social, emotional, behavioral, or substance use challenges, as well as specialized training, to support other parents and caregivers.”<sup>98</sup> Youth peer support providers connect “...youth and young adults with mental health conditions or substance use disorders with young adults who have experienced similar challenges and completed specialized training to learn how to use their experience to support others. Like adult peer support, [youth peer support] encompasses a range of activities and interactions focused on promoting connection, inspiring hope, and supporting young people with mental or substance use disorders to set their own goals and take steps toward building fulfilling, self-determined lives for themselves.”<sup>99</sup> Youth peer support also may be helpful as young people navigate the transition between, often disconnected, child and adult-serving behavioral health systems.<sup>100</sup>

One approach to supporting youth of transition age is the clubhouse model. This model was developed as a patient-led initiative in the late 1940s. Today, clubhouses are non-clinical peer communities of adults and youth of transition age (typically 14-26 years old). Activities are generally centered on employment (including supported employment), wellness, health promotion, and social/peer relationship building. A 2018 systematic review of clubhouses found that participation in clubhouse activities was associated with lower rates of ED use, re-hospitalization, and increased feelings of satisfaction and self-efficacy; however, the authors note these studies are of varying quality and generally have a small sample size.<sup>101</sup> A 2017 study found that clubhouse members who attended three or more days per week had average one-year mental health care costs of \$5,697 compared to \$14,765 for those who attended less often.<sup>102</sup>

A similar model, the living room model, includes clinical staff in addition to peers. The living room model aids in eradicating the stigma surrounding mental health and monitors the whole individual in assessing the hierarchy of basic needs alongside their crisis concerns. The living room is used as an alternative to the ED; they typically do not serve children but do offer services to youth of transition age. Individuals seeking services are referred to as “guests” and are assessed for safety, including danger to self or others, and basic health. Following the clinical assessments, individuals are paired with a peer to discuss the crisis, including any precipitating events, and to practice coping skills.<sup>103,104</sup> The living room model can also be helping to serve a marginalized/underserved population by working with the whole person and having such a strong peer component.

The inclusion of both family and youth peer support and peer-based models that help emerging adults throughout the crisis continuum, as available stabilization services is critical. Peer support reduces isolation; assists youth and families in navigating child-serving systems, including the often-difficult transition to the adult behavioral health system for those youth who need continued care; promotes hope and resiliency; improves help-seeking behavior; and fosters trusting and supportive relationships among those with lived experience.<sup>105,106</sup> Apart from individual or familial service provision, family and youth peers must be included in the planning, design, and implementation of stabilization services at a system level.

### *Intensive In-Home Services*

Intensive in-home services beyond crisis response include behavioral health and therapeutic services provided to children and families in their homes to address clinical needs and improve functioning. In-home services may be provided through a combination of licensed mental health professionals and other trained or certified individuals.<sup>107</sup> Several states include intensive in-home services in their Medicaid behavioral health service array.

In Massachusetts, In-Home Therapy is provided by a qualified clinician with one or more qualified paraprofessionals; the service includes interventions to enhance the family's capacity to improve the youth's functioning by implementing focused interventions and behavioral techniques.<sup>108</sup> Connecticut's Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS) has three treatment phases and provides four to five hours of clinical services over an average of six months in the home. This program demonstrated evidence that youth with serious behavioral health needs who received the service experienced improvements in psychosocial functioning.<sup>109</sup>

There are several evidence-based practices (EBP) that can be utilized with intensive in-home services, including Family Centered Treatment (FCT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST).<sup>5</sup>

### *School-, Community-, and Office-Based Services*

There are numerous effective services and supports that can be provided in community-based settings, including in traditional clinics, outpatient behavioral health treatment centers, and schools. Stabilization service providers may want to connect families to practitioners to receive individual, family, or group-based therapies or treatment to address needs identified throughout the assessment and stabilization process. Availability of services will vary by community; however, some of the EBPs that may be available in a community-based setting include Acceptance and Commitment Therapy (ACT); Aggression Replacement Training (ART); Brief Strategic Family Therapy (BSFT); Child-Parent Psychotherapy (CPP); Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Eye Movement Desensitization and Reprocessing (EMDR) for child trauma; Familias Unidas; Integrated Dual Disorder Treatment (IDDT); Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Program (MATCH-ADTC); Parent-Child Interaction Therapy (PCIT); Stop Now and Plan (SNAP); The Seven Challenges; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Triple P-Positive Parenting Program. \*\*

Some communities use telehealth consultation and learning opportunities to buttress primary care and to extend access to care especially in the context of shortages of licensed providers and provide initial and ongoing psychiatric consultation as part of stabilization services. Examples of such services include:

- **Massachusetts Child Psychiatry Access Program (MCPAP)** is an example of one state's system of regional behavioral health consultation teams based at academic medical centers designed to provide additional resources to help primary care clinicians (PCC) and their practices to promote

<sup>5,\*\*</sup>: See the California Evidence-Based Clearinghouse for Child Welfare (<https://www.cebc4cw.org/>), the Washington State Institute for Public Policy (<http://www.wsipp.wa.gov/>), the Title IV-E Prevention Clearinghouse (<https://preventionservices.acf.hhs.gov/>), the Blueprints for Healthy Youth Development (<https://www.blueprintsprograms.org/>), and the What Works Clearinghouse (<https://ies.ed.gov/ncee/wwc/>) for more information evidence-based and evidence-informed interventions

and manage the behavioral health needs of youth. The MCPAP provides free collaborative support to all PCCs by implementing a system for the PCC to obtain (1) immediate informal telephonic consultation regarding the mental health needs of any child in the primary care setting within 30 minutes, (2) timely, as needed, provision of formal outpatient consultation for children referred by the PCC, (3) assistance in coordinating care for children who need community mental health services, and (4) continuing professional education regarding children's mental health designed specifically for PCCs.<sup>110</sup> Similar lines and services exist in over 35 states, with more states developing similar models.<sup>111</sup>

- **Project ECHO (Extension for Community Healthcare Outcomes)** is a hub-and-spoke model - the "hub" site offers services and acts as an anchor institution branching out through physically distant "spokes" – that assists a cohort of community providers in responding to challenging cases. Project ECHO has been rigorously evaluated as evidenced by dozens of peer-reviewed journal articles and found effective in delivering behavioral health care to historically underserved populations.<sup>112</sup> Several states, including Colorado, Montana, Nevada, New Mexico, and Oregon have used Project ECHO to facilitate multidisciplinary collaboration to improve behavioral health outcomes for youth and families.<sup>113</sup>

Many schools offer mental health services, including some EBPs, like CBT. As many as 70-80% of children who receive mental health services do so in schools and treatment can be particularly effective when integrated into the youth's academic setting.<sup>114</sup> Schools may have psychologists, social workers, school counselors, or other professionals who can provide individual and group interventions. These services may be provided without a cost to the student, depending on the source of the funding (e.g., Medicaid, block grants, discretionary grants, state/local allocations, etc.).<sup>115</sup>

Caring for a youth's behavioral health condition places unique demands and stressors upon caregivers. Apart from the availability and accessibility of EBPs and other HCBS, respite can provide a safe and supportive environment on a short-term basis for youth with behavioral health needs when their families need relief.<sup>116</sup> Respite is a service intended to assist children to live in their homes in the community by temporarily relieving the primary caregivers. Respite may be offered to families (foster, kinship, adoptive, and birth) during emergencies or on a pre-planned basis to improve youth and family functioning and stability.<sup>117</sup> Although the preference is to provide respite care in the home or community, some youth and families may have a need that is best met with short-term, facility-based care. While respite can play an essential role in reducing caregiver stress and improving quality of life,<sup>118</sup> the benefits are not solely reserved to caregivers. Respite can allow siblings uninterrupted time with their caregiver and give them an opportunity to "recharge" from the stress of living with a sibling with a behavioral health challenge. For the youth, respite care can offer a safe and supportive environment, build life skills, and most importantly help them remain in their own home and community, preventing the need for an out of home placement.

### *Crisis Stabilization Units*

As noted, the preference is to treat the youth in the home and community, yet some youth may need acute care services, including inpatient care, residential treatment, or short-term, facility-based crisis care, sometimes referred to as "23-hour units" (though states vary in the duration of these programs, with some running up to 72 hours, for example). These crisis stabilization units (CSU) should have the capacity to provide urgent diagnostic and functional assessments; crisis intervention, treatment, and support; and medical assessment, including for youth with co-occurring disorders. CSUs also may offer further diagnostic testing, withdrawal management, medication administration or management and



response monitoring, and linkages to home- and community-based services and social supports. CSUs provide an alternative to ED or inpatient hospitalization.<sup>119</sup> As with other services in the continuum, it is essential that CSUs that serve youth incorporate SOC values and principles (Figure 1). CSUs that serve youth must be staffed by providers with appropriate pediatric and adolescent clinical expertise, experience working with family systems, and a commitment to teaming and collaboration. A few states have begun developing youth-specific CSUs:

- **New York** emphasizes that Children’s Crisis Residence (term used for their CSU services) “...are one component of a comprehensive continuum of crisis services, intended to help avert extended emergency room visits and inpatient hospitalizations. Community-based crisis services available within the continuum include crisis hotlines, mobile crisis intervention, and other crisis service components under Children and Family Treatment Supports and Services, as well as Comprehensive Psychiatric Emergency Programs. For children in crisis who are identified as needing a short-term higher level of care, the expanded benefit of a Children’s Crisis Residence [can now offer children and their families the greater level of service and support needed to help ensure a more successful return home.”<sup>120,121</sup>
- **Oklahoma**, which has been a leader in developing mobile crisis services, has two children’s crisis stabilization units: the Counseling and Recovery Service Child and Adolescent Life Management (CALM) Center and Red Rock Behavioral Health Services Children’s Crisis Unit. Both units offer services for children and youth ages 10-17.<sup>122</sup>
- **Virginia** began Medicaid reimbursement for several new crisis services in 2021, including MST, FFT, mobile crisis, community stabilization, 23-hour crisis stabilization, and residential crisis stabilization units as part of Project BRAVO (Behavioral Health Redesign for Access, Value, and Outcomes).<sup>123</sup>

Additional community-based resources may include referrals to concrete services and supports, such as eviction prevention, security deposit funding, and other housing services; intimate partner/domestic violence services; support to access benefits, such as food/nutritional, energy, cash assistance, child care vouchers, mobility support and enrollment in Medicaid/CHIP; tutoring, job training, GED, or other educational and vocational supports; and connections to recreational and social organizations and activities, including camps, after school programming, mentoring, and faith-based entities.

Stabilization service providers should ensure that the physical well-being of the youth and family is addressed in the plan. Providers should check that the youth and family have an identified primary care provider and oral health care provider and receive routine health screens and immunizations. Children and family members with chronic medical conditions (e.g., diabetes, hypertension, asthma, heart disease, etc.) should be supported to access specialty treatment or resources, as needed.

As with all services, referrals should be consistent with the youth and family’s goals, strengths, and needs and should be respectful of their identities and preferences.

### *Population-Specific Services*

All care plans should be customized to the individual strengths and needs of the youth and family and reflect their goals for themselves. Further, there are populations of youth who may benefit from additional population-specific interventions during and after stabilization services. These populations include children and youth with intellectual and developmental disabilities, youth experiencing foster care, and youth with prodromal symptoms of psychosis or early-onset psychosis.

### *Children and youth with intellectual disability/developmental disorder (ID/DD)*

An estimated 1-3% of children and youth have an ID/IDD, with as many as 40% of those children experiencing a co-occurring mental health disorder.<sup>124</sup> However, only approximately 1 in 10 children with a co-occurring ID/IDD and mental health disorder receive specialized mental health services. Co-occurrence of mental illnesses are higher within other neurodevelopmental disorders as well.<sup>125</sup> These children and youth may benefit from receiving a more comprehensive approach to their needs, particularly since this population is heterogeneous with considerable variability in their capabilities, symptom expressions and available natural supports.<sup>126</sup> Some guidelines exist for mental health practitioners to better treat children and youth with a range of challenges from various neurodevelopmental disorders, including adapting psychotherapy approaches to the expressive and receptive language skills of the youth. Adaptations could include language used; length, frequency, and/or duration of therapy; modification of interventions; and engaging in a team approach.<sup>127</sup>

### *Youth experiencing foster care*

Youth experiencing foster care are more likely to experience behavioral health disorders than other children.<sup>128,129</sup> This is due in part to their experiences of child maltreatment, trauma related to removal from the home, and instability while in out-of-home placement.<sup>130,131,132,133</sup> Children in foster care also are more likely to receive behavioral health services in more costly and restrictive environments typically in a child welfare-based residential care system for youth.<sup>134</sup> Youth in foster care who experience a behavioral health crisis are commonly referred to EDs and are at increased risk of placement disruption. Mobile response teams can provide early intervention and support to youth experiencing foster care and to their caregivers to minimize the likelihood of future crises and placement disruptions, but such families often need additional supports and services to maintain stabilization.

Therapeutic foster care (TFC) is a community-based treatment option for youth with serious behavioral health needs. Models of TFC vary by state and community and there is no single approach or set of standards. However, the Family Focused Treatment Association, a membership organization of providers, states that TFC provides the “positive aspects of the nurturing and therapeutic family environment” with “active and structured treatment.”<sup>135</sup> Typically, TFC requires caregivers to complete initial and ongoing trainings, partner with the child’s treatment team and child welfare worker, engage with the child’s family (if appropriate), and support implementation of the child’s plan of care, including any behavioral interventions.

Two evidence-based TFC models are:

- **Treatment Foster Care Oregon** (TFCO; previously referred to as Multidimensional Treatment Foster Care) provides a consistent environment for the youth with daily structure, close supervision, and support to help the youth develop prosocial relationships. TFCO views the foster home as the primary clinical environment and provides daily contact with the foster parent while supporting skill development to address problematic behaviors. TFCO has a model for preschoolers, children, and adolescents.<sup>136,137</sup>
- **Together Facing the Challenge** (TFTC) trains foster parents and agency staff and supervisors to utilize effective parenting techniques, build therapeutic relationships, and prepare youth for adulthood. TFTC utilizes a trauma-informed approach and promotes cultural sensitivity, problem-solving, and cooperation.<sup>138</sup>

### *Youth with prodromal symptoms of psychosis or early-onset psychosis*

Psychosis includes symptoms such as hallucinations, delusions, or confused thinking. Psychosis is most often associated with schizophrenia, which typically does not manifest fully until late adolescence or early adulthood. Some youth may experience what are known as prodromal or early signs of psychosis, which can include bizarre behavior, changes in thinking or speech, preoccupation with a particular topic, and social withdrawal.<sup>139</sup> Individuals experiencing their first episode of psychosis (FEP) benefit from timely linkage to evidence-based services and interventions, including supportive approaches, family work, and medications, as these are critical to reduce the risk of suicide and more intense or worsening symptoms.<sup>140</sup> A host of resources are also available that address the evidence-based practice of Coordinated Specialty Care (CSC) for individuals with FEP.<sup>141</sup>

Clinics and programs across the country are providing specialized treatment to youth and young adults experiencing prodromal symptoms or FEP. The NASMHPD Early Intervention in Psychosis virtual resource center<sup>142</sup> includes information on effective interventions to support these individuals. The Early Psychosis Intervention Network (EPINET)<sup>143</sup> includes eight regional hubs and more than 100 early psychosis clinics across 17 states. Additionally, SAMHSA maintains a treatment locator for early serious mental illness, including psychosis.<sup>144</sup>

## **Conclusion**

The developmental, social, and clinical needs of youth are different from those of adults. A robust crisis continuum of care is needed specifically to meet the needs of youth and families in their homes and communities. Comprehensive crisis response systems geared for youth and family needs include mobile response as well as considerations for a safe place for the youth to be, which can include in-home stabilization services and linkages from mobile interventions to an array of other offerings. The provision of crisis stabilization services in homes and communities for up to six to eight weeks to meet the needs of youth and families who require ongoing stabilization after initial mobile response is a critical component of a continuum, as are appropriately designed settings for acute care. Attention to the needs of diverse populations is essential to ensure equity and access. The stabilization services provided after a crisis are important to ensure that all youth and families have the resources they need to implement crisis plans, improve functioning and well-being, maintain safety, and decrease the likelihood of future crises or other poor outcomes.

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# INNOVATION AND DETERMINATION

How Three States Are Achieving Comprehensive, Coordinated,  
and Sustainable Behavioral Health Crisis Systems

September 2022

Paper No. 5 in the *From Crisis to Care* Series

# Innovation and Determination: How Three States Are Achieving Comprehensive, Coordinated, and Sustainable Behavioral Health Crisis Systems

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## **Abstract:**

State mental health leaders and their numerous partners are enthusiastic about building crisis services systems because they understand the value to both the individuals utilizing the services and the states' mental health systems overall. Yet, the challenges associated designing, building, and funding crisis systems often seem so onerous that they are viewed as barriers that are too difficult or time-consuming to overcome. To help illuminate approaches to overcome these barriers, this paper reviews the current work within three states. These states, Arizona, Utah, and Virginia had a vision for their crisis systems and the conviction to creatively design, build, and adequately fund them. They averted the decades old mindset that all behavioral health system changes are funded through grants, embraced rather than feared learning about complex but ample Medicaid opportunities, and used legislation where it would benefit the new design. Though many states are identifying similar and other strategies, this paper looks at the stepwise approaches used in three unique state systems in creating their new crisis services systems and their successes in developing diverse and sustainable financing methods.

## **Highlights:**

To build a crisis continuum,

- Arizona:
  - Incrementally expanded expectations for the delivery system to create more crisis services capacity,
  - Used a managed care structure to ensure provider choice, comprehensive services, and budget optimization; and
  - Braided additional funding into managed care contracts to cover services that are not compensable by Medicaid.
- Utah:
  - Utilized strategic initiatives to plan and implement crisis programs and track goals and outcomes,
  - Built a crisis system overseen by a Behavioral Health Crisis Response Commission, and
  - Funded Behavioral health services in Utah's Public Behavioral Health System through 6 funding streams.
- Virginia:
  - Began a crisis system transformation with a vision document incorporating recommendations for improvements in behavioral health care for the Medicaid population,
  - Relied upon and credited the Medicaid expansion for shifting the behavioral health system,
  - Continued to expand funding options, with their 988 service fee solidifying sustainability, and
  - Was the first state to enact 988 legislation and with a user fee (March 18, 2021).

## **Recommendations for Policymakers:**

1. Establishing a vision and the approach to system design is critical.
2. Looking within Medicaid is a key strategy for expanding services and funding opportunities.
3. Facilitating adoption of approaches to reduce health inequities and utilize best practices will improve quality.
4. Establishing a multi-year incremental approach can be an important strategy for a smooth implementation given the size and scale of developing these systems.
5. Integrating physical and behavioral health provides for additional gains.
6. Exploring MCO capitation rate options may result in finding cost containment and service flexibility.
7. Identifying the most appropriate service billing codes will assist with generating revenue and promoting parity.
8. Committing to community-based partnerships with payers, providers, organizations, and law enforcement will help solve problems and improve relationships.

The nation has grown in its understanding of the importance of better serving individuals experiencing a suicidal or behavioral health crisis. States are increasingly recognizing the need to build and finance effective service systems to better serve individuals during such crises, in order to improve mental health outcomes, responsibly manage available funding, and save lives. However, across states, crisis services are inconsistent, inadequate, and uncoordinated, and they have not yet realized the vision of “continuum of services” and often do not represent “systems” at all. There are many reasons for these limitations especially in the context of provision of crisis services: definitions of services and provider types vary, organizations and types of services differ, and funding mechanisms are insufficient, siloed, and divergent.<sup>1</sup> Searching for solutions has brought states to the reality that there is no one-size-fits-all crisis system. The essential components of building crisis systems will require creativity, patience, money, compassion and determined collaborators. This paper will examine how three states, Arizona, Utah, and Virginia, created crisis service systems by building on the mix of crisis services already in place while using a different combination of service delivery and financing methods to advance toward sustainable models.

## Arizona’s Behavioral Health Crisis System

For more than 20 years, Arizona has been developing a behavioral health crisis system that has shown considerable success in serving individuals experiencing a crisis. This system has also succeeded in keeping people experiencing a crisis out of jails and hospital emergency departments. It is a system of best practices to which states around the nation are looking to for guidance.

### *The Path to 988 in Arizona*

The desire to progress toward a crisis “system” in Arizona began in the Phoenix metropolitan area with a vision of what a patient-centered crisis system should be, and later grew incrementally to become a regionally-based, statewide system. The state’s approach to crisis services was premised on a model of identified best practices that would serve *anyone, anywhere, anytime*.<sup>2</sup> The architects began with building a partnership that included providers, advocates, Managed Care Organizations (MCO), state agency leaders and law enforcement. The partnership determined that the MCO contracts would serve as the vehicle to realize the services with the following values, guiding system principles and goals:

1. Member and family member involvement at all system levels;
2. Collaboration with the greater community;
3. Effective innovation by promoting evidence-based practices;
4. Expectation for continuous quality improvement;
5. Cultural competency
6. Improved health outcomes;
7. Reduced health care costs;
8. System transformation;
9. Transparency;
10. Prompt and easy access to care; and
11. The Adult Service Delivery System-Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems.



### *The Path to Medicaid as an Option*

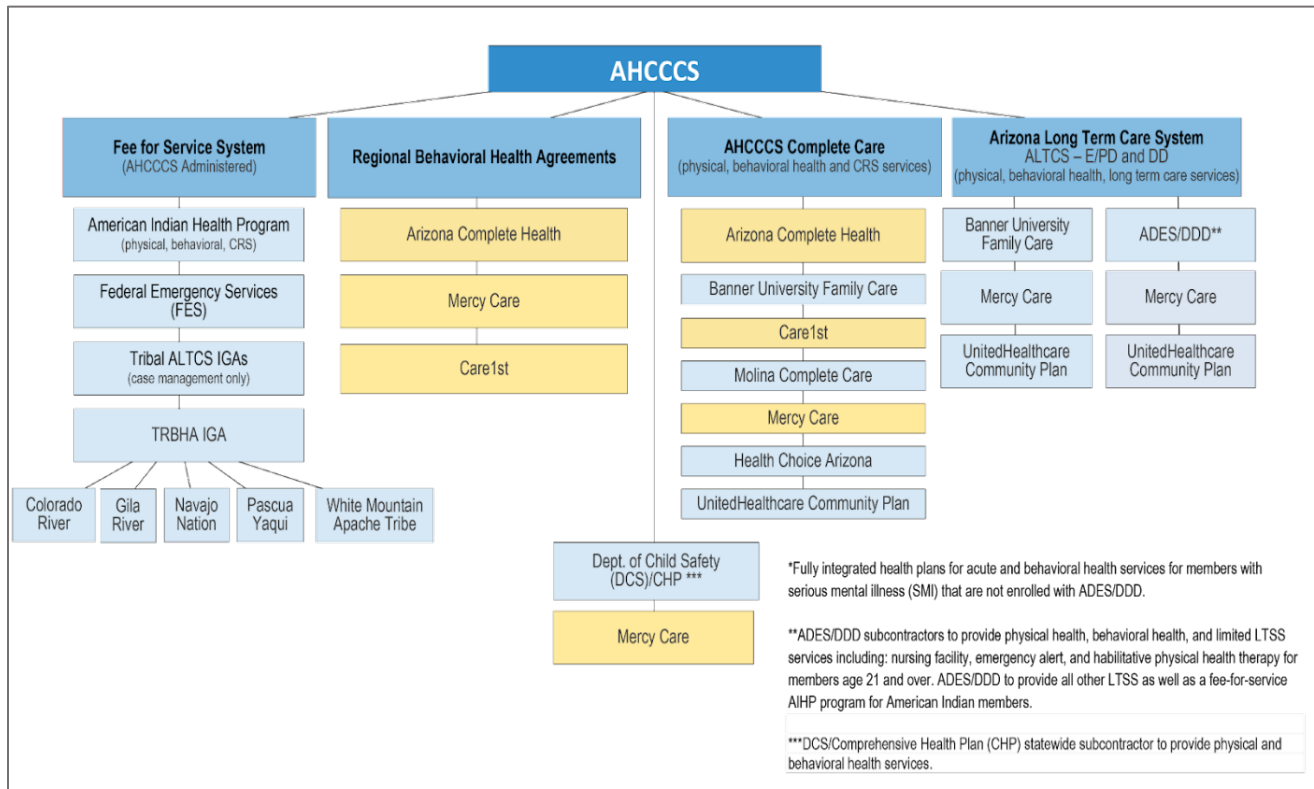
Arizona was the last state to implement a Medicaid program, establishing in October 1982 the Arizona Health Care Cost Containment System (AHCCCS pronounced 'access'), which is Arizona's Medicaid program. Since its inception, Arizona has operated under an 1115 waiver establishing mandatory managed care except for Native American tribes. In 2000, Arizona leveraged the 1115 waiver to expand coverage up to 100% of the Federal Poverty Level (FPL). Some of the expansion populations were frozen during the Great Recession from 2011 to 2013. As a result of legislation enacted in 2013, Arizona restored and expanded coverage up to 138% FPL as established in the Affordable Care Act, which also included enhanced federal matching funds for certain populations. Today, AHCCCS covers 2.1 million Arizonans or roughly 28% of the State's population. Federal funding through Titles XIX (Medicaid) and Title XXI (Children's Health Insurance Program – CHIP) of the Social Security Act is provided to AHCCCS through the Centers for Medicare and Medicaid Services, under the Department of Health and Human Services.

For the first thirty years of the program, AHCCCS operated a carve-out of behavioral health services administered by Regional Behavioral Health Authorities (RBHAs). Starting in 2014, through a series of competitive procurements, Arizona began integrating services. This process began with the RBHAs integrating services for individuals with serious mental illness. Over the next several years, AHCCCS has been integrating physical health and behavioral services at the MCO payer level for all Medicaid populations.

As detailed in **Figure 1**, Arizona has several different MCO contracts:

- The RBHAs are responsible for providing fully integrated services for individuals with serious mental illness and crisis services for all Arizonans.
- AHCCCS Complete Care (ACC) plans are responsible for providing services to the vast majority of AHCCCS members including most children, parents, and adults without dependent children.
- Arizona Long Term Care System (ALTCS) MCOs provide a fully integrated products for those individuals that require long term services and supports.

**Figure 1: Arizona’s Managed Care Organization Contract and Fee for Service Structures for Medicaid Services**



Arizona’s experience building crisis services provides several lessons. As states evaluate options to expand crisis services, delivery system design decisions will be a critical component for leaders to evaluate. With 69% of Medicaid beneficiaries enrolled in comprehensive managed care plans nationally, MCOs play a critical role in the fiscal implications for states.<sup>3</sup> This fiscal impact will necessitate policy-level decisions regarding how services are delivered in a comprehensive crisis system.

To advance a crisis system that would leverage Medicaid to serve anyone, anywhere, Arizona incrementally expanded expectations for the delivery system to create more capacity to serve all Arizonans. The AHCCCS Managed care structure ensured provider choice, and an array of comprehensive services for members. As part of the expansion enacted in 2000, Arizona also leveraged the Rehabilitative State Plan option to create a more expansive behavioral health service package (Figure 2).

**Figure 2: Rehabilitative State Plan Options**

<b>Arizona’s Medicaid Expansion Benefits</b>
<ul style="list-style-type: none"> <li>• Screening</li> <li>• Assessment</li> <li>• Diagnosis</li> <li>• Mental health and addiction treatment services</li> <li>• Targeted case management</li> <li>• Psychiatric rehabilitation services</li> <li>• Peer and family supports</li> </ul>
<b>Current AHCCCS Covered Behavioral Health Services include, but are not limited to:<sup>4</sup></b>
<ul style="list-style-type: none"> <li>• Inpatient hospital services • Behavioral Health Inpatient Facilities (BHIF) • Behavioral Health Residential Facilities (BHRF) • Partial care (supervised day program, therapeutic day program, medical day program) • Individual therapy and counseling • Group and/or family therapy and counseling</li> <li>Emergency/crisis behavioral health services • Behavior management (behavioral health personal assistance, family support, peer support) • Evaluation and diagnosis • Psychotropic medication, including adjustment and monitoring of medication • Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support) • Laboratory and Radiology Services for medication regulation and diagnosis • Screening • Case Management Services • Emergency Transportation • Non-Emergency Medical Transportation • Respite Care (with limitations) • Therapeutic foster care services</li> </ul>

*Additional Contract Requirements*

Arizona braids additional funding into the MCO contracts to cover services that are not compensable by Medicaid. These funding sources include SAMHSA block grants, state only funds and county funding. Finally, Arizona also has been a leader in leveraging strategies to better align services for dually eligible Medicare and Medicaid members.

Arizona has leveraged its regulatory authority to greatly expand expectations for MCOs and providers to deliver crisis services for all Arizonans through contracts and policy. The AHCCCS program is a partnership that includes the State of Arizona, its counties, the federal government, MCOs, and AHCCCS members. At the state level, the program is administered by the Arizona Health Care Cost Containment Administration. The Administration’s basic responsibility is to plan, develop, implement, and administer an indigent health care program based on competitively bid prepaid capitated contracts designed to provide quality health care while containing costs. The Administration’s main responsibilities are member services, quality assurance of medical care, provider and plan oversight, procurement of MCOs, and program operations. AHCCCS oversees the delivery of behavioral health services and the administration of all SAMHSA block grant funds.

The RBHAs within the contractor’s geographic service area(s) are responsible for the delivery of timely crisis services, including telephone, community-based mobile and facility-based stabilization (including observation not to exceed 24 hours). The RBHAs were awarded specialty contracts that assume the financial risk (via actuarially sound capitation rates that reflect actual costs) for crisis services during the first 24 hours of a crisis onset, and any services required after the 24<sup>th</sup> hour are the financial responsibility of the regular MCOs. The managed care aspect of the system provided flexibility by averting a bed limit under Medicaid’s Institutions for Mental Diseases (IMD) waiver that would have had a negative impact on reimbursement. Requests for Proposals and the resulting contracts included a list of requirements that have brought considerable improvements to the system.

Arizona requires contractors to provide a robust behavioral health crisis services network available to any Arizona resident regardless of health insurance coverage. Services are predicated on the Crisis Now model and include:

- 24/7/365 crisis telephone lines operated by trained crisis specialists. The crisis lines are available in all 15 counties and 4 Tribal Nations. They include a line for teens, veterans, COVID-19, and the National Suicide Prevention Lifeline (NSPL). The state has executed a plan to move to a single statewide call center vendor and is looking to expand services to include chat capability.
- 24/7 mobile crisis teams (MCTs), including youth MCTs, are staffed by behavioral health professionals who travel to the individual experiencing a crisis and provide assessment and stabilization services. These teams will triage the individual to a higher level of care, as appropriate. Regional crisis call centers screen and deploy MCTs within each RBHA region.
- Facility-based crisis stabilization centers offer crisis stabilization and observation, including access to Medication Assisted Treatment (MAT). This service is also provided through the RBHAs.

The contract requirements for crisis stabilization centers are detailed in **Figure 3**.

***Figure 3: Request for Proposals/Contract Provisions’ Requirements for Managed Care Behavioral Health Organizations (MCBHO) Crisis Stabilization Centers***

- stabilization of individuals as quickly as possible
- solution-focused and recovery-oriented interventions including avoidance of unnecessary hospitalization, incarceration, or placement in segregated settings
- engagement of peer and family support services
- assessment of and connection to the individual’s needs/supports and services
- no prior authorization
- subcontracted providers to deliver crisis services/response during regular business hours
- local county-based stabilization services to prevent out-of-area transport
- coordination of crisis services on tribal lands with the tribes’ crisis providers
- data and information sharing through a health information exchange to analyze, track, and trend crisis service utilization data for service improvement

- care coordination and collaborative relationships with community partners including fire, police, emergency medical services, hospital emergency departments, Arizona Medicaid, and providers of public health and safety services
- annual training on mental health and crisis services
- information sharing for timely access to Court Ordered Evaluation
- services that are community based and recovery oriented
- MCBHO enrollment within 24 hours of a member engaging in crisis services outside of the system
- defined call center telephone response times
- mobile crisis teams' capabilities, crisis stabilization settings and capabilities
- geographic capitation rates
- provider network capabilities and expectations, and
- service standards, provider qualifications, and coding for and definitions of covered services

*Crisis Services Coding*

**Figure 4** highlights the codes Arizona designates to be used for billing services and defines the services.

**Figure 4: Arizona Crisis Services Billing Codes (FY22)**

<b>Emergency Department (CPT coding)</b>			
<b>99281 – 99285</b>	Emergency department visit for the evaluation and management of a patient. Code depends on key components involved.	varies	varies
<b>Crisis Intervention Services (Mobile, Community Based) (HCPCS coding)</b>		Physician	MCO
<b>H2011 HT</b>	Crisis Intervention Service, multi-disciplinary team	\$71.89	\$51.34
<b>H2011</b>	Crisis Intervention Service, per 15 minutes	\$48.64	\$34.74
<b>Crisis Intervention Services (Stabilization, Facility Based) (HCPCS coding)</b>			
<b>S9484</b>	Crisis Intervention Mental Health Services – (Stabilization) Up to 5 hours.	\$88.66	\$63.33
<b>S9485</b>	Crisis Intervention Mental Health Services – (Stabilization) From 5 to 24 hours.	\$490.71	\$350.51
<b>Crisis Intervention (Telephone)</b>			
<b>Varies</b>	Use appropriate case management service code	varies	varies

The overall allocation of costs by service is as follows: call centers 10.7%, mobile crisis teams 15.7%, and crisis receiving and stabilization facilities 73.6%.

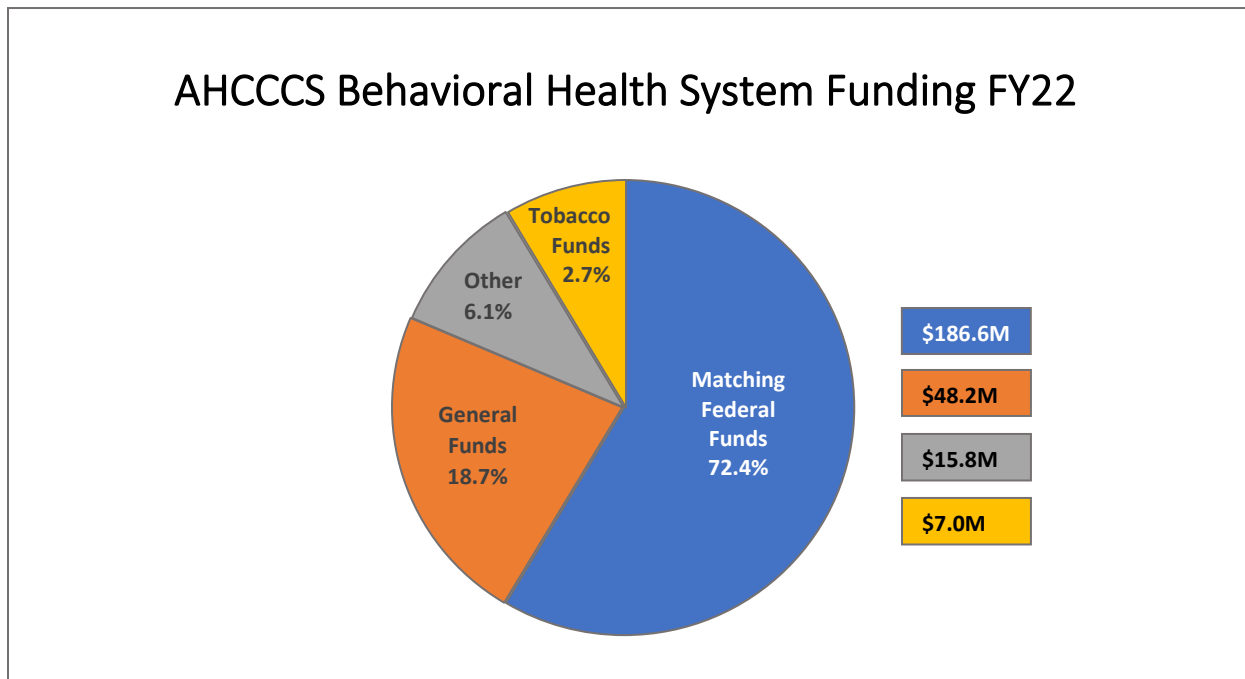
### Funding

As highlighted above, Arizona deploys a diverse financial strategy to achieve its goal of comprehensiveness and sustainability. Medicaid financing is fully leveraged, and state and local dollars are braided to cover the costs of the uninsured and underinsured. In fiscal year (FY) 2020, Arizona spent \$245 million on these services. Medicaid funded the majority (\$217 million), and state and local funds were used to serve individuals who were not eligible for Medicaid (\$28 million). Medicaid funding is provided to the RBHA MCOs through a designated capitation rate that was established to fund crisis services.

The RBHAs receive a specific per member funding stream for each adult and child member enrolled in the AHCCCS program. This is a very unique approach that ensures crisis funds are in essence dedicated for these purposes.

As part of the strategy to leverage appropriate Medicaid claiming, the state also can have the crisis call centers' hotlines bill Medicaid for crisis intervention and emergency management services rendered by mental health providers employed by the hotlines. Although some states have been successful in using Medicaid administrative match to support call center activity, at this time Arizona is the only state that has been identified that leverages program funding. The sources of funding for the FY22 budget for the entire behavioral health system in Arizona can be seen in **Figure 5**.

**Figure 5: Depiction of Arizona's Funding Allocations for Behavioral Health<sup>5</sup>**



### Enhancing the Crisis System Continuum in Advance of Building 988

In 2021, AHCCCS facilitated more than 10 stakeholder meetings and focus groups with people who have lived experience with behavioral health crises and conducted a survey of those with lived experience who have engaged with the crisis system. The survey received responses from 589 people in Arizona, including 180 individuals who had engaged with the crisis system for themselves, and 391 individuals

who had engaged with the crisis system for someone else. A summary of survey results was presented to stakeholders in December 2021 and relevant survey results have been integrated into the 988 and crisis continuum plan as they relate to SAMHSA’s processes and qualities for a successful crisis management system:

- Standardizes crisis care processes and quality.
- Promote suicide prevention as a core component of healthcare services.
- Focuses on resolving mental health and SUD conditions.
- Decreases psychiatric bed overuse and eliminates ED boarding.
- Decreases drain on law enforcement.
- Decreases fragmentation of behavioral healthcare.

Three regional RBHAs have a contract with AHCCCS to cover the continuum of behavioral health crisis services. Individuals who are not Medicaid beneficiaries may receive crisis services from the RBHAs for up to 72 hours. By contract MCOs must serve individuals who are Medicaid beneficiaries after 24 hours and the RBHAs serve non-Medicaid beneficiaries for up to 72 hours. All these services are covered by a mix of State and Medicaid funding.<sup>6</sup>

Arizona will employ an “airport model” using GPS technology to enhance their ability to notify mobile crisis teams to deploy, track their geographic locations, and ensure communications are operational. As their model has an established and successful relationship with law enforcement, a behavioral health professional will be in contact with the responding officer to assist. These calls will be considered a priority for MCT responses, currently with an average 30-minute response time.<sup>7</sup> Arizona already has one of the highest answer rates for the Lifeline today and these strategic steps should ensure that Arizona is well positioned to have the capacity necessary as 988 implementation goes live nationally.

### *Barriers, Challenges, and Unique Population Needs*

Arizona’s Crisis Services System is a comprehensive and coordinated system, but no good plan is created without first addressing the barriers.

Medicaid carveout: The State staff worked to convince lawmakers that eliminating a behavioral health carveout was a sensible plan. They used data (premature deaths of individuals with mental illness and better care through a service continuum) to highlight the dramatic negative impact increased fragmentation had on those experiencing both chronic medical conditions in addition to significant behavioral health needs. Although provider groups and some advocacy organizations had historically opposed integration efforts, the legislature moved unanimously to support the efforts of the Executive branch to transform the delivery system. Arizona began integration efforts in 2015 after the State expanded Medicaid.

Billing codes for Mobile Crisis Services: A limitation in almost every state is billing for mobile crisis services that includes travel time in addition to time with the individual. Billing coding and funding for crisis services must progress to sustain services. Lack of parity with medical care through insurance loopholes make it difficult for providers to obtain reimbursement and patients to get affordable care.

Rural area challenge: Workforce shortages are everywhere but with rural areas in particular there are limits to geographic accessibility. Arizona was able to address workforce issues with a telehealth response system during the pandemic that includes a handoff to physicians who respond to the crisis virtually. Arizona has also provided extensive limited funding for workforce investments by leveraging the enhanced Home and Community Based Funding authorized by the American Reinvestment Program Act (ARPA).

Affordable Care Act (ACA) conflict: The ACA benefited the Arizona system by covering the costs that had been absorbed for some of the population that was uninsured and underinsured individuals for about 10 years.

Sovereignty of Tribal Nations: The 22 Native American tribes in Arizona have the right to define their own crisis services (some consistent with cultural beliefs) and the sovereignty of tribal governments including tribal law enforcement are critical to recognize in developing partnerships. As a result, the crisis “system(s)” for the 22 tribes continue to evolve as they are shaped by each Tribe.

### *Lessons Learned*

Even a very well thought out plan and effective system changes come with some regrets and lessons learned. Arizona would have preferred to be able to work through the nationwide issues presented by private insurance and ERISA health plans related to behavioral health parity. The Mental Health Parity and Addictions Equity Act (MHPAEA) (2008)<sup>8</sup> and the Consolidated Appropriations Act (CAA) (2021)<sup>9</sup> provided regulatory authority to the Department of Health and Human Services and the Department of Labor to ensure coverage of behavioral health services are equivalent to that of physical health services. However, enforcement at the federal level has been problematic, and as such states are beginning to take enforcement actions on their own. Arizona would also like to encourage related changes in Medicare policy. Expanding the system services to children (including those in foster care), individuals with substance use disorders (SUD), and individuals with intellectual and developmental disabilities (IDD) became a recognized need, and these expansions are currently being planned.

### *Sustainability of the System*

There are five factors that were critical in creating a sustainable crisis system in Arizona:

1. Strong system design that created an accountable organization with expectations and funding to develop a system that would serve all Arizonans.
2. Comprehensive funding strategy that fully leverages Medicaid and braids other funding sources to cover the uninsured and underinsured.
3. Incredible community partnerships between payers, providers, community organizations, agency leaders and law enforcement to solve complex operational and logistical issues and overcome historical silos.
4. Strong State leadership and commitment to work through and resolve complex funding, billing, operational and policy issues.
5. An incremental approach that continually looks to improve the system to better serve Arizonans.



## Utah's Behavioral Health Crisis System

Utah has made considerable progress toward a crisis system with efforts by leadership to improve suicide prevention and crisis services. It has roots tackling a broad range of areas such as prevention services through schools, firearm safety education legislation, a student safety and crisis tip line commission, peer-to-peer suicide prevention, resiliency, anti-bullying programs in elementary schools, programs that target populations at high risk such as LGBTQ+ youth, and certification of assertive community treatment teams (ACT teams).

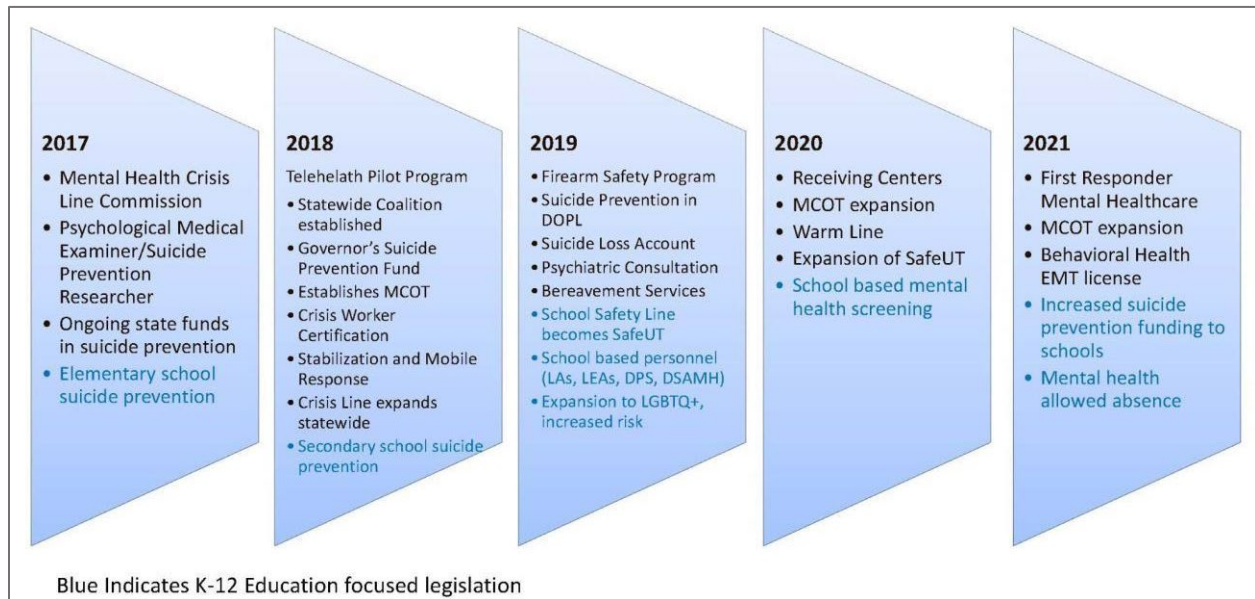
### *A Path to 988 in Utah*

Utah consistently ranks in the top ten in the United States for suicide deaths. From 2016 to 2018, Utah had an average of 647 suicides per year and 4,574 suicide attempts.<sup>10</sup> The Division of Substance Abuse and Mental Health (DSAMH) has been taking action to change this using strategic initiatives to plan, develop and implement programs, while tracking goals and outcomes. Their planning has identified five primary strategic initiatives with a focus on:

1. Prevention and early intervention
2. Adoption of the Zero Suicide model
3. Promoting recovery
4. Improved care for children and youth, and
5. Health system integration.<sup>11</sup>

A foundation for suicide prevention in Utah was formed prior to the first Utah Suicide Prevention State Plan in 2017 (Figure 6). SB37 (2017) created a statewide Lifeline call center (local call centers were already in place).<sup>12</sup> In 2019, the Utah Department of Commerce Division of Occupational and Professional Licensing (DOPL) required a suicide prevention training course for physicians. In 2021 four bills targeting suicide were enacted: Utah HB60 that provides for the transfer of unused funds in the Concealed Weapons Account to the DSAMH for suicide prevention efforts;<sup>13</sup> Utah HB336 created a program to provide training to health care organizations related to reducing suicides;<sup>14</sup> Utah SB127 required congregate care programs to maintain suicide prevention policies;<sup>15</sup> and Utah SB155 created the 988 Mental Health Crisis Assistance Account,<sup>16</sup> designed to strengthen and fund the crisis system.<sup>17</sup> The account was appropriated \$15.9M to support all 988 services as well as the continuum of crisis services including 988 call centers, mobile crisis outreach teams (MCOTs), crisis receiving and stabilization and a list of other state agencies performing related tasks. This comprehensive funding approach has helped the continuum's growth. Their primary funding sources are provided in **Figure 7**.

**Figure 6: Live On Utah's Timeline<sup>18</sup> for the State and Legislative Commitment to Suicide Prevention**



**Crisis System Oversight:** The Utah Behavioral Health Crisis Response Commission, effective March 11, 2021 and Code Section 63-18202, provides oversight/recommendations for the crisis system including what would comprise a sustainable funding source, a 988 fee to improve financial assistance, and a requirement for their Medicaid agency to adopt or apply for a state plan amendment or waiver to support crisis services. Membership represents private and public mental health partnerships, state Medicaid authorities, 911 Public Service Access Points (PSAP), law enforcement, persons with lived experience (member of the public), the telecommunications industry, and six members of the legislative body. A working group of the Commission has developed processes and procedures for the relationship between 911 and 988 like that operating in Los Angeles now. The new procedures are currently being implemented in Salt Lake City. The Commission is also responsible for modeling financial options.

**Crisis Contact Centers:** Suicide contact centers have contracts with the Local Mental Health Authorities (LMHAs) and counties. Utah's contact centers' call volume was 79,645 in FY19, followed by a 32% growth in total calls between FY20 and FY21. During that period 1,353 lifesaving interventions were initiated for the callers at imminent risk of suicide.<sup>19</sup> The centers are funded with General Funds and Federal ARPA and COVID-19 funds. Senate Bill 155 (2021) created the Statewide Behavioral Health Crisis Response Account that authorizes funding through legislative appropriations or private donations. Funds are maintained in a restricted and non-reverting fund managed by DSAMH.<sup>20</sup> The account would then be used for the costs of running 988 including assistance to local crisis teams. It was supported in committee by several organizations including the Chiefs of Police Association. The bill also created and tasked the Behavioral Health Crisis Response Commission to make recommendations to prepare for the implementation of the statewide 988 hotline.

**Mobile Response Teams:** Utah's Mobile Crisis Outreach Teams (MCOTs) are run by the LMHAs rather than by the contact centers. However, the crisis center provides dispatch support based on the assessed need of the caller for in-person crisis support and coordinates dispatches for MCOTs across the State.

SB37 (2017) Statewide Crisis Line created the Mental Health Crisis Line Commission that later became the Behavioral Health Crisis Response Commission guiding the call centers and MCOTs including monitoring response times and ensuring accreditation standards for the MCOTs.<sup>21</sup> MCOTs are available throughout the State and, with exception of a few rural areas, function 24/7. MCOT teams are staffed by a master's level clinician and a certified peer support specialist who has lived through their own experiences with mental health challenges.

Crisis Receiving and Stabilization centers: Utah has two official crisis receiving and stabilization centers (Davis and Utah Counties) providing short-term (23-hour) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. Four more are planned, one in a rural area and three in urban/suburban areas. Two will be operated by an LMHA and the others by a private provider in partnership with their local mental health authorities. The largest of the new centers are planned to open in 2023-2024 making available: 32 beds for receiving and 23 beds for stabilization and withdrawal management services; high acuity short-term residential treatment units; and case management and assisted care transitions and transportation. Additional centers are planned for the southwest area of the State for 2024, the four corners area of the State, and urban Weber County. Although they accept walk-ins, referrals and police drop-offs, law enforcement is also a priority for drop-offs at the crisis receiving and stabilization centers.

A pilot in Davis County reported that in the seven months the receiving center has been open, 228 people have been helped. Without these services, 45% of those referred by law enforcement would have gone to jail, and 18% would have gone to the emergency department. Another 19% would have stayed home, 9% would have gone to a different emergency shelter or crisis center, and the remaining nine percent selected "other." Forty to fifty percent of individuals experiencing a crisis are dropped-off by law enforcement. However, early results from a study being conducted by the University of Utah demonstrate a reduction in law enforcement drop-offs when community referrals increase, as well as success in diverting patients from emergency departments and lowering health care systems' costs.<sup>22</sup>

### *Funding Behavioral Health Services*

Sixty-one percent of Utahans are covered by employer-sponsored insurance, which is the highest rate of employer-sponsored insurance in the country.<sup>23</sup> Although only 12% of Utahns are enrolled in Medicaid, it is the primary funder of behavioral health services in the State. Utah became a Medicaid expansion State when it received approval from the Centers for Medicare and Medicaid Services (CMS) to implement an expansion (effective April 2019) to incorporate adults earning up to 100% of the federal poverty level (FPL). The expansion provided a 70% federal/30% state match rate. Then in December 2019 a second expansion was approved for Utah adults with annual incomes up to 138% of the FPL. This expansion became effective January 2020 with a 90% federal/10% state match rate and with an expectation of an additional 120,000 adults as beneficiaries. Between 2013 and early 2021 the Medicaid enrollment had increased 37% significantly reducing the number of uninsured individuals in the State.<sup>24</sup>

**Figure 7: Primary Funding Sources for Behavioral Health Services in Utah (FY2023)**

Total Funding	General Funds	Medicaid Funds	MHBG & SAPT Block Grants	ARPA & COVID-19 Funds
\$39,688,932	\$36,112,536	\$788,900	\$371,971	\$2,395,525
100%	91%	2%	1%	6%

The Division of Substance Abuse and Mental Health (DSAMH) operates within the Department of Health and Human Services and is responsible for overseeing Utah’s Public Mental Health Delivery Systems. DSAMH contracts with the counties and State funding is appropriated to provide behavioral health services to Medicaid enrollees, uninsured individuals, and other underinsured populations. The General Fund appropriation supports both the Local Mental Health Authorities (LMHAs) and the Utah State Hospital and provides leverage for the funding they receive from SAMHSA federal block grants.<sup>25</sup>

The Division of Medicaid and Health Financing (DMHF) funds the provision of select mental health services provided to Medicaid beneficiaries in the fee-for-service system and beneficiaries enrolled in Medicaid managed care plans (Accountable Care Organizations (ACOs), the HOME Program, and the Children’s Health Insurance Program (CHIP). Most of these services are carved out of fee-for-service (FFS) Medicaid and provided through Prepaid Mental Health Plans (PMHPs) that contract with the LMHAs and are paid a capitated rate for Medicaid enrollees accessing services through the LMHAs. The LMHAs are the major provider for the Public Mental Health Services serving Medicaid enrollees, uninsured individuals, and underinsured populations as well as individuals with Medicare and private insurance. Currently there are 13 LMHAs serving all 29 counties. Funds are allocated to the LMHAs using a needs-based funding formula and the counties are required to provide a fund match of 20% or more. Under the expansion, the Medicaid bundled rate is 7%, but under the FFS system only 3 counties are billing Medicaid. DSAMH’s goal is to maximize the discrete and bundled billing of Medicaid. The share of the State match provided by the LMHAs is used to fund the outpatient portion of the capitated rates paid to the PMHPs, but the State share for the cost of inpatient care is appropriated directly to DSAMH.<sup>26,27</sup>

Public behavioral health preventive services and education are made available through the Utah Department of Health and Human Services and financed with both State and Federal funds (Figure 8 & 9).

- inpatient mental health services
- residential care
- psychotropic medication management
- case management
- outpatient mental health services
- 24-hour crisis care and services
- community supports, including in-home services, housing, family support services, and respite services
- consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information

**Figure 9: Medicaid Covered Mental Health and Substance Use Benefits**

- psychiatric diagnostic evaluations
- psychological testing
- psychotherapy for crisis
- nurse medication management
- psychosocial rehabilitative services
- psychotherapy with evaluation and management services
- qualified targeted case management (provided only to Medicaid recipients with SMI and individuals with SUD)<sup>10</sup>
- mental health assessments
- psychotherapy
- pharmacological management
- therapeutic behavioral services
- peer support services

*Funding Behavioral Health Services for Children, Youth and Families*

The Children, Youth and Families system is managed through the LMHAs, and the contracted providers’ scope of work for the system is funded through numerous sources including appropriations and grant funding. DSAMH provides the data collection and analyses. Youth mobile outreach crisis teams are available 7am to 11pm every day of the year and offer consultation and support to individuals, families, schools, treatment providers, and first responders. Follow-up services, like ongoing support including intensive in-home stabilization services and referrals to health care providers and behavioral health services in the community, are also provided.

*Funding for Physical Health*

Physical health services are provided through Utah’s Medicaid ACOs. Because they only cover limited mental health screening, evaluation, and maintenance services, Medicaid patients in need of mental health care who seek treatment from their primary care provider are typically referred to the LMHAs.

*Challenges for the Public Behavioral Health System*

Utah identifies one of the greatest challenges that their system faces currently is the recent strains associated with workforce issues. The size of the provider workforce is not keeping pace with the growing number of Medicaid enrollees. This is coupled with the fact that only a small percentage of

Utah's mental health workforce accept Medicaid patients (35.7% in 2015). Utah's urban areas had 171 mental health full-time equivalents (FTE) per hundred thousand people in 2015. Rural areas, however, only had 141 FTEs per hundred thousand people.<sup>28</sup> The State is undergoing a further system transformation with the integration of the Department of Human Services with the Department of Health to build a more inclusive public health system, the Department of Health and Human Services. Though there are promises with this shift, there are also challenges as the new agency will shift budgets, positions and organizational framework and yet continue to work on building out this crisis continuum.<sup>29</sup>

### *Lessons Learned*

Utah shared three lessons learned while building their crisis system:

1. Use leveraging to the extent possible;
2. Move to discreet billing codes but be sure to both enforce a crisis system funding route and build the administrative infrastructure to support it; and
3. Obtain legislative and stakeholder backing for any policy issues.

### *Sustainability of the System*

There are three factors that provide for the support for a sustainable crisis system in Utah:

1. History of policymakers actively supporting continued growth in suicide and crisis services;
2. Behavioral Health Crisis Response Commission, a large and diverse group, whose sole purpose is providing guidance for the system and examining sustainable funding sources with required reporting in December 2021 and December 2022; and
3. Diversified list of funding sources, strong in General Funds, Medicaid financing, and Federal Block Grants.

## **Virginia's Behavioral Health Crisis System**

Virginia's journey to a system for crisis services began about five years ago when the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) collaborated with the Farley Center at the University of Colorado to develop an enhancement proposal for a trauma-informed, evidence-based, and cost-effective behavioral health care continuum.<sup>30</sup> The agencies also conducted a service analysis to identify gaps and existing services, review evidence-based practices, and perform a stakeholder survey. This collaboration resulted in the development of a vision document entitled the "Virginia Medicaid Continuum of Behavioral Health Services" (2018) which provided recommendations to achieve the vision of improved behavioral health care for Virginia's Medicaid population.<sup>31</sup> The recommendations included a comprehensive review of evidence-based practices, an examination of current services and gaps in Medicaid-covered behavioral health services, and input from diverse stakeholders invested in better behavioral health care for all Virginians. The recommended enhancement initiative redirected Medicaid toward an integrated behavioral health system. Concurrent with the planning efforts, Virginia was also initiating a shift in the Medicaid program that included an eligibility expansion (effective January 1, 2019), as well as a process to integrate behavioral health services into managed care organizations (MCO). The shift to Medicaid expansion changed the behavioral health landscape in Virginia, as it created greater necessity for Community Service Boards to bill Medicaid as the uninsured population decreased and the overall

demand for services increased. It also underscored the need for the full behavioral health network of providers to meet this need. Indeed, current data demonstrates that most Medicaid members participate in services with private providers rather than with community service boards in Virginia.

### *The Path to 988 in Virginia*

The overall vision of behavioral health enhancement in 2018 was to rebalance Virginia’s Medicaid behavioral health system away from high-cost inpatient hospital and residential settings toward lower cost outpatient, prevention and promotion services, and evidence-based community services, while maintaining budget neutrality and not increasing the overall spending of the Medicaid program. This enhancement initiative redirected Medicaid toward integrated behavioral health services, outpatient services, and comprehensive community-based crisis supports that included the pillars of a crisis services system – warm lines, 24/7 crisis call centers, peer crisis services, mobile crisis services, 23-hour stabilization, and short-term crisis residential stabilization services.

### *The Path to Medicaid as an Option for Funding and Enhancing Crisis Services*

DBHDS credits the Medicaid expansion for shifting the behavioral health system, by increasing the population eligible for Medicaid services and increasing the role of Medicaid in the public system. Virginia authorized major changes to its Medicaid program in 2018, including expanded eligibility to cover more adults, including those without children; cross disability and generational expansions; and employment and housing support for high need populations. More than 674,000 Virginians are currently enrolled in Medicaid because of expanded eligibility rules that took effect in January 2019.<sup>32</sup> More than 300,000 individuals enrolled in Medicaid expansion during the first eight months. The total uninsured rate declined from 12.3% to 11% between 2018 and 2019.<sup>33</sup> Prior to these changes behavioral health was a carveout, and emergency departments were the door to the crisis system.

### *Other Collaborations and Concurrent Events that Drove Change*

Stakeholders: Project BRAVO (originally called Behavioral Health Redesign and then Behavioral Health Enhancement), was launched in 2018 under the leadership of DMAS and DBHDS with strong stakeholder engagement. Over 100 stakeholders from provider groups, community service boards (CSBs), providers, criminal justice, Public Safety Answering Points (PSAPs), and mobile crisis teams collaborated with the State agencies on a continuum of behavioral health enhancements through a multi-phase initiative. Then funding cuts and COVID-19 caused delays, but BRAVO achieved broader financing through service enhancements (Figure 10) that were all implemented by December 2021:<sup>34</sup>

- multisystemic therapy
- functional family therapy
- intensive outpatient services
- partial hospitalization programs
- assertive community treatment
- mobile crisis response
- community stabilization
- 23-hour crisis stabilization
- residential crisis stabilization

Call Center Changes: In order to improve crisis call centers and become compliant with the National Suicide Prevention Lifeline’s (NSPL) accreditation standards and answer rates, Virginia applied for planning and implementation grants, and purchased a data platform. The 988 call centers are organized into five regions and accredited by the NSPL. Call centers request insurance information enabling them to direct uninsured individuals to State reimbursed services. Each regional hub (State fiscal agent who subcontracts with the call centers) will have memorandums of understanding (MOUs) with service providers in their area. The MOUs allow private crisis providers to bill Medicaid or other insurance, or when available, receive payment from the regional hub if the provider serves an uninsured person. This arrangement allows call centers to dispatch any type of mobile crisis service provider, whether State-funded or private. Virginia’s 911 call matrix has four risk levels—routine (level 1), moderate (level 2), urgent (level 3) and emergent (level 4). The 911 call centers triage the first two levels to regional 988 call centers, including moderate calls requiring in-person intervention.<sup>35</sup> Three NSPL call centers serve the entire State, and 40 emergency service lines are associated with each of the CSBs. Currently, there are six crisis lines for children spread regionally across Virginia, and four adult and child I/DD crisis lines. These efforts have improved the in-state call answering rate by 35 percentage points, from 50% to 85%.<sup>36</sup>

Mobile Crisis Teams: System Transformation Excellence and Performance, or STEP – Virginia, a group of executive directors from the 40 CSBs, convened to work on implementation of mobile crisis teams, and crisis system quality, outcomes, and universality. Mobile crisis service delivery reflects the provider patterns found overall in the Medicaid behavioral health program—most services are provided by private providers, while the CSBs serve as the safety net with a mandate to serve the un- and under-insured. CSBs were accustomed to a system funded through general revenues and block grants with more flexibility in funding than that of private providers. However, private providers in all regions are required to be linked to the CSB Regional Hub and the data platform. As Virginia worked through stakeholder engagement issues around crisis systems development, CSB and private providers were challenged to consider their roles in creating a comprehensive system for the commonwealth. Both sets of stakeholders worked collaboratively to develop the protocols that are the backbone of the establishment of Marcus Alert programs, named for Marcus-Davis Peters, a young, Black biology teacher who was killed by Richmond police in 2018 while experiencing a mental health crisis. The initiative was implemented in all regions of the State to provide evidence-based responses to behavioral health emergencies and reduce negative outcomes involving the use of force in law enforcement interactions when an individual is experiencing a crisis related to mental health, substance use, or I/DD challenges.

Because a behavioral health emergency requires a behavioral health response, DBHDS worked with the Department of Criminal Justice Services to create a framework for a statewide implementation plan to achieve this behavioral health response and each locality was required to use the framework to write a more specific local plan. Per Senate Bill 1302 by July 1, 2026, CSBs in Virginia with a population base greater than 40,000 must establish community care teams (CCTs) or mobile crisis teams (MCTs) with protocols in place for a diversion of certain 911 calls to 988 crisis call centers, and for law enforcement participation in the Marcus alert system.<sup>37</sup> An MCT includes a mental health professional, a peer recovery specialist, or a family support partner. A CCT includes a mental health service provider and may also include registered peer recovery specialists and law enforcement agencies, but with mental health providers leading to help stabilize and law enforcement providing backup support. Children’s mobile



crisis teams were prioritized in 2020. The Commonwealth has been thoughtful about developing a system for all generations and needs, but it is still growing and at risk of exceeding capacity.

Virginia addresses health disparities by requiring provision of linguistically and culturally competent care. Teams must also reflect the diversity of the community and include individuals with lived experience. Managed Care Organizations are all in network for mobile response. In addition, the legislation required reports on successes and problems, analysis of operations, any disparities in response and outcomes by race and ethnicity, and recommendations for program improvements.

Crisis Receiving and Stabilization Services: Virginia has 36 Crisis Intervention Team Assessment Centers (CITAC), 12 Adult Crisis Stabilization Units (CSU), 3 State funded child CSUs, 5 Crisis Therapeutic Homes (CTH) for adults with an I/DD, and 2 CTHs for children with I/DD. Comprehensive crisis receiving centers are funded by the DBHDS through CSBs. Crisis receiving centers use Medicaid billing, general funds, and block grants. One CSB contracts with a private provider for their crisis receiving center. Prevention following a crisis is community-based and uses community stabilization as a bridge to prevent cycling until longer term community services are available.<sup>38</sup>

Funding Crisis Services: Virginia Medicaid provides an array of behavioral health services through two Medicaid Managed Care programs, CCC Plus and Medallion 4.0, and contracts with six Managed Care Organizations (MCOs) and the Medicaid Behavioral Health Services Administrator, to provide healthcare coverage for these services. However, Virginia has taken the approach of many other states and is looking to funding sources to cover infrastructure and services not covered by Medicaid. The mix of financing methods described below will enhance the sustainability of system funding.

SAMHSA Grant Funding: For Fiscal Year 2022, the Commonwealth was awarded \$20,807,818 in Mental Health Block Grant (MHBG) funds and \$46,202,091 in Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Other SAMHSA funding was also provided for a total of \$67,009,909. These funds support a wide variety of services provided by Virginia's community services boards and private providers.

Commonwealth General Funds: The Governor's budget for the Commonwealth is appropriated for 2-year periods. General funds appropriated in the FY2023 budget for crisis services by line item for Year 1 and Year 2 include:

- Community Services Boards and Behavioral Health Authorities pursuant to the STEP-VA process and Chapters 607 and 683, 2017 Acts of Assembly - \$ \$117,164,556 in FY 23 and \$123,943,663 in FY 24.
- Crisis services for individuals with mental health or substance use disorders - \$13,954,924 and \$26,954,924 for STEP VA Crisis in both FY 23 and FY 24. The FY 23 amount includes \$13.0M in State and Local Fiscal Recovery Funds and the remainder is General Funds.
- 32 drop-off centers to provide an alternative to incarceration for people with serious mental illness and individuals with acquired brain injury and co-occurring serious mental health illness. (Priority for new funding was given to programs that have implemented Crisis Intervention Teams (CIT) and conducted planning for drop off centers.) - \$10,500,000 and \$10,500,000
- CIT Training programs in six rural communities - \$657,648 and \$657,648

- Crisis intervention assessment centers in six unserved rural communities - \$1,800,000 and \$1,800,000
- Crisis Team Assessment Centers of Crisis Stabilization Units (dedicated to a specific geographic area) - \$2,000,000 and \$9,000,000, plus an additional \$7,000,000 from the State and Local Fiscal Recovery Fund in FY23 (dedicated a to specific geographic area)
- STEP-VA for crisis detoxification services - \$2,000,000 and \$2,000,000
- STEP-VA Marcus Alert - \$6,000,000 and \$6,000,000
- STEP-VA Crisis Call Center Dispatch - \$4,697,020 and \$2,697,020, and an additional \$4,732,000 in FY23 and \$7,453,798 in FY24 from the Crisis Call Center Fund

Service Fees: Virginia was the first state to enact 988 service fee legislation (March 18, 2021).<sup>39</sup> The law is very comprehensive, covering all provisions in the 988 Model Bill and creating 988 crisis contact centers (utilizing calls, chats and texts that are interoperable across emergency response systems), community care teams, and mobile crisis teams.<sup>40</sup> Their Crisis Contact Centers Fund is a dedicated and non-reverting fund. 988 fees from wireless bills include a monthly fee of \$0.12 assessed on wireless accounts and \$0.08 on prepaid accounts to be deposited into the Crisis Call Center Fund. The fee amounts were based on call center costs using Virginia and Vibrant estimate methodologies. Fee revenues are held in a Crisis Contact Centers Fund and are to be spent on the crisis system along the entire continuum of care including the crisis contact centers, community care, mobile crisis teams, crisis stabilization centers, and the Mental Health Awareness Response and Community Understanding Services (MARCUS) alert system. The bill also provided for 911 enhancements - next generation of 911, i.e., direct dial, notification, and dispatchable location requirements. The 2021 Fiscal Impact Statement provided by the Department of Taxation states that the Crisis Contact Centers Fund would receive \$9.2 million in FY22 and \$10 million in FY23 and each year beyond (Note: Of the \$10 million allocated, half is from 988 legislated fees; in FY23 general fund reimbursements doubled (half fees and half general funds); and an additional \$2m is expected from SAMHSA).

The costs associated with establishing a crisis hotline infrastructure were \$5 million in FY21 for the Crisis Contact Centers. In FY22, costs are \$4.7 million for Crisis Contact Centers staffing and \$375,000 for maintenance, and in FY23 would increase to \$9.5 million and \$500,000, respectively. The 988 call centers infrastructure is not built from scratch but requires leveraging existing local call centers and consolidating their phone numbers as part of the system enhancement.

Crisis Services Medicaid Program and Billing Structure: In the March 2021 Medicaid Bulletin, “Enhanced Behavioral Health Services/Project BRAVO: Behavioral Health Redesign for Access, Value & Outcomes” Virginia implemented programmatic changes and developed new service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for crisis services (Figure 10 & 11).

**Figure 10: Services Codes and Reimbursement Rates for New and Affected Services for dates of service on or after December 1, 2021\***

Service Name/ Procedure Code	Rate Range	Modifier Criteria
<b>Multisystemic Therapy H2033</b>	\$46.03 to \$55.03 per 15 minutes	New vs. Established Team QMHP/E or CSAC/S Masters vs. bachelor's degree
<b>Functional Family Therapy H0036</b>	\$34.11 to \$44.17 per 15 minutes	New vs. Established Team QMHP/E or CSAC/S Masters vs. bachelor's degree
<b>Mobile Crisis Response H2011</b>	\$63.18 to \$117.27/ per 15 minutes	LMHP-type Emergency vs. Non-Emergency Custody Order Prescreening QMHP-A/QMHP-C/CSAC with or without PRS or CSAC-A, A/C/E, and # of QMHPs
<b>Community Stabilization S9482</b>	\$35.76 to \$76.29 per 15 minutes	LMHP-type QMHP-A/QMHP-C/CSAC with or without PRS or CSAC-A, A/C/E
<b>23-Hour Crisis Stabilization S9485</b>	\$817.83 per diem	Emergency Custody Order (ECO) or Temporary Detention Order (TDO)
<b>Residential Crisis Stabilization Unit H2018</b>	\$684.48 per diem	Emergency Custody Order (ECO) or Temporary Detention Order (TDO)
<b>Applied Behavior Analysis 97151- 97157 0362T, 0373T</b>	\$11.35 to \$68.11 per 15 minutes	LBA, LMHP, LABA, Technician Level 2 staff or additional staff with child

Key: QMHP: Qualified Mental Health Professional (QMHP), QMHP-Child, QMHP-Eligible (the same as Board of Counseling QMHP-trainee); CSAC/S: Certified Substance Abuse Counselor or Certified Substance Abuse Counselor Supervisee; LMHP Type: Licensed Mental Health Professional (LMHP), LMHP-Resident, LMHP-Resident in Psychology, or LMHP Supervisee, CSAC/S: Certified Substance Abuse Counselor or Certified Substance Abuse Counselor Supervisee; Technician level includes LMHP-Rs, LMHP-RPs, LMHP-Ss, Registered Behavior Technicians (RBTs) and other unlicensed level staff.

\* Rates are all subject to a 12.5% rate increase that went into effect July 1, 2022

**Figure 11: Implementation Timeline Chart**

<b>2017</b>	<ul style="list-style-type: none"> <li>Behavioral health is carved into Medicaid managed care</li> </ul>
<b>2018</b>	<ul style="list-style-type: none"> <li>Launch of 1115 Medicaid expansion, resulting in a significant shift in financial landscape for behavioral health</li> <li>Move to align crisis services with national best practices ensuring cross disability and generational expansion</li> <li>BRAVO was not funded in Governor’s budget</li> <li>April - rate study funded in budget; used rate increase for Fall 2019 and 2020 budgets</li> </ul>
<b>2019</b>	<ul style="list-style-type: none"> <li>May/June - visited GA and AZ to study comprehensive crisis systems</li> <li>September - received 988 implementation grant to improve Call Center answer rates</li> <li>December - Mercer completed a rate study that determined provider reimbursement rates</li> </ul>
<b>2020</b>	<ul style="list-style-type: none"> <li>COVID froze the budget and funds were unallotted, but then were reallocated in November 2020</li> </ul>
<b>2021</b>	<ul style="list-style-type: none"> <li>January - year later received planning grant that was implemented in 2019-2021</li> <li>February - funds allotted for Crisis Receiving and Stabilization and MCTs</li> <li>July - purchased data platform</li> <li>July - outpatient CPT crisis codes came on board</li> <li>December - CRS and MCTs went live; rates for all remaining crisis services went live in Medicaid</li> </ul>
<b>2022</b>	<ul style="list-style-type: none"> <li>June - MCT dispatch launches</li> </ul>

*Barriers, Challenges, and Unique Population Needs*

The transition from the original to the new crisis services system required operating two crisis systems simultaneously. Because Virginia is in mid-transition and putting tremendous efforts into education about the new system and its related culture change and because these are large and complex systems, it will take considerable time especially with new partners to realize the benefits.

Workforce: Although great efforts have been made by the CSBs to stand up mobile crisis teams, staffing shortages have made it difficult. The percent of need for mental health professionals met in Virginia is 42.6%, compared to the national percent of need met (28.1%).<sup>41</sup> The programs below are examples of initiatives underway to address workforce concerns:

The Virginia Health Care Foundation has proposed a pilot program to pay the fees (currently \$10,000 or more) for supervision by licensed behavioral health professionals as they work to obtain their licenses. It will target graduates, including people of color and providers hoping to work in underserved areas. There is a contract with the Foundation for \$3M for a pilot to remove this barrier.<sup>42</sup>

The Direct Support Professional Career Pathway Program was developed to create a more positive workplace, raise morale, and improve recruitment and retention. It includes partnerships involving DBHDS, community colleges, College of Direct Support, and others. It is envisioned that the career pathway will improve the overall competency level of staff, lead to a more positive workplace

environment, raise morale, improve recruitment and retention measures at the facilities while supporting higher quality care and service.<sup>43</sup>

The Virginia Public Sector Leader Program is a leadership development certificate program of Virginia Tech's School of Public and International Affairs. The curricula are developed by the faculty and the four program levels all address emotional Intelligence, management functions, leadership and decision-making, team building and influence, and strategic process.<sup>44</sup>

Culture change related to law enforcement's role in crisis response: Virginia has worked to achieve and desires a culture change regarding a law enforcement response. However, three areas related to law enforcement are hampering progress in that area. Law enforcement is heavily involved and still has concerns about not being on scene (interest in and involvement with MCTs varies geographically). The second barrier is Virginia's law requiring the individual to be in custody at the crisis centers. In addition, mobile crisis response has a legal base in assessments for temporary detention orders. Using the data platform for future reporting of outcomes such as the number of calls transferred from 911 to 988 and the number of crisis responses handled successfully without law enforcement may be helpful in changing the law enforcement mindset and move Virginia closer to the MARCUS law requirements.

Challenges: As the fee is very important to the sustainability of the crisis system, a challenge was planning the legislative approach for a fee. The agencies were fortunate in finding a legislator who both supported the effort and was creative in structuring a bill that would be successful.

Although all states are suffering with workforce challenges, Virginia was successful in using workforce policy changes to shape the behavioral health system. The Commonwealth expanded nursing scope-of-practice provisions and granted autonomous practice to nurse practitioners, growing the number by 52% in five years. They also began registering Qualified Mental Health Professionals (QMHPs) and peer recovery specialists experiencing a growth to 20,000 over a two-year period.<sup>45</sup>

### *Lessons Learned*

Virginia shared four lessons they learned while building their crisis system:

- Developing strong partnerships and fostering those partnerships in person (or virtually) is particularly meaningful.
- The path would have been easier if they had engaged in more and earlier partnering for the process, demonstrating accomplishments, and investing in people through truly engaging stakeholders.
- Some conversations are more meaningful when in person, but conversations are the key even if virtual.
- Identifying a crisis point person whose sole responsibility is building out the crisis system would be a tremendous support for facilitating change. All coordination and communications would be through that individual. An additional point person in Medicaid, or one individual representing both agencies, would also be beneficial.

## *Sustainability of the System*

Of the individuals receiving mental health services in SFY2018, 71% of all adults served had a serious mental illness, and 73% of all children served had or were at risk of having a serious emotional disturbance. In addition to growth in the CSBs, Medicaid expansion and integration has resulted in provider expansion through private and non-profit organizations. The need for behavioral health services is growing, and the provider base is growing, but can it grow to fit demand, and can Virginia afford to finance the growth? The financial modeling by the contractor Mercer looked at utilization, billing codes, etc. to help direct the system in a fiscally sustainable direction. A rate structure is critical, and Virginia required the MCOs to use the network and pay established rates. This thoughtful rate approach coupled with MCO mandated expectations around crisis, Medicaid expansion and integration have resulted in Medicaid becoming a significant part of the overall sustainability strategy for Virginia.

The Virginia General Assembly approved Medicaid expansion as part of its FY 2019-2020 budget in May 2018, and enrollment began on November 1, 2018. More than 641,000 people were enrolled as of March 2022. Virginia also has a State-run health exchange that covers over 308,000 individuals in private individual market plans. These programs diversify funding and thus are critical to the sustainability of the system.

Funding sustainability is solidified in the 988 fees and in Medicaid where one in four persons are Medicaid beneficiaries. Given the multi-system involvement of many individuals with behavioral health issues, Virginia's crisis system approach utilized administrative infrastructure and leveraged strategic funding strategies to improve care coordination and outcomes, manage costs, and better invest resources for a growing crisis delivery system.

## **Conclusion**

In their *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, SAMHSA emphasizes that crisis services must be designed to serve *anyone, anywhere and anytime*.<sup>46</sup> Communities that commit to this approach and dedicate resources will see better care, better health outcomes and lower costs. SAMHSA has also noted that a successful crisis management system has the following processes and qualities:

- Standardizes crisis care processes and quality
- Promotes suicide prevention as a core component of healthcare services
- Focuses on resolving behavioral health conditions
- Decreases psychiatric bed overuse and eliminates ED boarding
- Decreases drain on law enforcement
- Decreases fragmentation of behavioral healthcare.

Arizona, Utah, and Virginia have committed to SAMHSA's best practices and developed well-designed, comprehensive crisis management systems that are supported by their state and

### **General Resource List**

*Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies, Authored by Manatt Health, February 2022*

*Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid, Report to Congress on Medicaid and CHIP, MACPAC, June 2021*

*Guth, M, State Policies Expanding Access to Behavioral Health Care in Medicaid, Kaiser Family Foundation, Dec 09, 2021*

*Norris, L, Arizona and the ACA's Medicaid expansion, December 1, 2021.*

local governments. The three service features that the three states have in common are those recommended in the *National Guidelines*: regional or statewide crisis call centers coordinating in real time; centrally deployed, 24/7 mobile crisis services; and short-term crisis receiving and stabilization programs.<sup>47</sup> Their effective systems are sustainable in that they have not relied solely on grants, nor on braiding of small or unreliable sources of funding. They have worked to incorporate a mix of funding sources that will grow as their programs grow and have adopted systemwide continuous quality improvement methodologies to ensure that the services work together, offer quality, and are cost-effective thus producing positive outcomes for the individuals they serve. The lessons they have learned in building these services can provide a useful playbook as other states embark on similar activities.

Although three states are highlighted in this paper, it is important to acknowledge that many other states are continuing to push for change that is envisioned with a new crisis services system. For the first time in many decades, there will be opportunities to expand behavioral health crisis services in dramatic ways. Arizona, Utah, and Virginia leaders are to be commended for providing information for this paper that can help others be educated and simultaneously inspired.

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# CLIMATE-RELATED DISASTERS

Understanding Causes, Consequences, and Interventions  
to Protect Community Mental Health

September 2022

Paper No. 6 in the *From Crisis to Care* Series

# Climate-Related Disasters: Understanding Causes, Consequences, and Interventions to Protect Community Mental Health

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*Sixth in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs  
Focused on Building from 988 and Beyond for Better Mental Health Outcomes*



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## **Abstract:**

Climate-related disasters are a profound and devastating effect of a changing global climate. These events result in an established range of individual psychological and behavioral responses as well as a predictable pattern of community responses that evolve over time. Unlike the medical impact of climate-related disasters, various factors enhance the transmission of mental health effects beyond the geography of the event. Subsequent and co-occurring disasters, such as the global COVID-19 pandemic, amplify distress and significantly complicate disaster response and community recovery. Certain populations are particularly vulnerable to the mental health effects of disasters with various communities disproportionately bearing the impacts. Understanding the effects of disasters, where risk is concentrated, and how it changes throughout the course of disaster response and recovery are important to optimize interventions. Evidence-informed interventions can reduce distress, improve well-being, enhance functioning, and foster sustainment for individuals, organizations, and other communities. Effective preparedness requires understanding these factors, incorporating them into all aspects of disaster management, and ongoing education and training for disaster planners, responders, and the public.

## **Key Highlights:**

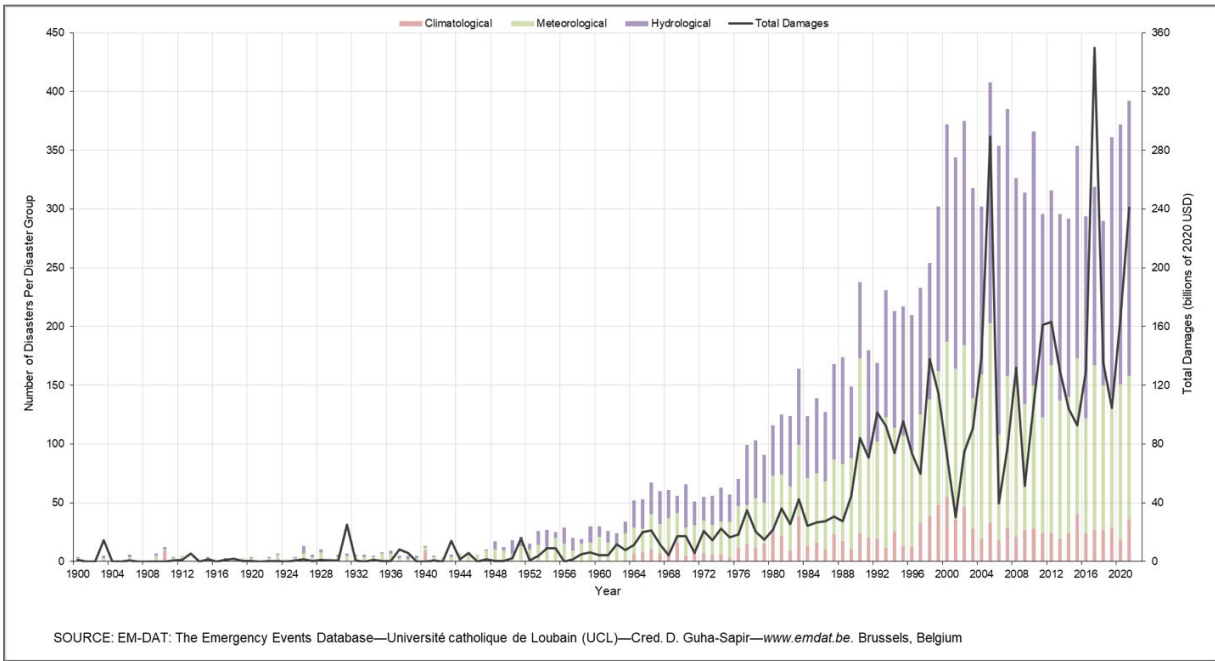
- Climate-related disasters are profoundly disruptive and produce psychological and behavioral effects that significantly exceed the physical health impact of the event.
- Distress reactions and health risk behaviors are early and common responses to climate-related disasters that produce significant morbidity and functional impairment, and negatively impact operational sustainment.
- Risk and protective factors in disasters result from pre-event factors, aspects of impact, and recovery variables. Risk is not distributed equitably and changes over time.
- Public mental health interventions in disasters are scalable and address a range of community needs to promote resilience and foster community recovery.

## **Recommendations:**

1. Public health early interventions that are scalable are essential to support community mental health during climate-related disasters.
2. Distress and risky behaviors are early responses to disasters, that should be the focus of prevention and wellness interventions.
3. Public health and community surveillance that is conducted early and regularly throughout all phases of disasters helps identify areas of evolving risk to ensure timely and tailored resources are delivered to those most in need.
4. Early interventions use an evidence-based framework based on the essential elements of Psychological First Aid (safety, calming, self- and community-efficacy, social connectedness, and hope) to enhance well-being, reduce distress, and mitigate disorders.

Disasters are severely disruptive events that overwhelm community resources and can outpace coping capacity of an affected community. Climate-related disasters can be abrupt, extreme weather events, unfolding over minutes or hours (hurricane, tornado, tsunami), or slow-moving events that span days, weeks, or months (wildfires, floods, droughts). Other disasters include natural disaster events, such as earthquakes, and biological events like the global COVID-19 pandemic. Human-generated disasters can be intentional, such as mass shootings and war, or unintentional, including accidents like an airplane crash or industrial fire. Many disasters include elements of natural or climate-related events that are further exacerbated by human behaviors. For instance, Hurricane Katrina started as a storm, but poorly maintained levees resulted in the catastrophic flooding that killed two thousand and displaced over one million people.<sup>1</sup> The COVID-19 pandemic may have originated through an animal reservoir but was then spread around the world by human travel and close contact. The global COVID-19 pandemic remains an active public health emergency around the world, with the virus infecting more than 579 million people and killing over 6.4 million as of this writing.<sup>2</sup> The pandemic has remained a primary focus of global health efforts and a threat to global health security. However, climate-related disasters continue to impact the world. In fact, data from the Center for Research on the Epidemiology of Disasters indicates that climate-related disasters are increasingly common and becoming more costly; **Figure 1** lists climatological (e.g., wildfires), meteorological (e.g., storms, extreme heat), and hydrological (e.g., floods) events from 1900-2021. These changes are attributed in part to a changing global climate, one of the greatest threats to global health in the 21<sup>st</sup> century.<sup>3</sup> These disasters create disruption through physical injury and death, damage to property, displacement of individuals and families, and prolonged disruption to a broad range of services upon which communities rely, ultimately resulting in significant psychological distress. The convergence of climate-related disasters with other events, such as war, pandemics, and other disasters can further distress and complicate response and recovery efforts.

**Figure 1: Frequency and Financial Cost of Climate-Related Disasters by Type and Year**



The increased frequency of climate-related disasters further the need for improved planning to mitigate the adverse effects of these events. All-hazards planning addresses the full spectrum of threats from all types of disasters and is the current framework for global disaster management.<sup>4</sup> Communities (schools, neighborhoods, healthcare facilities, workplaces) have unique needs that benefit from tailored planning and preparedness. Effective preparedness improves response and recovery following a disaster and may reduce overall resource requirements. As noted in the *Disaster Behavioral Health* paper as part of the National Association of State Mental Health Program Directors *Ready to Respond 2021* series, disaster behavioral health is increasingly a part of disaster management.<sup>5</sup>

Disasters strike at the fault lines of communities by exacerbating divisions around issues of race, socioeconomics, religion, and other areas within specific contextual factors of a given community. Different factors impact the community experience of a disaster (Table 1).

**Table 1: Factors Impact Community Experience of Disaster**

Prior exposure to disasters
Politicization of disaster and response efforts
Disparities in pre-existing socioeconomic resource
Religious and cultural beliefs attributed to the meaning of the disaster
Trust in institutions and officials (elected officials, law enforcement, aid organizations)
Prior experiences with national and/or international government intervention
Additional co-occurring disasters (e.g., a hurricane during a pandemic)
Presence of litigation

Disasters in which cultural and contextual factors were critical to community partnership and effective response include: 1) Hurricanes Katrina and Rita in 2005, which were characterized by perceived disparities in response efforts within affected communities of color, 2) the 2010 earthquake in Haiti, which required knowledge and incorporation of voodoo as a religious ritual integral to how citizens conceptualized and responded to healthcare interventions,<sup>6</sup> and 3) COVID-19 pandemic in which willingness to engage in protective health behaviors was significantly impacted by political party affiliations.<sup>7</sup> Each of these events, as with all disasters, necessitated an understanding of sociocultural and contextual factors within the communities to optimize response and recovery efforts. These and other factors create a disaster ecology in which various forces of harm impact individuals, communities, and societies.

How the psychological response to disaster across large and diverse populations is managed is, perhaps, the most critical factor in a community’s ability to recover. Effective interventions are rapid, coordinated, and sustained. Leadership is critical, particularly knowledge of community resilience and vulnerability as well as awareness of how community members respond to major events. Coordinated approaches across emergency response, medical systems, behavioral health and public health are essential to address mental health of disaster affected populations.

All hazards planning focuses on preparedness to address the full range of threats to communities, including both climate-related and other disasters. The Haddon Matrix is a risk management planning tool that considers the host, agent/vector, and physical and social environments across the pre-event, event, and post-event time periods (Table 2). The use of an established framework that addresses

factors across various phases of disaster ensures planning and preparedness activities are comprehensive and structured, reducing the chance that disaster managers overlook important factors during the high stress environment of disaster response. Effective planning can also reduce distress for affected personnel and community members and optimizes access to needed mental health care and other resources in the wake of a disaster.

**Table 2: Haddon Matrix applied to a Hurricane**

	<b>Host</b>	<b>Agent/Vector</b>	<b>Physical Env</b>	<b>Social Env</b>
<b>Pre-Event</b>	-Response training -Public education -Personal/family preparedness -Pre-existing mental & physical health	-Proximity to infrastructure -Resilience of structures to impact -Early warning systems	-Existing care services -Proximity to exposures	-Culture of readiness -Knowledge of roles -Baseline trust -Culturally based risk perceptions
<b>Event</b>	-Protective behaviors -Notification speed	-Duration and intensity -Location and movement -Emergency medical systems and training	-Identification of risk indicators -Knowledge of care services (where/how) -Barriers to care	-Comm/Org response to communication -Grief leadership -Access to crisis resources
<b>Post-Event</b>	-Evacuation -Psychological resources -Resiliency	-Response and recovery systems and infrastructure	-Availability of resources -Application of lessons learned	-Help-seeking -Comm/Org trust in health/other

Psychological and behavioral health impacts represent a significant portion of human suffering and healthcare expenditure following climate-related disasters. Following Hurricanes Katrina and Rita in 2005, cost modeling revealed that screening and evidence-based treatment in the affected population for just three common mental disorders would cost nearly the same as subsequent restoration of the failed levy system around New Orleans (which was the source of catastrophic flooding leading to property damage as well as most injuries and deaths).<sup>8,9</sup> Repairing the damaged levy system in advance of the disaster would have cost just a portion of the overall expense to healthcare and human suffering.

It is also critical to understand the relationship of disaster exposure to chronic health conditions, specifically those that do not result from disaster-related injury but, instead, changes in health behaviors that lead to chronic disease and associated public health burden. A pre- (2015) and post-study (2019) to understand the effects of Hurricane Maria (2017) on reported chronic health diseases in residents of Puerto Rico found elevated rates of abdominal obesity, sedentarism, hypertension, triglycerides, and binge drinking.<sup>10</sup> These modifiable health diseases result largely from adverse health behaviors that may be influenced by exposure to extreme stressors and traumatic events, such as climate-related disasters. An understanding of the economic costs to mental and physical health allows for more informed decision-making regarding disaster preparedness and management.



## Psychological and Behavioral Effects of Climate-Related Disasters

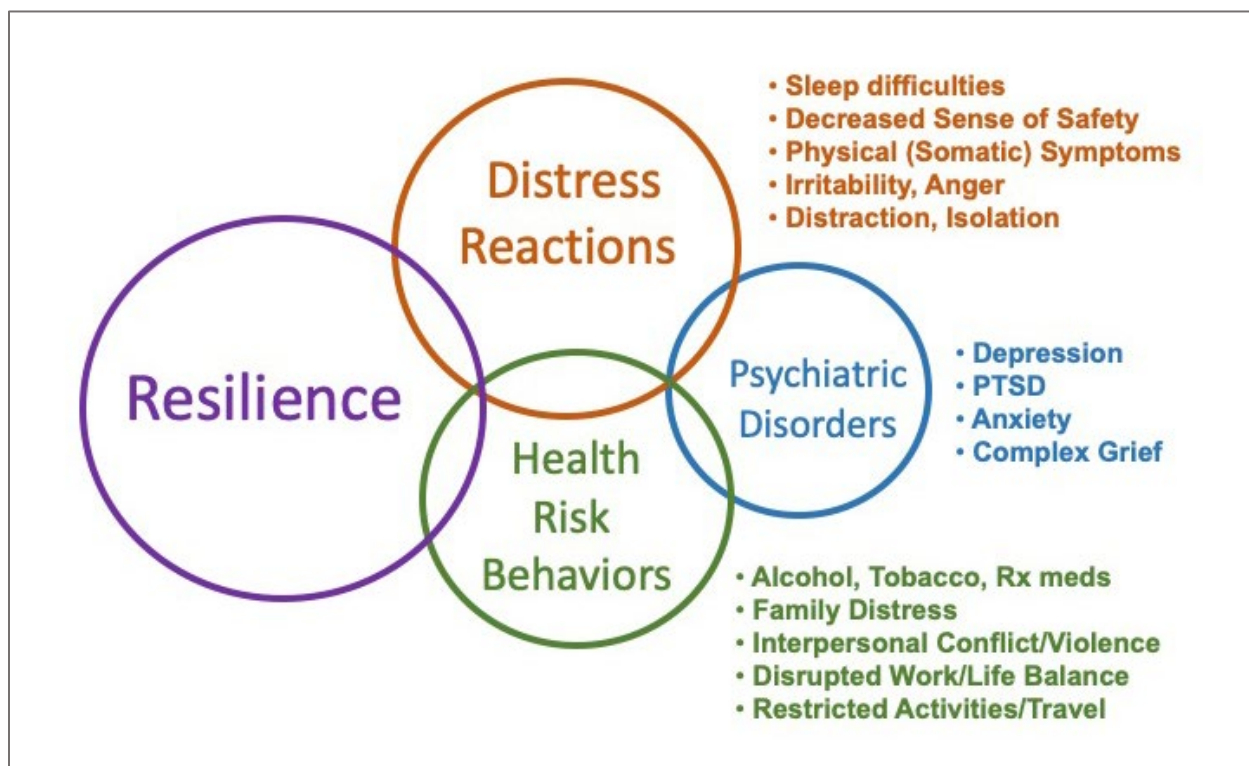
Following climate-related disasters, many people will be okay and promptly recover previous function. Though many are affected by the event, they are able to manage social and occupational responsibilities and expectations. Some people ultimately develop an enhanced perception of their ability to manage future stressors, sometimes referred to as post-traumatic growth. These are important messages because they acknowledge the reality of climate-related disasters, but also foster a sense of hope for the future. Even though most people recover, many will experience some degree of adverse mental health effects. The psychological and behavioral effects of climate-related disasters begin immediately following the event and may persist for extended periods of time, extend beyond the geographic region directly impacted by the event, and are experienced within the broader cultural and contextual factors of a community. Adverse mental health effects of disasters are a significant public health concern that creates considerable human suffering and adverse effects on community functioning. Hurricane Harvey, which was a category 4 hurricane, made landfall in August of 2017 in Texas and Louisiana, ultimately inflicting \$125 billion in damages, the second costliest hurricane in U.S. history. Harvey's rainfall averaged more than 40 inches over a four-day period, flooding hundreds of thousands of homes and displacing nearly 30,000 people. The Health of Houston Study, which collects population level data, was used to compare pre- and post-Harvey community data, in which respondents reported an average increase of 1.31 poor mental health days per month, which exceeded the reported increase of 1.12 poor physical health days per month.<sup>11</sup>

Considerations of adverse psychological and behavioral effects often focus on psychological disorders, such as posttraumatic stress disorder (PTSD), depression, and others. Disorders do occur following disasters and result in significant morbidity and mortality, warranting prompt assessment and evidence-based treatment. However, disorders often take weeks, months, or years to emerge. Earlier and more common responses, including distress reactions and health risk behaviors (Figure 2),<sup>12</sup> produce the bulk of the mental health burden, particularly in the early hours, days, and weeks after a disaster. They are important targets for early interventions (discussed in a later section) that foster resilience and protect mental health. When these responses present to healthcare, concerns such as insomnia, fear, and altered substance use are typically identified in primary care and emergency settings. It is critical that healthcare systems ensure providers in these settings have education in disaster mental health and are properly resourced following disasters to manage the predictable responses. For instance, after a hurricane, large numbers of community members may present with concerns of difficulty sleeping. An awareness that problems with sleep may be the result of an altered sense of safety and an inability to feel calm after a life-threatening event should inform diagnoses, prognosis, treatment planning, and patient education. Understanding the range of adverse mental health effects can enhance planning, preparedness, response, and recovery efforts by disaster managers, healthcare personnel, and community members. Embedding mental health personnel with training in disaster mental health principles into these healthcare settings can facilitate rapid identification, triage, and interventions for early responses to disasters.

Because disasters impact local, regional, and national communities, easily accessible national resources are important to support community mental health after disasters. The National Distress Helpline ([1-800-985-5990](tel:1-800-985-5990)), sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), is an important resource to assist community members experiencing psychological distress following disasters. The helpline provides multilingual crisis counseling services 24 hours a day, 365 days

a year to assist community members with disaster-related distress. It augments the counseling services available through the 988 Suicide and Crisis Lifeline, which offers assistance to individuals experiencing any type of mental health crisis. In the wake of disasters, SAMHSA’s Crisis Counseling Assistance and Training Program (CCP), funded and implemented by the Federal Emergency Management Agency, provides short-term disaster relief grants for states, U.S. territories, and federally recognized tribes following a presidential disaster declaration and are used to support community-based outreach, counseling, and other mental health services to survivors of all types of disasters.

**Figure 2: Psychological and Behavioral Responses to Disasters**



Distress reactions are early and common manifestations following traumatic events, representing the bulk of early public mental health burdens following climate-related disasters. Insomnia is common and increases the risk for other psychological and physical health problems.<sup>13</sup> Belleville and colleagues found that even three months after the evacuation following the Fort McMurray wildfires in Canada, 43.6% of the evacuees reported insomnia, which was more prevalent than PTSD, depression, or anxiety.<sup>14</sup> Anger is common following disasters and is associated with an increased likelihood of negative mental health outcomes.<sup>15</sup> Decreased sense of safety, distractibility, guilt, demoralization, and loss of faith can also occur.

Distress often results from the complex interaction of various factors in the post-disaster environment. For instance, following a hurricane, wildfire, or flood, community members may be forced to evacuate their homes, ultimately residing transiently in shelters, makeshift lodging, or camps. These are often cramped, noisy, and have minimal security. This environment may feel unsafe, making sleep more difficult. The resulting insomnia reduces the ability to manage strong emotions like anger, leads to distractibility, and diminishes problem-solving skills resulting in difficulty making decisions that protect the health and safety of the individual and their family. An awareness of these potential cascading

events is essential for disaster planning and response. Public mental health interventions should address environmental factors to reduce distress and improve functioning.

Health risk behaviors are maladaptive coping strategies to manage distressing emotions and include increased use of tobacco and alcohol.<sup>16</sup> Increased use of alcohol, regardless of whether someone has a disorder, is a significant public health problem associated with increased rates of accidents, interpersonal violence, workplace presenteeism and errors, and a range of adverse physical and psychological health effects. Though less commonly studied than changes in substance use behavior, some disasters have been associated with the initiation of substance use. In a study of 37,867 individuals who were non-drinkers prior to the Japan triple disaster in 2011, 9.6% reported starting drinking in 2012; among those who started drinking, 53.8% continued drinking in 2013.<sup>17</sup> Following climate-related disasters, individuals may restrict their activities or become isolated, which can limit the utilization of important healthcare and social support resources.<sup>18</sup> Over-dedication to disaster response activities may lead individuals to overlook important social and occupational responsibilities. Primary care and emergency department personnel are critical in the identification of high-risk health behaviors following disasters and initiation of interventions including education, basic self-care actions, linkage to additional support services, and follow up continuity. Telehealth and virtual support, which have become increasingly accessible during the COVID-19 pandemic,<sup>19</sup> can aid in providing timely and tailored support to mitigate distress for disaster responders as well as victims, Public health messaging from community leaders and the media are important sources of education information, including information about normal responses to disasters, risky health behaviors to avoid, protective and health-promoting coping mechanisms, warning signs that additional help may be warranted, and where to get help if needed.

Psychiatric disorders may also develop following climate-related disasters, which result in significant morbidity and mortality that requires healthcare interventions. The most studied are PTSD,<sup>20</sup> depression,<sup>21</sup> and anxiety.<sup>22</sup> A review of the impact of wildfires by To and colleagues found rates of various psychological disorders elevated 3 months after the event for PTSD (24-60%), depression (25-33%), and anxiety (17.4-27%).<sup>23</sup> Population level screening, assessment, and evidence-based interventions are clinical best practices.

The extreme and prolonged stress of climate-related disasters have led to concerns about suicide in those impacted by disasters. It is clear that recovery following disasters is often prolonged and stressful. Health, financial, occupational, and family stressors mount, though coping capacity may be reduced while external support and government resources diminish. As a result, suicide receives significant attention in healthcare and media following disasters. Suicide is a complex and devastating event and, though rare overall, rates of suicide outside of disaster contexts have increased in the United States in the past 20 years. However, there are limited studies examining the associations of suicide with climate-related and other disasters. Some find that suicidal thoughts and behavior increase, likely resulting from a milieu of pre- and post-disaster factors that overwhelm coping capacity.<sup>24</sup> Reifels and colleagues examined population level data in Australia and found that suicidal behavior was increased in those exposed to multiple, but not single, disaster events.<sup>25</sup> Importantly, some research has observed suicidal thoughts and behavior to diminish moderately from baseline in the early weeks and months following a climate-related disaster<sup>26</sup> consistent with the “Honeymoon” phase of community recovery, but then increase from baseline during the ensuing months and years<sup>27</sup> corresponding to the “Disillusionment” phase (Figure 3).

Interpersonal violence has been shown to increase following climate-related disasters, with women and children being most affected.<sup>28</sup> In a study of the impact of the 2009 bushfires in Victoria, Australia, increased violence against women was highest for those in areas most affected by the fire and families in which income loss occurred because of the fires.<sup>29</sup> In addition, displacement and migrations, food scarcity, breakdown of community infrastructure, loss of employment, and diminished social connectedness have negative psychological and behavioral health consequences after climate-related disasters.<sup>30,31</sup>

Grief is a nearly universal reaction after climate-related disasters and occurs in response to profound loss. Losses can include one's home and cherished mementos, community support, comfort routines, familiar surroundings, and even the lives of friends, loved ones, and cherished pets. Displacement to evacuation centers and shelters may further lead to the loss of a sense of safety and security. Traumatic grief from the abrupt death of a loved one resulting from the disaster increases adverse mental health outcomes. A study of bereaved Norwegian family members whose loved one died during the 2004 Southeast Asian tsunami found that 36% of respondents had a psychiatric disorder six years after the event, and those with prolonged grief disorder were more likely to have persistent functional impairment.<sup>32</sup> Enduring resources available to disaster-affected communities that address issues of grief improve community functioning and recovery.

### *Children and Adolescents*

After disasters, children may have reactions like adults. They also have additional reactions based on their developmental stage and other factors, which can be easily overlooked or misinterpreted. For example, the reasons for "acting out" or behavioral dysregulation in a child in distress following a disaster may be relatively unnoticed by parents, educators, and school administrators who are distracted and experiencing elevated stress themselves.<sup>33</sup> Younger children may revert to earlier childhood behaviors, such as loss of toilet training, desire for stuffed animals and comfort objects, and increased need for physical closeness and proximity to caregivers. Older children and adolescents might display aggression, diminished academic performance, and social isolation.<sup>34</sup> Separation from primary attachment figures, parental distraction and family strife, and disruption in schedules and routines increase distress and adverse mental health for children and adolescents. Important interventions can help address some of the challenges that youth may face

***Interventions that may help children post-disaster:***

- 1) Keep children and adolescents close to trusted caregivers,
- 2) Re-establish routines after evacuation or displacement,
- 3) Answer questions they ask but avoid providing excessive details based on caregiver concerns,
- 4) Share information in language appropriate to developmental stage.

(Text Box). Ensuring the well-being of caregivers is also essential in protecting the mental health of children and adolescents; when the needs of caregivers are met, they have the physical and mental resources to attend to the needs of children. Education and support resources for caregivers, teachers, and other school personnel can aid in the identification of distress reactions in youth and the timely delivery of effective interventions.

### *Exposure and Contamination*

Climate-related and other ecological disasters can also result in infrastructure damage that creates a risk of exposure and contamination by chemical, biological, radiological, or nuclear (CBRN) material. These require specific public health preparedness measures.<sup>35</sup> Overflowing waste treatment plants after Hurricane Harvey, damage to nuclear facilities after the tsunami in Fukushima, and human corpses inadvertently exhumed by flooding after Hurricane Katrina create unique psychological and behavioral responses within affected communities.<sup>36</sup> In 2011 on the island of Honshu, Japan, an earthquake and tsunami damaged nuclear power plants in Fukushima, exposing the community and environment to nuclear material. Subsequent fear and uncertainty about nuclear contamination led to ostracizing and hostility toward displaced individuals from the region.<sup>37</sup> CBRN materials are perceived as mysterious and dangerous, as well as novel and unfamiliar to most citizens, disaster managers, and healthcare professionals. Uncertainty about exposure, concerns about isolation and quarantine, and fears of shortages for needed prophylactic and treatment medications increase distress, distort perceptions of risk, and alter the willingness of community members to participate in health behaviors required to properly respond and manage these events.<sup>38</sup>

CBRN events lead to surges in healthcare demand with anxiety related somatic symptoms, often referred to as Medically Idiopathic/Unexplained Physical Symptoms (MIPS/MUPS). The risk of CBRN exposure highlights the importance of the perception of risk, which is typically much higher than the actual risk. Public health education is critical to inform the public on actual risks, steps being taken to mitigate them, and when to get additional help.<sup>39</sup> Healthcare facilities should be prepared to receive and triage high volumes of individuals presenting with elevated levels of somatic concerns related to fear of exposure. Mental health personnel trained in the effects of mass trauma and evidence-based interventions, embedded in emergency and primary care/general medical care settings, can provide support and initiate early interventions to reduce distress. In addition, planning should account for increased rates of absenteeism among healthcare workers who may fear exposing themselves and family members to CBRN agents or concerns about the adequacy of equipment, policies, and procedures to protect healthcare workers safety during such an event.

### *Compound Effects of Disasters*

Climate-related disasters may also occur during a CBRN or other ecological disaster event, such as the global COVID-19 pandemic. In the United States, wildfires, tornadoes, floods, hurricanes, as well as human-generated mass violence events, all occurred during the pandemic. This “collision of disasters” complicates the experience of each disaster for community members, as well as disaster planning, response, and recovery efforts, and is often found to exacerbate mental health effects above and beyond what is seen during a single disaster event.<sup>40</sup> Agyapong and colleagues examined the mental health effects of exposure to the Fort McMurray wildfires in 2016, regional floods in 2020, and the COVID-19 pandemic. When compared to those who only experienced the COVID-19 pandemic, those exposed to the pandemic and either wildfires or floods, as well as those exposed to the pandemic, floods, and wildfires, had markedly higher rates of symptoms of generalized anxiety disorder and PTSD.<sup>41</sup>

Though life stressors can ultimately create growth for some, the enhanced effects of multiple disaster events may result in worse mental health, particularly in the subsequent weeks and months following the event. Beyond co-occurring disasters, certain disasters may lead to other disasters, such as

Hurricane Katrina, which ultimately caused most of the disruption and morbidity from subsequent flooding due to damaged levees. Individuals may also be exposed to the same type of disaster repeatedly, with increased risks in disaster prone areas and for those who are unable or unwilling to relocate. In a multi-wave study of Florida residents, those exposed to Hurricane Irma in 2017 and subsequently to Hurricane Michael in 2018 reported higher levels of posttraumatic stress symptoms, distress, and impairment in function, with those who experienced storm-related loss, injury, or evacuation having the most persisting symptoms.<sup>42</sup> Given the increasing frequency and severity of climate-related disasters (see Figure 1), community planning should consider efforts to address unique risks and concerns of individuals with previous disaster exposure.

### *The Role of Media*

Media is an important source of information for disaster affected communities, providing information on evolving risks, recommended health behaviors, and access to resources. Media also transmits fear and distress. Most studies of media in disasters have examined the impact of media consumption following mass violence. However, research after climate-related disasters, such as hurricanes, finds an increased consumption of disaster-related television and social media is associated with a range of adverse psychological effects. A multi-wave study by Thompson and colleagues examined the impact of media consumption during Irma's landfall and one month after landfall on the subsequent development of posttraumatic stress (PTS), which revealed increased media consumption was associated with higher levels of PTS.<sup>43</sup> Increased media consumption may also represent efforts to control or alleviate distress in those already experiencing it, with causal relationships not clearly established.

In addition to the transmission of distress, there is increasing evidence from studies of the COVID-19 pandemic, that media, particularly social media, represents an increasing source of misinformation.<sup>44</sup> Although the role of media-derived misinformation in climate-related disasters is not well studied, the proliferation of social media as a primary news source for many citizens, coupled with the extraordinary adverse public health implications of misinformation, disaster planners should anticipate and prepare to counter misinformation regarding climate-related disasters.

The media will understandably expect to hear from those involved in disaster management. Community leaders, responders, and healthcare personnel engage with the media during disaster response and recovery. Working collaboratively with media helps ensure timely, accurate dissemination of important public health information. Abruptly displaying graphic content can enhance distress for viewers. In addition to balanced reporting of risks and protective aspects of a disaster, encouraging the media to provide warnings before showing graphic disaster-related material allows people to reduce abrupt and unintended exposure. While indicating the date of the content shown helps lower fear and distress for individuals who may otherwise believe an additional disaster event is occurring.

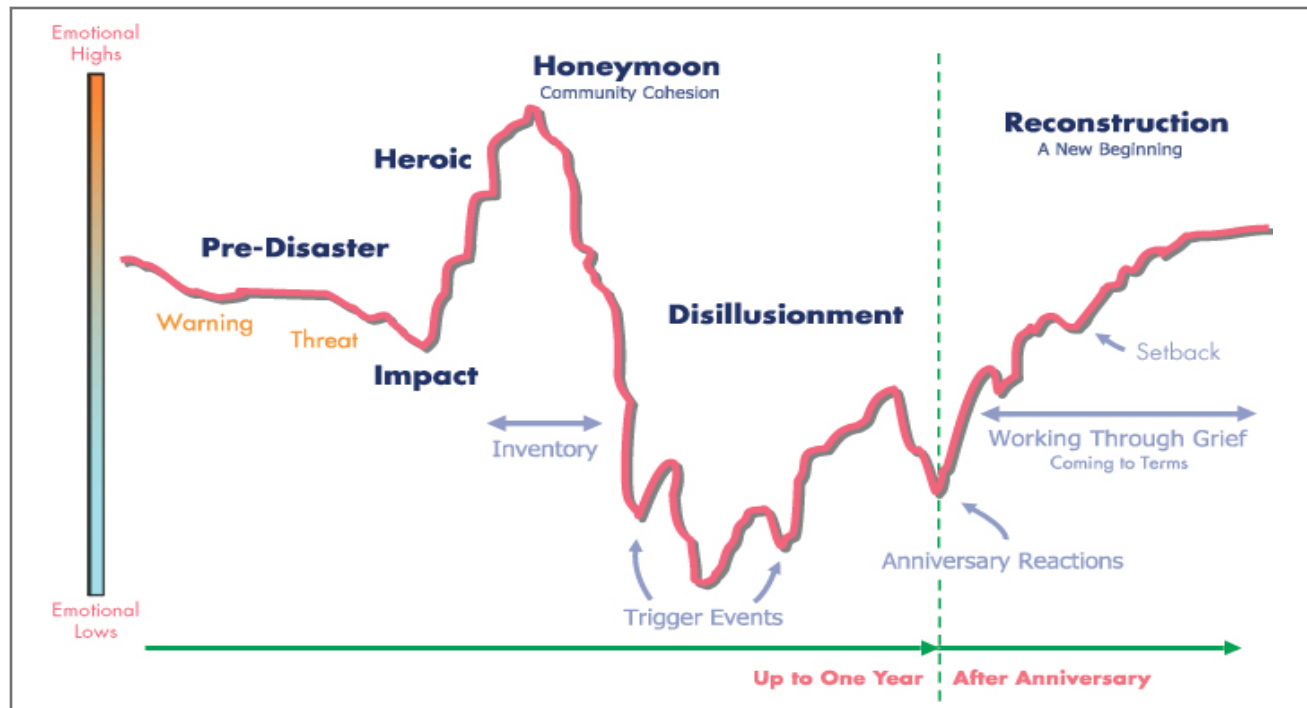
#### ***Tips for Contacting Media and Disaster Graphic Content***

- Collaborate with media to facilitate clear, timely, accurate dissemination of important public health information.
- Displaying graphic content can enhance distress, if it needs to be shown, provide warnings in advance of what is forthcoming.
- Provide the date of any images of recent past disaster content to lower fear of ongoing disaster events.

## Community Phases of Disaster

Following a climate-related disaster, particularly those involving a single acute event that occurs over a discrete period (e.g., hurricane or tornado), communities progress through psychological and behavioral phases of response (Figure 3). Several of these phases inform important considerations of disaster planning and resource allocation.

**Figure 3: Psychological and Behavioral Phases of Disaster**



Source: DeWolfe DJ: Training manual for mental health and human service workers in major disasters. (D. J. Nordboe, Ed.) (2nd ed.). SAMHSA, 2000. <https://files.eric.ed.gov/fulltext/ED459383.pdf>

The *Honeymoon* phase coincides with increased availability of government, volunteers, and international assistance. Community bonding occurs through a shared catastrophic experience as well as giving and receiving assistance. Survivors are more hopeful and optimistic the help they receive will restore them to wholeness. Disaster mental health workers are more accepted by community members and can develop a foundation on which to assist in difficult phases ahead. The subsequent phase of *Disillusionment* is characterized by disappointment as the presence of disaster assistance agencies and volunteer groups diminish and hopes for restoration to pre-disaster “wholeness” go unmet. Community cohesion often diminishes as people focus more on unmet needs. Resentment may surface as survivors receive unequal monetary compensation for what they perceive as similar damage. Less impacted neighboring communities may have returned to life as usual, which can discourage and alienate those more severely impacted. Survivors may become physically exhausted due to growing financial pressures, unaddressed medical concerns, family strife, stresses of relocation or home repair, bureaucratic hassles, and limited self-care. The disaster “Anniversary” experience occurs during this phase and serves as an important opportunity for leaders to support the psychological well-being of victims through openly acknowledging and memorializing losses, helping make meaning of the event, and looking hopefully to the future. Failure to address a disaster anniversary experience often demoralizes survivors, exacerbates

distress, and impairs community recovery. The *Reconstruction* phase lasts for years, and survivors attempt to rebuild homes and communities as well as social and occupational identities. Some will accept new circumstances, find meaning, and even increase strength in the ability to manage future disasters. Others may remain caught in a cycle of despair and hopelessness, possibly assuming the identity of a victim.

Disaster planners and victim service providers should understand the characteristics and evolution of these psychological and behavioral responses over time. Those with more severe exposure and impact, limited resources post-disaster, and lower coping skills are more likely to develop persistent symptoms requiring additional interventions. Anger is often directed at caregivers and community leaders if these factors are not sufficiently accounted for in medical and psychological response plans. In addition, in communities with lower resources or trust in government and institutions, these phases may be altered. Lower acceptance of support from outside the community may change the ability to optimize response and support efforts. A disaster involving concerns about exposure and contamination often alters these phases, such as limiting the “coming together” typically characterizing the *Honeymoon* phase due to fear of contracting illness from other community members. Anticipating and planning for various disaster-specific factors, including their impact on these established community psychological and behavioral phases is critical to timely and effective disaster response and recovery efforts.

### ***Key Points of Psychological and Behavioral Effects of Climate-Related Disasters:***

1. Response to climate-related disasters includes distress reactions, health risk behaviors, psychiatric disorders, and resilience. Understanding the psychological and behavioral impacts and where these are present within a community enables the development of comprehensive recovery plans.
2. Psychological and behavioral responses to climate-related and other disasters occur along a continuum of stress. Interventions that extend beyond a focus on psychological disorders facilitates the development of interventions that lower barriers to care.
3. The impact of climate-related disasters unfolds over time with adverse effects on community functioning and occupational performance, which are important targets for interventions that protect health and enhance individual functioning and sustain operations.

## **Risk and Resilience in Disasters**

Risk and protection in climate-related disasters result from various factors, including pre-event characteristics, event impact, and recovery variables (Table 3). Various populations are at increased risk for adverse mental health effects of climate-related disasters and warrant special consideration in disaster preparedness, response, and recovery.



**Table 3: Risk Factors to Mental Health Effects of Disasters Across Disaster Phases**

<b>Pre-Event Characteristics</b>	<b>Event Impact</b>	<b>Recovery Variables</b>
Socioeconomic Status	Duration & Severity of Exposure	Relocation
Social Support	Displacement	Financial Stress
Gender	Home Damage	Victim Litigation
Age	Physical Injury	Social Support Loss
Reliance on Care Systems	Bereavement	Job Loss

### *Individual Characteristics and Differential Impact of Disasters*

Lower socioeconomic status is often associated with worse outcomes following disasters, as those with less financial resources often reside in locations that are more prone to and less resistant to the effects of climate-related disasters.<sup>45</sup> Also, they often receive care in systems less equipped to address the full needs of disaster victims. Less financial resources increase risks for homelessness, reduced preparedness behaviors, barriers to evacuation, limited access to healthcare, and subsequent psychological distress and disorder.<sup>46</sup> Those experiencing homelessness have additional challenges, including an absence of a physical dwelling structure for protection, lack of access to disaster preparedness information, decreased means of communication, and high rates of chronic medical and mental health conditions.<sup>47</sup>

Individuals with pre-existing mental health conditions, particularly those with serious mental illness (SMI), often experience difficulties following large-scale community disasters.<sup>48</sup> Like others, most with mental health conditions will rise to the occasion and participate in disaster response efforts. However, people with mental health conditions may be less prepared for disasters than others,<sup>49</sup> experience disruptions in their ability to attend clinical care activities,<sup>50</sup> and have difficulty obtaining medications or accessing support services.<sup>51</sup> Individuals taking psychotropic medications may experience diminished heat regulation and impaired fluid homeostasis during extremes of temperature, resulting in adverse medical events.<sup>52</sup> Diminished community infrastructure, higher rates of poverty, and co-occurring substance use increase the risk for people with SMI.

Children and adolescents experience increased risk for adverse psychological and behavioral outcomes following climate-related disasters with elevated rates of PTSD, anxiety, depression, behavioral disruption, and substance use. Parental loss, distractions, and distress following a disaster are important predictors of child well-being. In addition, the quality and style of the parenting relationship are important aspects of child vulnerability.<sup>53</sup> A review of factors associated with recovery in youth following natural disasters revealed that female gender, more life stressors, greater trauma exposure, negative coping, and lower social support, increased risk of negative mental health effects.<sup>54</sup>

Literature on the vulnerability of older adults to disasters is mixed, with some studies revealing increased rates of adverse mental health outcomes.<sup>55</sup> However, age can also be protective, providing greater life experience in managing adversity and enhanced stress tolerance. Overall, research suggests that risk is predominantly associated with conditions of aging (cognitive difficulties, mobility limitations, vision impairment, dependence on systems of care), rather than age per se.<sup>56</sup> Ensuring that disaster messages are understandable, availability of transportation, and optimizing access to care in the post-disaster environment all serve to enhance outcomes for older adults.

Women may be at increased risk for adverse psychological outcomes following disasters.<sup>57</sup> Several factors may contribute to this finding. Women are often increasingly burdened with managing the distressing social dynamics that occur in a family impacted by disaster. Intimate partner violence increases in both frequency and severity following disasters, with victims predominantly being female.<sup>58</sup> In communities affected by civil unrest and war, women more commonly than men experience poly-victimization because of theft, physical assault, and sexual harm. Pregnancy and post-partum women are also at increased risk for mental health challenges following disasters.<sup>59,60</sup>

First responders and public health emergency workers are exposed to trauma and a range of stressors during non-disaster work but may be especially so during climate-related disasters and experience increased mental health burdens.<sup>61</sup> These challenges result from a range of individual, organizational, and leadership factors across the disaster life cycle as highlighted in Table 4. These individuals often have a considerable stress burden in the response and recovery phase of disaster events. Stressors include long work hours, exposure to severe injuries and mass death, high pressure to perform, and potentially also being a disaster victim, whose own family needs additional support. Responders may experience “psychological identification” during exposure to human remains (“that could have been me” or “that could have been my child”), an aspect of disaster exposures for which training is often absent or inadequate. These exposures, coupled with “psychological identification”, increase the risk for adverse mental health effects including depression and posttraumatic stress.<sup>62</sup> A study of first responders (police, firefighters, emergency medical, and city workers) involved in Hurricane Katrina response efforts revealed that at six to nine months post-disaster, 40% reported increased alcohol use and 25% reported high levels of depression; the latter persisting at 18 months post-disaster.<sup>63</sup> The use of high-quality training, strong organizational and leadership support, as well as formal peer support, have shown promise in protecting the mental health of responders in disasters.

**Table 4: Risk and Protective Factors for Disaster Responders**

	<b>RISK FACTORS</b>	<b>PROTECTIVE FACTORS</b>
<b>PRE-EVENT PERIOD</b>	<ul style="list-style-type: none"> <li>• Active health problems, mental health, substance use</li> <li>• Need for access to self/family healthcare</li> <li>• Limited/poor coping skills</li> <li>• Limited social supports</li> <li>• Financial difficulties</li> <li>• Lack of training</li> <li>• Poor team cohesion</li> <li>• Resistance to help-seeking</li> </ul>	<ul style="list-style-type: none"> <li>• Positive health status</li> <li>• Availability/use of health resources</li> <li>• Limited exposure to adverse environmental health factors</li> <li>• History of positive adaptation to stress or stress resistance</li> <li>• Hopeful outlook</li> <li>• Creative coping skills/strategies</li> <li>• Screening and identification of health risk status</li> <li>• Reducing stigma for non-frontline personnel</li> <li>• Adequate training and preparation</li> </ul>
<b>EVENT/IMPACT PERIOD</b>	<ul style="list-style-type: none"> <li>• Requirement to use crisis (altered) standards of care</li> <li>• Inadequate equipment</li> <li>• Moral distress/injury</li> <li>• High exposure to infection</li> <li>• Exposure to death, dying, and human remains</li> </ul>	<ul style="list-style-type: none"> <li>• Short duration, minimal disruption to work/personal life</li> <li>• Community fabric intact</li> <li>• Adequate equipment</li> <li>• Exposure risks and sacrifices shared equitably</li> </ul>

	<b>RISK FACTORS</b>	<b>PROTECTIVE FACTORS</b>
<b>EVENT/IMPACT PERIOD (CONT.)</b>	<ul style="list-style-type: none"> <li>• Required work outside specialty training</li> <li>• Weakened community fabric</li> <li>• Punitive or unsupportive work environment</li> <li>• Toxic leadership</li> <li>• Lack of empathy</li> <li>• Poor communication</li> <li>• Death of loved ones</li> </ul>	<ul style="list-style-type: none"> <li>• Clear communication about evolving infection control and safety policies &amp; procedures</li> <li>• Supportive &amp; accessible leaders</li> <li>• Help-seeking organizational culture</li> <li>• Regular monitoring of health and BH status through multiple means</li> <li>• Early identification and intervention with health and BH issues</li> <li>• Accessible supports, interventions, and referral options</li> <li>• Monitor impact of organizational status and change on wellbeing of all personnel</li> </ul>
<b>RECOVERY PERIOD</b>	<ul style="list-style-type: none"> <li>• Illness stigma from neighbors/family/friends</li> <li>• Disjointed community response</li> <li>• Isolation from social support systems</li> <li>• Inability to grieve</li> <li>• Job loss</li> <li>• Extended virtual/home school requirements</li> <li>• Lack of access to child-care</li> <li>• Fatigue; inability to reset or recover</li> <li>• Diminished health</li> <li>• Vaccination concerns and barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Strong workplace and personal support</li> <li>• Range of supports and interventions</li> <li>• Options and opportunities for personnel interactions</li> <li>• Family friendly personnel policies and strategies</li> <li>• Adaptation to changing patterns of needs, demands</li> <li>• Work culture continues to encourage interventions and support</li> <li>• Rest and reset options provided and encouraged</li> <li>• Health issues addressed</li> <li>• Leadership remains engaged and communicating regularly with personnel</li> </ul>

*Response and Recovery Factors*

Climate-related disasters often result in devastating damage to infrastructure. Severe home damage can result in prolonged or permanent displacement, considerable physical and emotional energy managing the consequences of the damage, and increased risk for adverse mental health outcomes. Graham and colleagues surveyed over 7,000 citizens of England about their experiences of the unprecedented floods of 2013-2014. They found that property damage independently predicted increased risk for mental disorders with females, younger adults, and those of lower socioeconomic status having worse outcomes.<sup>64</sup> Exposure to extreme climate-related disasters, like hurricanes, increase risk for personal injury as well as property damage. A study following Hurricane Sandy found that individuals with both increased person and property exposure to the hurricane had higher rates of PTSD and these rates were more likely to persist over time.<sup>65</sup>

Displacement from a community following a disaster increases the risk of negative mental health effects. In addition to the abrupt requirement to find a new temporary or permanent home, displacements can negatively impact the experience of community cohesion and social support. It also requires an individual or family to navigate a range of new life stressors (shopping, eating, relationships with neighbors) in an environment not of their choosing at a time when they may also be contending with financial stressors, health problems, and feelings of loss for their previous home and community. A

qualitative study of community residents affected by the St. John's River flood in New Brunswick, Canada, in 2018 found that those who were displaced had significantly worse mental health effects when compared to those who were not displaced.<sup>66</sup> Like the study by Graham and colleagues, they found that property damage similarly exacerbated mental health concerns. Fussell and Lowe studied those displaced following Hurricane Katrina, comparing profiles of those in various states of displacement (displaced but returned, displaced and relocated, and displaced in unstable housing) and found that, compared to those who returned, those who did not have significantly higher levels of perceived stress and those who relocated to another community also had higher general psychological distress.<sup>67</sup>

Social support is one of the most significant predictors of outcomes following disasters, across cultures and around the world.<sup>68</sup> The perception of having support from social systems, whereby a person feels that others provide them with resources and assistance in times of difficulty, creates an important buffer during response and recovery from a climate-related disaster. In addition to lowering the risk for adverse mental health effects, the presence of social support has been shown to enhance positive outcomes. In a study of Louisiana residents after the 2016 floods, those who reported higher levels of social support also indicated greater post-traumatic growth.<sup>69</sup> Herberman Mash and colleagues studied the impact of repeated hurricane exposure on Florida Department of Health workers and found that those with higher levels of social support reported significantly improved recovery time after the events.<sup>70</sup> These findings reveal new and critical areas for disaster planning and response, as they indicate that social support is not only associated with psychological outcomes following climate-related disasters, but also key indicators of operational sustainment and community function.

### ***Key Points of Risk and Resilience in Disasters:***

1. Understanding various aspects of risk in a disaster, how it changes over time, and groups that are disproportionately at risk for adverse effects are important for disaster planning and response to optimize support and interventions.
2. Identifying individuals with elevated risk in the pre-disaster timeframe, mitigating the adverse effects of disaster impact, as well as factors that emerge during response and recovery, enhances well-being, fosters community resilience, and optimizes functioning.
3. Risk should be evaluated broadly with ongoing health surveillance among different communities and sectors of society informing where risk is concentrated to provide timely and tailored interventions.
4. Individuals with multiple risk factors (e.g., a child separated from a caregiver who is displaced from a home that was damaged, disaster responder with active mental health symptoms with repeated exposure to human remains) are at significantly increased risk. Identifying them early and providing timely and tailored interventions improves outcomes.

## **Interventions to Foster Community Recovery**


Community well-being and functioning in disasters are optimized through public mental health interventions, including health education, risk and crisis communication, and leadership actions.<sup>71</sup> Early, effective, sustained interventions following disasters promote recovery and optimize community

functioning. Many people will never come for formal mental health care, nor will most people exposed to a disaster need these services. Consequently, in addition to assessment and treatment for disorders, approaches should emphasize wellness, protective health behaviors, and lowering barriers to care through interventions that capitalize on existing community resources that are often most approachable for the public. Evidence-based interventions focus on reducing distress, enhancing well-being, and optimizing social and occupational function by enhancing the five essential elements of safety, calming, social connectedness, self- and community-efficacy, and hope.<sup>72</sup> These five elements collectively form the basis of Psychological First Aid (PFA, which will be discussed further later in this article) and an evidence-informed framework for supporting the mental health of individuals and communities after disasters.

The rest of this paper will focus primarily on interventions that foster PFA with an emphasis on issues relevant to public mental health. The scope and scale of disasters require public mental health interventions that focus on wellness and prevention, can be delivered at scale, and are easily utilized by a range of individuals involved in and impacted by any given climate-related disaster, including families, healthcare workers, first responders, emergency workers, and community leaders. Some people may ultimately require treatment for psychiatric disorders and further discussion of evidence-based treatment can be found elsewhere.

The *Stress Continuum*, adapted from the military’s Combat and Operational Stress Control framework, is a valuable tool when considering interventions (Figure 4). It depicts the range of effects that stress creates, and which resources are most useful in addressing challenges across that continuum. For healthcare systems often trained to think of individuals dichotomously as either sick or well, the *Stress Continuum* is a reminder that the responses most people have to stress would not in most cases rise to the level of mental illness and do not require clinical care. Establishing interventions that address the continuum of needs using a range of resources including self-help, peer support, organizational policies and procedures, and leadership actions, and, when needed, referral to healthcare for additional assessment, is important to protect mental health and foster resilience.

**Figure 4: Stress Continuum Model**

READY	REACTING	INJURED	ILL
<p><b>DEFINITION</b></p> <ul style="list-style-type: none"> <li>• Adaptive coping</li> <li>• Effective functioning</li> <li>• Well-being</li> </ul> <p><b>FEATURES</b></p> <ul style="list-style-type: none"> <li>• In control</li> <li>• Calm and steady</li> <li>• Getting the job done</li> <li>• Playing</li> <li>• Sense of humor</li> <li>• Sleeping enough</li> <li>• Ethical and moral behavior</li> </ul>	<p><b>DEFINITION</b></p> <ul style="list-style-type: none"> <li>• Mild and transient distress or loss of function</li> </ul> <p><b>FEATURES</b></p> <ul style="list-style-type: none"> <li>• Anxious</li> <li>• Irritable, angry</li> <li>• Worrying</li> <li>• Cutting corners</li> <li>• Poor sleep</li> <li>• Poor mental focus</li> <li>• Social isolation</li> <li>• Too loud and hyperactive</li> </ul>	<p><b>DEFINITION</b></p> <ul style="list-style-type: none"> <li>• More severe and persistent distress or loss of function</li> </ul> <p><b>TYPES</b></p> <ul style="list-style-type: none"> <li>• Trauma</li> <li>• Fatigue</li> <li>• Grief</li> <li>• Moral injury</li> </ul> <p><b>FEATURES</b></p> <ul style="list-style-type: none"> <li>• Loss of control</li> <li>• Can't sleep</li> <li>• Panic or rage</li> <li>• Apathy</li> <li>• Shame or guilt</li> </ul>	<p><b>DEFINITION</b></p> <ul style="list-style-type: none"> <li>• Clinical mental disorders</li> <li>• Unhealed stress injuries</li> </ul> <p><b>TYPES</b></p> <ul style="list-style-type: none"> <li>• PTSD</li> <li>• Depression</li> <li>• Anxiety</li> <li>• Substance abuse</li> </ul> <p><b>FEATURES</b></p> <ul style="list-style-type: none"> <li>• Symptoms persist &gt; 60 days after return from deployment</li> </ul>
Self Help	 Leadership/Organizational Support Peer Support		Screening/Referral

Adapted from: Nash WP. US Marine Corps and Navy combat and operational stress continuum model: a tool for leaders. In: Ritchie EC, ed. *Combat and Operational Behavioral Health*. Fort Detrick, MD: Borden Institute; 2011<sup>73</sup>

## *Psychological First Aid*

The five essential elements that reduce distress, improve well-being, and enhance functioning after disasters include promoting an increased sense of safety, calming, self and community-efficacy, social connectedness, and hope or optimism.<sup>74</sup> These form the basis of PFA. Enhancing these essential elements through community interventions that emphasize wellness and prevention are optimal following climate-related and other disasters. Disaster workers and leaders can support victims with practical actions in the post-disaster environment (Table 5).

**Table 5: PFA Actions for Workers and Leaders to Support Disaster Survivors**

Essential Elements	PFA Action to Support Disaster Survivors
<b>Safety</b>	<ul style="list-style-type: none"> <li>• Ensure immediate physical safety by removing hazards whenever possible.</li> <li>• Provide updated information on safety of loved ones.</li> <li>• Disseminate timely and ongoing information about threat level and relief efforts.</li> </ul>
<b>Calming</b>	<ul style="list-style-type: none"> <li>• Provide education and normalize common psychological responses to disasters.</li> <li>• Help people use their existing calming strategies and teach new ones if needed.</li> <li>• Conduct “walking rounds” at evacuation centers to provide information and reassurance.</li> <li>• Encourage limiting of media exposure to reduce arousal and distorted threat perception.</li> </ul>
<b>Efficacy</b>	<ul style="list-style-type: none"> <li>• Help survivors identify adaptive responses and use them.</li> <li>• Facilitate connection to needed information and resources.</li> <li>• Encourage self-advocacy and self-care to remind people of their abilities.</li> <li>• Encourage community input in activities to recognize losses and promote recovery.</li> </ul>
<b>Connectedness</b>	<ul style="list-style-type: none"> <li>• Facilitate survivors’ communication with loved ones and existing support networks.</li> <li>• Encourage informal support networks in evacuation centers and shelters.</li> <li>• Collaborate with other disaster workers to establish unified recovery plans.</li> </ul>
<b>Hope</b>	<ul style="list-style-type: none"> <li>• Emphasize survivors’ strengths and ability to recover from previous challenges.</li> <li>• Establish routines and activities that create some elements of “normal”.</li> <li>• Identify the community as resilient and promote a vision of recovery.</li> </ul>

Evidence-based resources that are freely available, easy to read, and highly actionable can aid families, healthcare workers, first responders, and emergency workers, as well as supervisors and leaders in knowing what steps to take, and some to avoid, to foster resilience and recovery. The organizations below have well-established resources to support stakeholders following different disaster events:

- Center for the Study of Traumatic Stress - <https://www.cstsonline.org/fact-sheet-menu/fact-sheet-search>
- National Child Traumatic Stress Network - <https://www.nctsn.org/what-is-child-trauma/trauma-types/disasters>
- Substance Abuse and Mental Health Services Administration - <https://www.samhsa.gov/resource-search/dbhis>



Mobile resources and web-based training in PFA can help healthcare personnel enhance their skills in trauma response. The National Child Traumatic Stress Network has free online PFA training that can aid healthcare professionals, responders, and community members to better support themselves and others after a disaster.<sup>75</sup> The National Association of County and City Health Officials has an online PFA training designed specifically for supervisors and leaders to help them address the unique challenges of supporting a workforce or other community in disaster response and recovery.<sup>76</sup>

Adapting evidence-based interventions from other professions can facilitate rapid implementation of strategies to protect mental health and foster resilience in climate-related and other disasters to promote worker sustainment through actions by individuals, organizations, and leaders (Table 6). For instance, during the COVID-19 pandemic, healthcare workers experienced extreme and prolonged stressors including ongoing threats to safety for themselves and their family, shortages of protective equipment, constantly evolving health guidance, exposure to death and human remains, and the moral distress of rationing care because of resource scarcity. A range of evidence-based interventions was adapted from other high-risk occupations for use within healthcare systems to protect the mental health of workers during the pandemic.<sup>77</sup> These actions all foster the essential elements of PFA and can be used to enhance organizational sustainment and well-being in climate-related and other disasters.

**Table 6: Actions to Promote Individual and Organizational Sustainment during Disasters**

<b>INDIVIDUAL</b>
<i>Be Prepared.</i> Having a plan and supplies is calming and lowers stress.
<i>Media Use.</i> Limiting exposure to disaster related and other negative media lowers distress.
<i>Self-Care.</i> Sleep, nutrition, hydration, and exercise help with decision-making.
<i>Self-Monitoring.</i> Taking our own “pulse” through self-checks and feedback from others.
<i>Self-Advocacy.</i> Speaking up when things don’t seem right improves efficacy.
<i>Social Support.</i> Reaching out and connecting with others enhances connections.
<b>ORGANIZATIONAL</b>
<i>Education.</i> Understand normal psychological and behavioral responses to stress.
<i>Training.</i> Thorough and realistic training to prepare workers lowers uncertainty.
<i>Communication.</i> Timely, regular, updated, accurate messages build trust.
<i>Camaraderie.</i> Connections among personnel (colleagues, managers, neighbors, others).
<i>Practical Supports.</i> Meeting basic needs for food, clothing, and shelter are essential.
<i>Equipment.</i> Adequate supplies of needed equipment to feel safer.
<i>Peer Support.</i> Peer “buddies” and other support systems to feel safe and prevent isolation.
<i>Embedded Mental Health.</i> Clinical team peers encourage self-care and self-advocacy.
<i>Reintegration.</i> Aid in challenges of returning from the “hot zone” back to routine activities.
<i>Growth Mindset.</i> Team learning and growing together through difficulties.

Psychological debriefings, often referred to as “critical incident stress debriefings”, are a central element of “Critical Incident Stress Management” and still utilized in some settings with the goal of reducing adverse outcomes. However, most research indicates that debriefings following exposure to trauma do

not prevent disorders like PTSD.<sup>78</sup> These debriefings should generally be avoided, particularly for groups that do not work and train together and those who experience varying levels of trauma exposure during a disaster. In the latter, the aspect of debriefings that involves sharing about ones' trauma exposure from the event may have the unintended consequence of individuals with high exposure transmitting the distress of their experiences to individuals with low exposure. Psychoeducation, normalizing of reactions, ensuring access to helping resources, and reducing barriers to care are more preferred methods of optimizing recovery following disasters.

### *Leadership in Disasters*

Research on the impact of leadership in disasters has primarily been conducted in the context of human-generated events, such as terrorism and war, and examined the impact of leadership behaviors on workplace communities. The impact of leadership behavior on workers' stress is well established, with leaders serving to either exacerbate or buffer against the effects of stress in the workplace.<sup>79</sup> Increasingly, research has focused on various domains of leadership, such as leadership behaviors to foster a sense of purpose, improved sleep, or posttraumatic growth with empirical evidence revealing a range of leadership behaviors associated with improved psychological health and operational sustainment among workers (Table 7). Several leadership behaviors will subsequently be discussed in additional detail.

**Table 7: Leadership Behaviors to Foster Sustainment and Recovery in Disasters**

<b>Be Present.</b> Listen and connect; provide resources, support, and encouragement.
<b>Ensure Preparedness.</b> Provide training for exposures and common psychological responses.
<b>Communicate Effectively.</b> Using proven strategies builds trust and optimizes behaviors.
<b>Foster Cohesion.</b> Create time for team connection, discourage gossip and scapegoating.
<b>Optimize Sustainment.</b> Meet basic needs for food and sleep, create peer buddy systems.
<b>Model Self-Care.</b> Enhances performance and gives permission for others to do the same.
<b>Lead by Example.</b> Gives permission and encourages others to do the same.
<b>Normalize Reactions.</b> Talk openly about common responses, normalize different expressions.
<b>Prevent Moral Injury.</b> Correct distorted thoughts and create a culture of learning together.
<b>Facilitate Help-Seeking.</b> Share helping resources and openly encourage their use.
<b>Help Regulate Emotions.</b> Validate feelings, direct them appropriately, model acceptance.
<b>Foster Meaning &amp; Purpose.</b> Tell people work is valued, remind them of their purpose.
<b>Think Forward.</b> Be realistic about challenges, but hopeful about the future and success.
<b>Grief Leadership.</b> Acknowledge grief, honor losses, and make meaning to foster hope.

Birkeland and colleagues observed that leadership viewed as supportive or empowering was associated with significantly lower psychological distress for workers following the 2011 Oslo Ministerial bombings.<sup>80</sup> Leaders in the U.S. Army were randomly assigned to education on behaviors to foster improved sleep for soldiers and those who received training had unit members who reported getting more sleep, but also the leaders who received training indicated getting more sleep as well.<sup>81</sup> Another study in the U.S. Army by Woods and colleagues examined the extent to which posttraumatic growth leadership impacted the well-being and functioning of soldiers and found that in units with leaders who



fostered a greater sense of growth after traumatic events, unit members had lower rates of PTSD and depression and reported high levels of unit cohesion.<sup>82</sup> In addition to a growing empirical evidence base, the experiences of senior disaster managers demonstrate that leader behaviors have a significant impact on the recovery of communities and organizations following a broad range of disaster events.<sup>83</sup>

Leadership self-care is critical in disasters. Ensuring adequate sleep, nutrition, hydration, work-home balance, and stress management protects the mental health of leaders and serves as a role model encouraging similar behavior throughout the workforce. Ongoing self-care protects against mental and physical exhaustion and can prevent compassion fatigue and burnout. Part of self-care involves finding peers with whom to talk, vent, and get advice and support. A formal or informal support network among leader peers can enhance well-being and sustainment, enhance learning, and improve overall disaster response and recovery efforts.

Ongoing communication by leaders using established principles of risk and crisis communication (see next section) enhances trust and engagement in protective health behaviors within a workforce or other community. It's ideal to remember that "people want to know that you care before they care what you know." Communication marked by active listening, empathy, support, and a desire to help reduces community fear and isolation. Effective communication by leaders can serve as an important initial source of support to individuals impacted by disasters, a critical element in reducing distress and promoting recovery. Accurate and ongoing appraisal of threats, reminding people of normal reactions, elaborating on steps being taken to mitigate risk and protect community members are additional important aspects of leadership communication.

Grief is one of the most universal experiences following a disaster. Grief can occur of course over the loss of human lives, but also over the loss of tangible items such as home, possessions, and cherished mementos, as well as loss of a sense of safety and certainty in the world. Leaders must address inevitable aspects of community grief following disasters, for those directly impacted as well as the broader community. Grief leadership involves open and ongoing communication that recognizes and gives voice to what has been lost following traumatic events. It also entails working with community members to create mechanisms for honoring grief in ways that cultivates a sense of meaning and, eventually, help people to look hopefully toward the future.<sup>84</sup>

Leaders exist at many levels, including office managers, team leaders, CEOs, and others. During disasters, leaders also emerge within communities. In 2017, Hurricane Harvey made landfall in Texas and devastated portions of the Gulf Coast, ultimately killing more than 100, displacing over 30,000 people, and causing \$125 billion in damages. Jim McIngvale, known in the community as "Mattress Mack", used his furniture store to house displaced residents, as a location for delivery and pickup of critical supplies, and as a focal point for rescue efforts.<sup>85</sup> His leadership gave refuge to citizens in need and fostered community connections, which served as a beacon of hope. These informal leadership behaviors occur spontaneously, augmenting formal community leadership.

### *Risk and Crisis Communication*

Communication is a critical public health intervention tool in anticipation of and response to disasters that serves as an important behavioral health intervention. Risk and crisis communication shape public perceptions and impact community behaviors. Effective communication during times of crisis builds

public trust, enhances participation in protective health behaviors (i.e., evacuation, shelter in place, social distancing), reduces distress, and fosters cohesion within communities. Leaders at various levels should use established principles and techniques of risk and crisis communication (Table 8) to develop initial and ongoing public health messaging.<sup>86</sup> Important questions about public safety and what is being done to manage the impact of disaster for all those affected are predictable and communicators should be prepared to address these and provide ongoing updates at established intervals or more frequently if the situation dictates. When the public trusts those delivering messages, understands information provided, and believes that disaster response resources are being provided equitably, compliance with recommended public health behaviors increases.

**Table 8: Risk and Crisis Communication Actions to Promote Health Behaviors**

<b>Do</b>	<b>Don't</b>
Communicate early and regularly	Provide false reassurance
Say what you know and don't know	Give vague responses or make up answers
Commit to finding answers and then do so	Deflect or respond with hostility
Plan messages using trusted principles	Message things "on the fly" or unplanned
Use simple and understandable words	Insert jargon or highly technical language
Keep messages brief and focused	Provide extraneous and overly detailed information

Disasters that are protracted or which evolve over time (e.g., COVID-19 pandemic, West Coast wildfires) create unique communication requirements because the perception of risk alters as the public's understanding of the event evolves. Perception of risk is an important determinant of community behavior. During the COVID-19 pandemic, Ning and colleagues found that citizens of China with greater knowledge about the pandemic, as well as those who use trusted sources of information, were more likely to engage in protective health behaviors such as social distancing and wearing masks.<sup>87</sup>

Communication should anticipate that certain populations will have difficulty accessing or understanding traditional information messaging. Those with cognitive impairment, institutionalized individuals, persons who do not speak the majority language, as well as those with vision or hearing impairment require additional consideration in the development and delivery of messages. Methodology of delivering messages may need to shift as well as some rely on electricity, phone lines and other connections that may not be available during a disaster. Engagement with community leaders can help identify specific groups who may benefit from tailored messages to address unique needs.

Enhancing understanding of communication which increases behavior change within different communities is important to refining messaging strategies that support risk communication. Social norms messaging, which describes undesirable behaviors as uncommon and desirable behaviors and common within certain groups and communities, has increasingly been explored to improve engagement in protective health behaviors. A study of social norms messaging exposed individuals to a simulated disaster and found that individuals who received social norms messaging were 11% more likely to report actual engagement in personal disaster preparedness behaviors.<sup>88</sup>

### ***Key Points of Interventions to Foster Community Recovery:***

1. The five essential elements of PFA (safety, calming, self- & community efficacy, social connectedness, and hope) form the foundation for early interventions in other disasters.
2. Effective interventions incorporate a stress continuum that extends beyond illness and addresses distress and health risk behaviors while incorporating actions that involve individuals, peers, and organizational practices.
3. The actions and words of leaders, at many different levels, will significantly impact the well-being of workers and others and influence the trajectory of recovery. Role modeling through self-care, communication, managing stress, and other established behaviors protects the mental health of community members and enhances operational sustainment.
4. Risk and crisis communication principles should inform messaging to organizations and the public to reduce community distress, inform risk perceptions, and optimize engagement in protective health behaviors.

## **Conclusion**

Climate-related disasters are profoundly disruptive events that impact communities far beyond the geographic boundaries of the event. Psychological and behavioral responses create significant and long-lasting public mental health burden. Understanding community responses, as well as cultural and contextual factors impacting the experience of the event, optimize response and recovery efforts. While certain groups are at increased risk in all disasters, each event creates unique risks for individuals and communities. Understanding where risk is concentrated and how it changes over time, through health surveillance and other forms of assessment, allows for timely and tailored interventions to protect mental and foster resilience. Some people will eventually develop mental health disorders that benefit from formal clinical assessment and treatment. However, early and common reactions benefit from early interventions based on PFA that enhance the essential elements of safety, calming, self- and community-efficacy, social connectedness, and hope. These resilience-focused interventions improve well-being, reduce distress, enhance functioning, and may lower the risk of developing psychiatric disorders. Risk and crisis communication are important behavioral health intervention that influences perceptions of risk and shape community behaviors. When leaders role model behaviors such as self-care and stress management, they influence community behaviors, and provide focal points for helping communities address grief, make meaning of events, re-establish a sense of purpose, and move forward with a sense of hope in the future.

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# CRISIS IN SERVICES

Self Care, Self-Directed Care, and the Use of Technology Supporting All

September 2022

Paper No. 7 in the *From Crisis to Care* Series



# **Crisis in Services: Self-Care, Self-Directed Care, and the Use of Technology Supporting All**

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**Abstract:**

People seeking behavioral health services, including crisis care, and providers delivering services are looking for options in new technologies to afford expanded access in a field acknowledging significant gaps in care. Technologies are emerging with little regulation to address some of the needs as a self-directed care approach. At the same time, the traditional behavioral health workforce, faced with immense shortages, problem solves local coverage issues and seeks more flexibility to balance work and personal needs. Options in care are essential to meet demands among providers and people seeking care. There was an unprecedented 27% increase in anxiety and depressive symptoms in the last two years, and expanding crisis services are being implemented nationwide. This paper reviews some of these challenges, describing national and state-level responses to meet supply and demand for services, means of relief and recovery via self-directed care and support, and how providers and people seeking care may navigate behavioral health issues in the future.

**Key Points:**

- Technology can increase options to support those seeking care and the providers of care.
- Software developers are encouraging the public to engage mental health related technology for self-directed care, and it is critical that this care is met with research to help determine quality and inform the public and providers of best use.
- Technology may address current problems in behavioral health, including the critical shortage of behavioral health professionals, increase demand for services, methods to support crisis care and 988 expansions, and reach into rural communities.

**Recommendations for the Future:**

1. Research evidence is needed to determine the effectiveness of behavioral health technologies in relation to populations, specific mental health conditions, and utilization for crisis response or follow-up.
2. Technology, particularly the increased capacity to capture and analyze large population data sets, will allow new examinations of behavioral health care and the potential design of new interventions.
3. Practitioners need guidance becoming comfortable incorporating technological supports for themselves and their clients, and they should take an active role in providing real-world application information for developers of technologies.
4. Policy must recognize, support, and standardize the use of alternative technological methods to keep the field, and those in need of care, receiving the benefit of these innovations.

**B**ehavioral health services are facing unprecedented challenges, with unparalleled attention, creating new opportunities for enhancements. Before the pandemic, workforce numbers were low, and the need for services was high. Now, people seeking care are experiencing a desperate search for care and providers are experiencing heightened stress. How is the behavioral health workforce addressing its own state of crisis? This paper examines two populations that are more similar now than ever: the fragile behavioral health workforce that is caring for itself and the individuals seeking behavioral health services in new ways from a struggling field of professionals. In today's climate, providers have one foot in serving those in crisis and the other in managing their problems amidst the pandemic, national staffing shortages, and higher demand.

People seeking behavioral health services are looking for options in new technologies to afford expanded access in a field acknowledging significant gaps in care. The need is driven by the good news of lower stigma placed on mental health conditions and treatment, as high-profile people publicly recognize their behavioral health challenges and funding is directed toward improvements. In the 2022 *From Crisis to Care* series, technology advances are identified as a key element to help move the system and individuals in care towards greater stability.<sup>1</sup> Apps and technologies are rapidly emerging with little regulation to address some of the needs, while the traditional behavioral health workforce problem solves local coverage, gaps in care, and providers seeking more flexibility in their ability to juggle work and personal needs. According to experts,

*“Digital and mobile technologies hold enormous potential for increasing access to services, facilitating self-help, monitoring and assessing variations in symptoms and wellness-promoting activities, and increasing health literacy. This potential will be fulfilled only if behavioral health service providers are willing to adopt effective new technologies, to develop the adequate skills to use them, and to fully support service users.”<sup>2</sup>*

Options in care are essential to meet the demands of providers and people seeking care. Technology is not the complete answer, but it offers advances. As noted by artificial intelligence (AI) developer Michael Tanana, “I’ve seen the inside of the systems and AI and chatbots aren’t ready to take over the world just yet; however, scripted AI is still better than random comparison samples in training suicide responses.”<sup>3</sup> This paper reviews some of these challenges, describing national and state-level responses to meet supply and demand for services, means of relief and recovery via self-directed care and support, and how providers and people seeking care may navigate behavioral health issues in the future.

## **Supply and Demand**

### *People Seeking Care*

In March 2022, the United States Senate Committee on Health, Education, Labor, and Pensions held a hearing to examine how Congress may respond to the impacts of the COVID-19 pandemic on the nation's collective mental health.<sup>4,5</sup> Recent data indicate a growing prevalence of mental health and substance use disorders nationally. According to the Centers for Disease Control and Prevention (CDC), household surveys administered in 2020 found that 38% of adults experienced anxiety or depressive symptoms, representing a 27% increase over the previous year.<sup>6</sup> Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated there were 52.9 million adults aged 18 or older living with mental illness in 2020.<sup>4</sup> However, over half (53.7% to 57%) did not receive mental health services they needed in the past year.<sup>7,8</sup>

In the United States, the disparity in access to behavioral health care services is not unique to the COVID-19 pandemic. Following the enactment of the Mental Health Parity and Addiction Equity Act of 2008, insurers were required to reimburse mental health and substance use services in a comparable manner to that of medical and surgical services.<sup>9</sup> Shortly thereafter, the Patient Protection and Affordable Care Act of 2010 expanded state Medicaid programs and designated mental health and substance use disorder services as an “Essential Health Benefit” (i.e., a category of services that health insurance plans must cover).<sup>10</sup> The result of these policies was a significant increase in the number of individuals with coverage seeking care without an analogous increase in the number of available providers.<sup>11</sup>

Without sufficient access to providers, many people are seeking crisis care through emergency departments. A study in Massachusetts reported patients with mental health complaints waited on average 16.6 to 21.5 hours for an admission or referral, as compared to 4-hours for those with physical health problems;<sup>12</sup> a wait time about 42% longer according to national studies.<sup>13</sup> A similar finding was noted in other research, where ED wait times went from 14.1 hours to 21.9 hours as a county decreased its inpatient and outpatient mental health services.<sup>14</sup>

### *Providers of Care*

Simultaneous to the increases in demand for behavioral health care services, the behavioral health workforce was experiencing chronic staffing shortages owed to insufficient numbers and an uneven distribution of providers geographically.<sup>15</sup> The behavioral health workforce refers to a range of practitioners specializing in prevention, treatment, and rehabilitation care for mental health conditions. As early as 1999, national data showed an inadequate supply of behavioral health providers, particularly in rural regions of the country.<sup>16</sup>

As of 2021, data from the Health Resources and Services Administration (HRSA) suggested that only 28.1% of mental health needs are met in designated health professional shortages areas throughout the United States.<sup>14</sup> An additional 6,559 practitioners are necessary to address the gaps in these regions of the country.<sup>17</sup> A report published by SAMHSA in 2020 estimated that the United States needs a total of 4,486,865 new behavioral health practitioners to offer access to evidence-based models of care to those with serious mental illness and substance use disorders.<sup>18</sup> In 2015, the United States Department of Health and Human Services (DHHS) used simulated models to determine the national supply and demand for behavioral health providers by the year 2025. According to the models, the projected workforce shortages will range from approximately 50,000 to 250,000 behavioral health practitioners.<sup>19</sup> Combined with existing demand, the recent implementation of 988 services, and a growing call for behavioral health crisis responders, the pressure on the behavioral health workforce is rising and only expected to increase.

## **Relief and Recovery by Innovative Means**

### *People Seeking Care*

Recent innovations in behavioral health services offer alternative means of relief and recovery for people seeking care. In particular, self-directed care options improve the availability of services in the midst of the pandemic and long-standing workforce shortages. According to the Centers for Medicare and Medicaid Services (CMS), self-directed care gives the individual, or their representative if applicable, decision-making authority over the services they receive.<sup>20</sup> Like consumer-directed services, it is an approach that assumes people have the ability to assess and seek care to meet their needs, including

evaluating the quality of those services.<sup>21</sup> Many modern behavioral health approaches now reflect the principles of self-directed or self-guided care, including virtual methods, clinically assisted or self-guided tools, and technology aids.<sup>22</sup> Technology is increasingly recognized for its value as a means to self-directed care. The landscape of technology-based mental health encompasses a wide range of services and methods, such as telehealth or teleconferencing software, mobile health solutions like smartphone applications and text messaging platforms, smart devices and wearable technologies, and recent innovations in AI, including machine learning to detect and diagnose mental health conditions.

Nationally, the growth of mobile health, including smartphone or tablet applications and text-messaging platforms, is unparalleled. In Oklahoma, a recent technological innovation offers a form of self-directed care for individuals with behavioral health needs leaving the emergency department (ED). To reduce the likelihood of returning to the ED or admission to inpatient psychiatric hospitalization, individuals receive tablets directly connecting them to behavioral health providers. Specifically, there are nearly 6,000 iPads in circulation to offer people in crisis an immediate method to connect with crisis line providers in Oklahoma.<sup>23</sup> Reports show the tablet-based system is HIPAA compliant, allows patients and first responders (e.g., law enforcement, emergency medical services, and fire departments) to remotely communicate face-to-face with a mental health professional, and lets providers conduct immediate assessments and referrals.<sup>24</sup> The system saves responder time in transport and prevents unnecessary visits to the ED and/or inpatient hospitalizations that may disrupt patients' lives and work.<sup>25</sup> The evidence of the system's success is mounting, with a 36% decrease among inpatient stays since its inception and an estimated savings of \$5 million.<sup>26</sup>

For self-directed care with little to no human interaction, software developers increasingly promote the availability of consumer-available self-help applications.<sup>27</sup> Currently, there are over 10,000 digital apps focused on some form of mental health, representing almost one-third of all health-related apps.<sup>28,29,30</sup> With more than 2.2 billion people worldwide with a smartphone, emerging mental health technologies are more accessible than ever.<sup>31</sup> These apps are not intended to replace therapy, but they are a free or inexpensive option, relative to the cost of traditional mental health therapy.<sup>32</sup> Some applications offer provider responses within minutes, which is unique from the wait times in conventional therapeutic settings.<sup>33,34</sup> Others allow individuals to create digital self-representations, also known as avatars, to facilitate privacy as they participate online. Research suggests avatars encourage clients to engage with therapy, form therapeutic alliances, express and explore their identity, and reduce communication barriers.<sup>35</sup>

Deeper in the technological world is the absence of a "therapist" and the introduction of AI and algorithms to respond to crises and mental health concerns. As school mental health resources are stretched thin, Chatbots are now an option for youth to share feelings of stress, anxieties, isolation, and other hardships.<sup>36</sup> The systems use AI to engage in text-based conversations between an individual and a computer. A form of AI, machine learning, may improve the detection and diagnosis of mental health conditions such as depression, Alzheimer's, and schizophrenia. The evidence for machine learning in treatment and support settings remains limited.<sup>37</sup> As a burgeoning field of study, further research will determine the applicability and role of AI in behavioral health services broadly.

Another emerging alternative to direct care, local provider shortages, and access are online therapy companies with some of the largest ones being BetterHelp and Talkspace Online Therapy. Talkspace, for example, is marketed to consumers who "can't afford to visit a therapist but still needing someone to talk to," Talkspace starts at \$65 per week and includes text messaging with a trained professional as often as the person needs for support through depression and more for couples and individuals.<sup>38</sup> However, there are currently no data available to show the effectiveness of this online texting therapy approach

that these services provide, including how well it might address barriers to care, crisis services, linkages to higher levels of care, and workforce shortages.

### *Providers Seeking Support and Information*

In addition to the individuals seeking care, providers benefit from innovations in self-directed care as they navigate the stress of the profession and the pandemic/post-pandemic environment. There is recent evidence that shows providers support the use of self-help technologies professionally and personally.<sup>39</sup> Behavioral health practitioners can now find supportive communities and learning communities using technology. They may also vary how they deliver care, using virtual options to maintain their clinical presence in the complicated work environment brought by COVID-19 restrictions.

In 2021, Louisiana offered an innovative, fully online approach to support the clinicians providing frontline care in the midst of a disaster (i.e., the pandemic) while simultaneously managing their own survival, recovery, and resilience in the disaster. The approach was a self-paced, interactive course using Skills for Psychological Recovery, which included independent web-based content to complete and two 2-hour live online group meetings to participate in. In general, Skills for Psychological Recovery is designed to teach skills to manage distress and improve coping related to experiencing traumatic events.<sup>40</sup> The skills covered included information gathering, problem solving, managing reactions, helpful thinking, positive activities, and creating or protecting social connections and supports. Approximately 200 providers participated in the hybrid, distance-accommodating approach, and feedback from the participants indicated that the skills taught by the course were applicable and helpful in a time of heightened stress.<sup>41</sup>

Equally important to provider support is the experience of flexibility afforded by technology, for training and continuing education attainment through online and remote spaces. In Philadelphia, a behavioral health technology company is conducting a partnership study called AI-Based Fidelity Feedback to Enhance Cognitive Behavioral Therapy Treatment (AFFECT), which will examine an existing AI platform known as Lyssn. Currently, training for behavioral health practitioners involves direct observation and performance-based feedback, which is time and labor-intensive.<sup>42</sup> Machine learning and speech processing technologies, like Lyssn, automate the feedback process. In the AFFECT study, investigators will determine if Lyssn software system can estimate CBT fidelity by analyzing audio recordings of CBT sessions. Beyond CBT training, Lyssn is also showing uptake in training skills via ClientBot, an AI-based training tool, to teach Motivational Interviewing (MI), an approach commonly included in person-centered crisis interventions. Supported by the facts that traditional training is costly, with few experts, high staff turnover, time constraints, and most does not include continuous quality improvement. In early randomized control studies, the AI approach outperformed traditional training in skills teaching and retention. Two AI studies are underway. One includes 1250 substance use counselors at the Prevention Research Institute, and the other encompasses the entire workforce at Covenant House in New York City (with shelter, FQHC, education, housing & employment services).<sup>43</sup> Although further research is coming, AI and machine learning innovations hold promise as alternative approaches to workforce development.

Surveys of behavioral health practitioners continue to suggest there is support for technological approaches in the delivery of mental health and substance use treatment services. Specifically, data suggests providers value technology-based options equally or prefer them in the domains of quality of care, convenience and efficiency of the format, and the benefits to the patient.<sup>44,45,46,47,48</sup> These data may indicate an expanded role of technology in helping navigate behavioral health workforce shortages by integrating technology to support clinical practice such as recommending app use to clients for both

homework and self-management, supplementing conventional care, and even providing alternative direct care.

A group focused on technological approaches, primarily operating as electronic learning community focused on mental health and substance use, is the eMental Health International Collaborative (eMHIC). According to their webpage, eMHIC “brings together global leaders, subject matter experts, enthusiastic professionals and our future leaders, to share knowledge and improve mental health outcomes for all by harnessing digital technologies.”<sup>49</sup> With mental health and addictions as critical areas to address in crisis work, eMHIC states that they aim to share knowledge on all topics related to eMental health and addiction, in efforts to support and improve outcomes for populations needing care. Their vision is a future “where everyone has access to digitally enabled promotion, screening, treatment, and social support to promote mental wellbeing and recovery at time and place of their choice...and prevent mental distress.”<sup>50</sup> As eMHIC enters its 8<sup>th</sup> global conference, this is a group worth paying attention to for discussions of growth, policy, and ethics surrounding technological approaches to behavioral health.

## **Navigating the Growing Behavioral Health Shortages Ahead**

### *People Seeking Care*

Although innovations in behavioral health services offer promising alternatives, the availability of technology-based behavioral health services should not be conflated with accessibility, particularly in navigating mental health crises. The potential for technology to expand the reach of behavioral health services—and supplement the providers in short supply in the behavioral health workforce—is limited by national disparities in affordable access, skills, and support to engage with the technology.

According to the National Digital Inclusion Alliance, there are five elements that are necessary for digital inclusion: (1) internet-enabled devices that meet the needs of the individual user, (2) affordable, robust broadband services, (3) access to digital literacy training, (4) technical support, and (5) applications and online content designed to enable self-sufficiency, collaboration, and participation.<sup>51</sup> Data collected by the Pew Research Center in 2021 shows that more than 90% of the 253.8 million adults in the United States use the internet. Among this population, 85% own a smartphone, three-quarters own a desktop or laptop computer, and half own a tablet computer.<sup>52</sup> However, there is evidence that at least 42 million Americans (13%) do not have access to broadband (i.e., high-speed internet), which is essential to using any technology-based behavioral health service meaningfully.<sup>53,54</sup> Moreover, a survey conducted by the Pew Research Center in 2019 estimates that only 40% of American adults are knowledgeable on a range of digital topics, including those in cybersecurity, such as phishing scams, data privacy, and website cookies.<sup>55</sup> These data are particularly troubling in the context of the largely unregulated and untested environment of technology-based behavioral health services.<sup>56,57,58,59,60</sup>

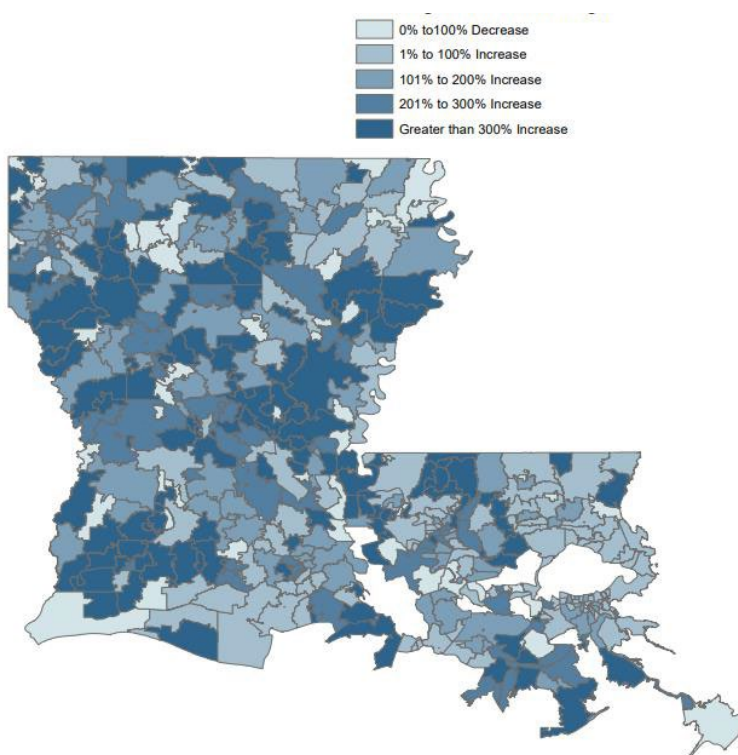
The extent and significance of the digital divide in the United States was laid bare by the pandemic. In response, the federal government accelerated legislation to address digital inequity. In 2021, the United States Congress appropriated tens of billions of dollars toward the goal of universal broadband access through the Consolidated Appropriations Act of 2021 and the American Rescue Plan Act.<sup>61</sup> The Infrastructure Investment and Jobs Act was also recently signed into law, guaranteeing \$65 billion in new spending for broadband improvements nationwide.<sup>62</sup> The bill represents the most significant investment in broadband to date, and the provisions will target unserved and underserved areas throughout the country. The recent federal activity to address the digital divide is an encouraging development. However, it does not represent an immediate solution to national disparities in digital



access, skills, and support. As innovations in behavioral health services continue to emerge, evidence shows that individuals seeking care may not experience the innovations equally.

In a preliminary examination of the possible digital divide in Louisiana, results are currently mixed. Researchers from the Center for Evidence to Practice, examining Medicaid claims associated with behavioral healthcare for youth and their families, found some of the greatest growth of telehealth technology utilization, over the course of 1.5 years, in rural and often impoverished areas of the state, as compared to urban/suburban communities. Still, in other areas the data showed there were decreases in Telehealth Use that warrant further examination. This study is still underway and continues looking for clarity regarding broadband access and quality of this technology-enabled care (Figure 1).<sup>63</sup>

**Figure 1: Changes in Use of Telehealth, based on Medicaid Behavioral Health Claims July 2020 through December 2021**



### **Doing More with Less: Implications for Research, Practice, Policy**

The emergence of technology and its growing ubiquity in behavioral health services will come as no surprise to any provider practicing in the last two decades. What may be surprising is the sheer volume of the various technologies, each with promises to fix, replace, enhance, or answer problems that have always been there—timely access to quality care. Regardless of how a service is delivered, it requires a workforce that is trained and supported to deliver the best care when needed. What is new is that the support for both providers and people seeking services may be more reliant than ever on technologies to supplement traditional practice, particularly mental health crisis response and/or follow-up supportive care. These evolutions in our field requires research, practice, and policy attention.

Noted in many of the descriptions above is the need for research. Knowing what is effective is important to reduce harm to those in need of critical support—providers and consumers. Funding to support

research on the effectiveness of these types of strategies to help populations with diverse needs, could help determine the utility of approaches. Interestingly, technology can also help with these studies. Researchers have noted that internet-based and mobile device-based data collection for studies is aided by tools for sample population recruitment, retention, and information collection.<sup>64</sup>

As identified above, practice limitations are profound with severe workforce shortages and increasing demand for care. Helping practitioners become more comfortable incorporating technological supports for themselves and their clients offers practical solutions. In addition to this, asking practitioners to engage in the study of these tools and their real-world applications could offer objective insights for developers and marketers of these technologies. However, questions remain in practice. For example, how will providers respond when individuals just stop coming to virtual spaces? What happens when crises emerge, like suicidality, and the provider is only available via text or the client disconnects from a smartphone telehealth session? Some apps use a members IP address to determine location to send first responders, but there is more to learn about the determination of the client's level of risk in text messages. Thus, it is unclear whether initiating a crisis response will be over utilized or underutilized from ambiguous information.<sup>65</sup>

Finally, policy must accommodate these needs. The American Psychological Association points out critical issues practitioners must attend to regarding technology. These include HIPAA compliance and patient privacy protections of technology based communications, state licensing laws for practitioners treating patients when location may be beyond their legal or ethical treatment allowance, as well as the ethics and practice parameters associated with the use of many apps and platforms that allow users to remain anonymous.<sup>66</sup> The American Psychiatric Association also has promulgated trainings and guidelines for practitioners with a complete telepsychiatry toolkit that attempts to address a number of issues relevant to practitioners and patients.<sup>67</sup>

Attention should be paid as tele practices role out to the potential disparities in care between large health systems and small providers/individual mental health practitioners. There is a significant investment to join in these technology advances. The fees associated with training, maintenance, and necessary cybersecurity may be financially out of reach for small organizations and sole proprietors.

Policy that fails to recognize, reimburse, and regulate alternative technological methods will keep our field from the innovation it needs now, particularly as demand grows. Continuing to advance quality technology-based options that showed effectiveness during the height of the COVID pandemic may be viewed as a silver lining. Although there is much at stake as the unwind from the public health emergency takes place, there have been invaluable lessons learned and policymakers appear ripe for taking advantage of important advances and continuing them forward beyond the emergency allowances. Applying the lessons learned from practice to inform research will be another step in a positive direction. With these advances, technology can be utilized with protections for both provider and consumer, so that technology continues to grow in a safe way and at an efficient pace to meet demand.

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# THE ROLE OF SUPPORTIVE HOUSING, CASE MANAGEMENT, AND EMPLOYMENT SERVICES IN REDUCING THE RISK OF BEHAVIORAL HEALTH CRISIS

September 2022

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# The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis

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**Abstract:**

There is significant momentum among state behavioral health authorities (SBHAs) nationally to develop accessible and responsive crisis services that will meet the needs of adults, children, and families when mental health emergencies occur. These important efforts should strengthen the crisis response capacity of behavioral health systems, expedite access to care, lower suicide rates, and reduce encounters with law enforcement. As states continue to plan and implement strategies that support more effective behavioral health crisis response systems, attention must be paid to integrating and providing access to other critical services and supports that both reduce crisis risk and support recovery. This paper builds the case for the importance of evidence-based and best practice supportive housing, case management, and employment services as integral components of a behavioral health system that help with crisis prevention, mitigation, and recovery — and offers strategies for supporting their effectiveness in doing so.

**Key Points:**

- Supportive housing, case management, and employment programs that use evidence-based and best practices provide critical opportunities to recognize the early warning signs of a behavioral health crisis and take steps to prevent it.
- High-fidelity supportive housing and supported employment programs serving individuals with mental illnesses and co-occurring disorders, including those who experience homelessness, integrate crisis prevention and intervention into their service models. When implemented effectively, these services can help reduce the severity of crises that do occur and can facilitate post-crisis recovery.
- Case management services that incorporate evidence-based and best practice interventions can function as a critical hub for engaging individuals, facilitating self-direction, and choice. Linkages to these and other services and supports can help reduce crisis risk and assist in recovery.
- SBHAs can strengthen the role of supportive housing, case management and supported employment in crisis prevention, mitigation, and recovery through policy, funding, and practice support. SBHAs can also help ensure effective coordination between upstream services that address social determinants of health (SDOH) and crisis services.

**Recommendations for the Future:**

1. As states enhance their behavioral health crisis response systems to support successful implementation of 988, SBHAs should commit to making supportive housing, case management, and supported employment services more available and accessible within their systems to address SDOH, reduce crisis risk, and support individuals in their recovery.
2. Policies, regulations, service definitions, and performance monitoring should reinforce key features of these services that make them effective in crisis prevention, mitigation, and recovery, and ensure their alignment and coordination with the crisis response system.
3. SBHAs should work in close coordination with state Medicaid agencies to ensure sufficient funding and coverage to support effective implementation of supportive housing, supported employment, case management and integrated peer supports, and advocate for adequate provider rates in their states.

4. Supportive housing, case management, and employment services providers should be equipped with guidance, tools, and protocols, and offered training and technical assistance to ensure they can effectively assess, plan for, and intervene to prevent or resolve crises as needed. They should also be trained on protocols for accessing local crisis systems and services.
5. SBHAs and providers should invest in recruiting and retaining a diverse, culturally competent and responsive workforce, and should partner with trusted community leaders in order to more effectively engage people of color in upstream services that improve SDOH and reduce crisis risk, and in crisis services as needed.

The ability of behavioral health crisis services to meet demand and successfully resolve crises is largely dependent on the ability of the behavioral health system to help prevent crises in the first place and to effectively manage and resolve a crisis when it does occur. As states continue to plan and implement strategies that support more effective behavioral health crisis response systems, in conjunction with the implementation of 988, attention must be paid to integrating and providing access to other critical services and supports that both reduce crisis risk and support recovery. Access to upstream services can help address social determinants of health (SDOH) like housing and employment which are general factors that play an important role in improving mental health and wellness, and also facilitate recovery among people with a mental illness and/or substance use disorder (SUD). Conversely, lack of access to these and other resources can both increase the risk that a person will experience a behavioral health crisis and affect their ability to recover from one.

Structural and systemic racism in the U.S. have contributed to behavioral health services often being inaccessible to people of color and to significant disparities in SDOH. Recent estimates are that African Americans represent only 13 percent of the general population but account for nearly 40 percent of people experiencing homelessness, and account for more than 50 percent of homeless families with children.<sup>1</sup> Black Americans also experience poverty<sup>2</sup> and unemployment<sup>3</sup> at elevated rates. Mental illness and/or SUD can contribute to, as well as be exacerbated by, homelessness and unemployment. Making housing, employment, and other supports more accessible to people of color can help address important SDOH, reduce crisis risk, and support recovery.

SBHAs play a critical role in determining the types of behavioral health services that are available in a system, including how they are funded and regulated, and for ensuring equitable access for all who need them. SBHAs and providers can help make services available in ways that help reduce unnecessary crisis services use and costs, and improve individuals' recovery outcomes.

## Background

As discussed in the National Association of State Mental Health Program Directors' (NASMHPD) 2018 report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*, ending homelessness among individuals with serious mental illness (SMI) — using interventions tailored to their unique needs — is critical to strengthening behavioral health systems and improving individual-level outcomes.<sup>4</sup> Individuals experiencing homelessness are at increased risk for experiencing a behavioral health crisis by myriad risk factors, such as high rates of abuse and trauma, higher prevalence of suicidal ideation and attempts, and untreated physical health conditions, as well as increased likelihood of being arrested and incarcerated, which leads to a cycle of disconnection from the behavioral health system and recurrent homelessness.<sup>5</sup> The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized **housing** as the “cornerstone” to recovery for individuals with mental illness and co-occurring disorders (CODs) who experience homelessness.<sup>6</sup> SAMHSA has also recognized the importance of pairing community-integrated, affordable housing with supportive services for this population through its endorsement of the evidence-based permanent supportive housing (PSH) model.<sup>7</sup>

The U.S. Substance Abuse and Mental Health Services Administration has recognized housing as the “cornerstone” to recovery for individuals with mental illness and co-occurring disorders who experience homelessness.

PSH services can help prevent an individual from experiencing a behavioral health crisis and can also reduce the likelihood that if a crisis does occur, it will lead to eviction or a return to homelessness. Research has found that individuals experiencing homelessness who also have behavioral health conditions experience improvements on housing stability and behavioral health measures and a

reduction in emergency department and hospital admissions when served by PSH.<sup>8,9,10</sup> PSH has been adapted to serve individuals with a broad range of behavioral health and housing needs, including families with children and persons exiting jails and prisons.<sup>11</sup> Supportive housing interventions have also been shown to reduce child welfare involvement and to help keep families together,<sup>12</sup> while the rate of incarceration in jails and prisons has been significantly reduced among PSH participants with prior histories of incarceration.<sup>13</sup>

**Supportive Housing** combines decent, safe, affordable, community-based housing with flexible, voluntary services and supports to help individuals achieve stable housing and community integration.

**Case Management** includes a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other essential services and supports.

**Supported Employment** assists with obtaining competitive, integrated employment opportunities consistent with individual choice, and offers ongoing customized supports to maintain employment.

By helping those who frequently use emergency departments, psychiatric and medical inpatient units, and other emergency services to quickly access PSH, not only are their crisis risks reduced, but also the costs associated with recurrent services utilization.<sup>14</sup> To be successful, PSH service providers must be linked with crisis systems and services to ensure early intervention, coordination, and post-crisis handoffs back into housing and services.

**Case management** services for individuals with behavioral health needs may either stand alone or be combined with other services or housing, and they may be offered either by behavioral health systems and providers or by non-behavioral health entities such as those within the homelessness system. Case management models serving behavioral health populations vary in intensity, focus, and duration — ranging from those such as Assertive Community Treatment (ACT), intensive and clinical case management models, which use small caseloads and provide ongoing services for individuals with chronic behavioral health conditions, to more generalist models characterized by larger caseloads and basic linkage and coordination with services and supports for longer-term care.<sup>15,16</sup> Both ACT and Critical Time Intervention (CTI), which provides continuity of care to individuals with SMI during transitions from homelessness, psychiatric hospitals, or other institutions into community housing, are evidence-based case management models associated with reductions in negative psychiatric symptoms, length of psychiatric hospital stays, and emergency department visits.<sup>17</sup> CTI has also proven effective in reducing recurrent homelessness<sup>18,19,20,21,22</sup> and has been shown to be cost-effective.<sup>23</sup> MISSION is another model that incorporates and has been shown when combined with PSH to help improve housing retention, mental health outcomes, and access to care.<sup>24</sup> Many features of these and other evidence-based interventions such as motivational interviewing, trauma-informed care, and harm reduction can be adapted to help case management programs effectively serve individuals who have one or more risk factors for experiencing a behavioral health crisis.

As a SDOH, **employment** plays a critical role in promoting recovery, while also reducing social exclusion, isolation, and poverty. Adults with SMI are more likely to be unemployed or underemployed, contributing to economic hardship that can further affect behavioral health.<sup>25</sup> Despite low employment rates, the majority of people with SMI are capable of and interested in working if connected with appropriate jobs and supports.<sup>26</sup> Supported employment (SE) services provide individuals with mental illness and CODs with specialized assistance in choosing, acquiring, and maintaining competitive employment. The evidence-based, SAMHSA-recognized Individual Placement and Support – Supported Employment (IPS-SE) model, which has been adapted for working with people who are experiencing homelessness and those who have been involved in the criminal justice system,<sup>27</sup> has been shown to increase access to competitive employment and income; reduce symptoms of mental illness, inpatient

hospitalizations, and psychiatric crisis visits; and improve self-esteem and overall quality of life.<sup>28,29</sup> Assisting individuals to achieve employment enables them to improve their social integration and networks as well as their living situation,<sup>30</sup> which can reduce crisis risk in addition to having positive impacts on other SDOH. Evidence also suggests SE as an important component of programs designed to support persons experiencing an early episode of psychosis, affecting community stability and recovery through sustained employment, improved quality of life and lower hospitalization rates during the early stages of psychotic illness.<sup>31,32</sup> However, relatively few people with SMI served by SBHAs receive SE services, due largely to lack of sustainable services funding. More can be done to promote employment as an achievable outcome during recovery at both the system and provider levels.

## **Reducing Crisis Risk through Effective Services Implementation**

Below are key features of supportive housing, case management, and employment programs that can help to reduce crisis risk. Common barriers to effective crisis prevention within these programs are also explored, along with strategies for increasing their effectiveness.

### *Supportive Housing Services*

Supportive housing services focus on proactively engaging and assisting participants in building the skills to access and maintain housing, and connecting them with treatment, supports, and community resources that support recovery. High-fidelity PSH programs that make services available on a 24/7 basis and integrate behavioral health services are perhaps most effective in reducing crisis risk. By maintaining low caseload sizes (e.g., 1:15) and routine face-to-face contact with tenants where they live, PSH providers are able to recognize the early warning signs of a potential crisis, and to adjust the frequency and intensity of services as needed to help avert a crisis.

Potential barriers to effective crisis prevention within PSH programs may include a lack of 24/7 service availability due to funding or workforce challenges; larger caseloads that limit the ability of staff to effectively monitor tenants for crisis risk; and lack of behavioral health services integration, such as when PSH is funded and operated within local homelessness systems. In these instances, PSH programs tend not to be naturally connected with behavioral health systems and services, and staff may not be equipped to recognize crisis risk factors.<sup>33</sup> Staff capacity and training in this regard may be lacking regardless of whether the program sits within or outside of the behavioral health system. Thus, PSH provider agency staff need training to identify risk factors and to proactively and effectively engage individuals in planning to reduce crisis risk.

PSH services are delivered based on individualized plans that assess tenant needs and preferences and ensure access to services and supports to address those needs. Ideally, this assessment includes consideration of the types of crises that may occur (e.g., psychiatric, substance use, medical, housing- or family-related). Plans should include monitoring these risk factors and engaging individuals in services and supports that specifically reduce risk. Some PSH programs require providers to develop a specific crisis prevention and intervention plan for tenants as a means of effectively planning for and intervening in the event of a crisis.<sup>34</sup> Plans are developed with tenants as workers are assessing housing-related strengths, barriers, and service needs prior to tenancy, and are updated throughout tenancy to reflect changing needs. Copies are given to the tenant and to the service provider.

Many providers embed peer workers into PSH service teams; these team members bring their own personal experience with mental illness, recovery from an SUD, homelessness, and/or justice system involvement. In addition to assisting PSH program participants with resource navigation and linkage, peer workers' expertise may be called upon when the PSH team is having difficulty engaging with a tenant who is at heightened risk for experiencing a crisis. Peer workers can effectively engage

participants in unique ways that help meet basic needs, build trust and rapport, and gradually gain voluntary participation in services, while also helping to de-escalate and divert potential crisis situations.

### *Case Management Services*

Case management services have the potential to address many of the risk factors associated with a behavioral health crisis. At a basic level, case management focuses on assessment, planning, linking, advocacy, and monitoring. ACT case management services use low caseload sizes (e.g., 10:1) in addition to directly delivering psychiatric and SUD treatment, employment, and rehabilitative services specifically for those with SMI and CODs who have the most acute behavioral health needs and are most at-risk of crisis (e.g., those with frequent hospital admissions, frequent use of emergency services, experience of homelessness, or involvement with the criminal justice system). ACT services are intensive, highly individualized, and delivered by multidisciplinary teams on a 24/7 basis to people wherever they are in the community, enabling providers to monitor and titrate service intensity to manage crisis risk. Funding and staffing limitations may challenge the ability of ACT teams to effectively prevent crisis, particularly where 24/7 service availability is lacking. Modifications may also be needed for ACT teams to effectively respond to SUD-related crises, homeless individuals in need of outreach and engagement, and for those also needing housing supports.<sup>35</sup>

Not all individuals need the level of service intensity provided by ACT, and case management programs offering less intensive supports tend to focus on service linkages that can prevent crisis risk, rather than on providing services directly. These programs can adapt principles and strategies from and train case managers in evidence-based interventions like motivational interviewing, trauma-informed care, and harm reduction to help strengthen their ability to engage individuals with behavioral health needs. This ability, in combination with good assessment and planning, is essential to creating effective linkages with the community-based treatment, services, and supports that may reduce an individual's crisis risk.

CTI is intensive, time-limited, and focused on assisting individuals with SMI to achieve housing stability; however, it has several elements that can be adapted by case management programs serving a broader range of individuals with behavioral health needs to help prevent crisis. During each phase of CTI services, staff focus on connecting individuals with treatment and community resources in one or two key focus areas that include: psychiatric treatment and medication management; substance use disorders management; life skills training; money management; housing crisis management and prevention; and family intervention. Case management assessments can be aligned with many of these focus areas, which are also tied to crisis risk. Other CTI elements that can be adapted include its emphasis on early engagement and ongoing relationship-building; planning to address risk factors through linkages with community providers and resources that promote stability; and gradually shifting responsibility for crisis prevention to longer-term treatment providers and other formal and natural supports. Regardless of program model, large caseloads may inhibit effective planning, monitoring, linkage, and coordination by case managers to reduce crisis risk. Training is needed for case managers in crisis risk assessment and planning, client engagement, and coordination with treatment and other service providers.

### *Supported Employment Services*

Supported Employment (SE) services promote competitive employment in the community based on program participants' interests and available choices, with service coordination and ongoing monitoring that can help reduce crisis risk. SE services may be standalone or integrated into other service models. When implemented to fidelity with the IPS-SE model, services emphasize the integration of employment services within clinical treatment teams and the provision of ongoing follow-along supports to help an individual maintain employment. By working in partnership with program participants' other behavioral health providers, such as psychiatrists, therapists, and case managers, employment specialists can

monitor for symptoms and stressors that may affect an individual’s ability to find and keep a job while also being informed of any changes, events or circumstances that could lead to a potential crisis. Where required, elevated risk of crisis can signal a need for modified employment supports, including more intensive on-site job coaching, mediation between an employer and the individual, or sometimes, assistance in exiting a place of employment and finding a job that is a better fit. Where employment specialists are not viewed as part of or able to regularly participate in clinical treatment team communication and planning, efforts to recognize crisis risk may be hampered.

SE service providers should ensure that employment specialists are trained to identify crisis risk factors, to assertively engage individuals and offer adjustments to employment supports as needed, and to have structures and protocols in place that ensure regular and effective communication between SE staff and clinical treatment providers. Yakima Neighborhood Health Services, an SE provider based in Washington State who also delivers supportive housing and health care services, allows SE and behavioral health clinical staff to share an electronic database in order to more effectively coordinate services.<sup>36</sup> This type of shared data system can allow for rapid communication between SE staff and the clinical treatment team to better support with recognizing and responding to situations involving elevated crisis risk. SE and behavioral health treatment providers could also codify partnerships using memorandums of understanding (MOUs) and operationalize integration by inviting employment specialists to weekly treatment team meetings; sharing employment and treatment/services plans between providers; and meeting jointly with program participants to ensure service coordination.

### **Crisis Mitigation and Recovery**

Just as supportive housing, case management, and employment programs can engage in approaches that help reduce crisis risk, many of the same strategies noted above can also help in mitigating and resolving crises when they do occur, as well as assist with post crisis recovery as defined in Figure 1.

<b><i>Figure 1: Effective supportive housing, case management and employment services have a role in:</i></b>	
Crisis Prevention →	Identifying crisis risk factors, intervening to reduce the risk of crisis occurring.
Crisis Mitigation →	Intervening to reduce the severity of a crisis, and to resolve it once it occurs.
Crisis Recovery →	Post-crisis connection with and return to services/supports that promote recovery and prevent recurring crises.

To be successful, PSH service providers must be able to respond on-site, by phone, or virtually to intervene with a developing crisis. Team-based case planning and service delivery helps ensure that any responding PSH service team member has an ongoing relationship with and can support the individual in accessing additional care as necessary. This can in turn help alleviate any feelings of anxiety or symptom presentation that a response from an unknown individual like a mobile crisis worker may exacerbate. Barriers to mitigating crises within PSH programs may occur where 24/7 ability to respond, team-based service delivery, and/or integration with behavioral health services, including crisis services, is lacking. PSH program staff need training in order to effectively intervene and deescalate a crisis, regardless of whether the program sits within or outside of the behavioral health system. Further, many PSH programs lack policies and procedures and clear protocols for *how* to call for backup when crisis intervention is needed beyond the scope of a PSH programs or provider’s resources. Providers must



have an understanding of the crisis response process in their community and know when and how to call on crisis services. PSH programs should establish policies and procedures outlining protocols for crisis response, supported by regular staff training on these processes and on services that can support ongoing coordination of care in the event of a behavioral health crisis.

Managing a behavioral health crisis is inherent to ACT which assumes this responsibility. Thus, these services should also be available to respond to crisis on a 24/7 basis, and all team members should be familiar *with and to* the individual experiencing a crisis to facilitate effective resolution. While workers in less intensive case management programs may not have primary responsibility for crisis intervention, they should receive training in de-escalation and have protocols in place for coordination with primary treatment providers, crisis services, and other supports equipped to intervene in the event of a crisis.

The integration of SE service providers with the mental health treatment team can improve opportunities to deescalate a crisis, help individuals stabilize, and avoid interruptions to their employment should a crisis occur. Where employment specialists are not integrated with the clinical treatment team, protocols should be in place that ensure timely communication between SE and treatment providers, including emergency notification to SE providers, in the event of a crisis.

When an individual comes into contact with crisis services, there is a need for post-crisis coordination and connections with services and resources, both in the immediate aftermath of a crisis experience and to sustain long-term recovery while minimizing the risk of a recurrence. This includes not only providing quick linkages with care following contact with any part of the crisis services continuum (call centers, mobile crisis, or crisis stabilization), but also to housing and employment services and resources.<sup>37</sup>

**Figure 2: Key Program Features & Strategies that Support Crisis Prevention, Mitigation & Recovery**

- ✓ **Crisis risk assessment and planning**
- ✓ **Proactive and ongoing engagement**
- ✓ **24/7 community-based availability**
- ✓ **Low caseload sizes**
- ✓ **Integration with behavioral health services**
- ✓ **Team-based case planning and service delivery**
- ✓ **Peers integrated as team members**
- ✓ **Ability to monitor and adjust service intensity/frequency**
- ✓ **Protocols for coordination with crisis services**
- ✓ **Timely post-crisis referrals and warm handoffs**

For those already participating in housing, case management, and employment programs, post-crisis coordination means ensuring these programs have protocols in place for receiving warm handoffs from crisis services providers and for quickly reengaging them into housing and services in order to promote stabilization and prevent future crises. Workers in these programs can assist individuals in navigating any challenges that may arise as a result of a crisis with landlords or employers, for example, and with any necessary disclosures or reasonable accommodation requests.

Figure 2 above offers several key program features and strategies that support crisis prevention and mitigation, as well as post-crisis recovery.

While behavioral health systems and providers may be inclined to recommend additional treatment (e.g., partial hospitalization, crisis residential program) to mitigate a crisis, a person's return to their housing, work, and other activities (e.g., school) as soon as possible may be their first choice and more likely to facilitate rapid re-stabilization and a return to one's recovery goals. Some crisis systems have infrastructure in place to support follow-up by existing behavioral health providers, including supportive housing, case management and employment services providers, when an individual accesses crisis services. For example, Georgia's Crisis and Access Line (GCAL) allows call center staff to identify ongoing behavioral health service providers and request provider follow-up at the time of the initial crisis call.<sup>38</sup>

In Washington, D.C., staff across the crisis continuum have access to a centralized database which allows staff to identify and coordinate with existing providers at the time of crisis.<sup>39</sup>

In order to secure post-crisis connections for individuals who are not already accessing housing and employment programs or resources, crisis providers need processes in place that ensure timely engagement, referrals, and warm handoffs to these connections on the back end of crisis services. Case management and care coordination play a significant role in supporting individuals coming out of crisis, and crisis programs should coordinate with or directly provide these services in order to facilitate linkages to appropriate supports. Most crisis stabilization units (CSUs) provide social workers and case managers to facilitate connection to behavioral health providers and coordinate care with existing providers. Connections Health Solutions in Arizona incorporates transitional case management services into the acute crisis stabilization unit it manages, in order to connect individuals with services and supports that prevent reemerging crisis.<sup>40</sup> States and providers have also utilized “peer bridgers” to assist individuals in making strong connections with resources and quickly integrating back into the community after crisis stabilization.<sup>41</sup> Tennessee has embedded peer support services like these into its CSUs.<sup>42</sup> Washington State’s Peer Pathfinder Program assists individuals who have experienced a substance use-related crisis with peer engagement and connection with behavioral health and other services including supportive housing and supported employment following utilization of hospital emergency rooms.<sup>43,44</sup>

Some states have also implemented short-term, intensive case management services, similar to CTI, as a bridge to support individuals with significant behavioral health and other challenges (e.g., high crisis service use, homelessness, justice system involvement) with community reintegration and connection to appropriate services post-crisis. Georgia’s High Utilization Management program offers short-term intensive care coordination, service linkage, and referrals for individuals who have a history of high crisis services utilization and are disconnected from community-based services and supports.<sup>45</sup> Following acute hospitalization, the Pathway Home program in New York connects individuals with significant behavioral health challenges who are not otherwise linked with behavioral health services to intensive short-term and mobile case management in order to help with the transition back to the community and ensure ongoing connection to supports to address SDOH, including rapid connection with housing.<sup>46</sup>

## **Strategies for SBHAs and Providers to Strengthen the Role of Supportive Housing, Case Management & Employment Services in Reducing Crisis Risk**

Both SBHAs and providers can support many of the strategies noted above. SBHAs must emphasize the importance of supportive housing, case management and employment services and their role in preventing, mitigating, and helping people to recover from behavioral health emergencies through policy, funding, and practice support. Systems should ensure the availability of these services, and work with providers to better promote the idea that people with high needs and complex conditions can live in independent, affordable housing in the community with the appropriate services and supports, and likewise that work can be part of their daily routine.

SBHAs can work with Medicaid agencies (if separate) to design and finance these services in ways that reinforce the key features and strategies highlighted in this paper and ensure their coordination with crisis services. Practice support is needed in order to help providers operationalize program standards, and workforce training and development efforts can help ensure that program staff have the critical skills necessary to effectively assess for crisis risk factors, and to plan for and intervene as needed.

Collaborative partnerships are also necessary to ensure effective coordination between behavioral health services, including those along the crisis services continuum (call center, mobile crisis, crisis

stabilization), and upstream services that address SDOH like housing and employment to ensure access to the services and resources individuals want and need, post-crisis and for long-term recovery.

### *Policy, Regulations, and Program Standards*

SBHAs should commit to supporting access to upstream services that address SDOH and are critical to preventing, mitigating, and recovering from behavioral health crises as the crisis system is developed. Policies and regulations should affirmatively articulate the role of these services in relation to the crisis response system. Since SBHAs generally have a direct or indirect oversight role in crisis services as well as in supportive housing, case management, and supported employment, they are uniquely positioned to ensure alignment and coordination of these services through regulations and service definitions.

SBHAs should also ensure that these services have the capacity to meet individual needs. Service definitions in and across regulations (e.g., SBHA and Medicaid regulations, if separate) should align and specify caseload sizes consistent with best practices; staffing that reflects the role and type of workforce needed, including peer support; and an adequately trained workforce to meet the diverse needs of service recipients. Service definitions should also address how these services support 24/7 access and provide the level of flexibility and intensity needed to be responsive to individuals.

Additionally, standardized tools could be encouraged or required that support the development and implementation of crisis prevention and intervention plans alongside individualized services plans. North Carolina's managed care organizations assess the capacity of PSH service providers to do this as part of provider readiness assessments.<sup>47</sup> Crisis plans should identify what constitutes a crisis; precipitating factors; support systems, individuals, or agencies the person wants contacted should a crisis occur; and, as appropriate, authorization to allow ongoing coordination between supports to mitigate potential crisis. Programs can also be encouraged to have protocols for ongoing assessment of an individuals' changing needs relevant to common crisis risk factors — such as unmet mental health or SUD treatment needs, medical concerns, lack of income, or risk of eviction — in order to adjust the frequency with which an individual is engaged based on their regularly assessed level of crisis risk.

Importantly, SBHAs must ensure reasonable quality and performance monitoring of these services. SBHAs should establish meaningful performance indicators and data metrics related to crisis prevention and intervention (e.g., crisis planning, ability to respond to or see individuals within reasonable timeframes, interaction with crisis programs, warm handoffs); evaluate compliance with minimum standards (e.g., caseload size, services, training); and engage in system- and provider-level evaluations against standards and benchmarks. Metrics should examine whether the expected outcomes of these programs are achieved in terms of connections with and sustainability of housing, employment, and other services and supports that can reduce crisis risk. In particular, SBHAs and providers can monitor to make certain that programs in which crisis prevention or response are inherent to the model do not overuse external crisis services. SBHAs and providers should talk with crisis programs to understand whom they may be mutually serving based on data and observation, and plan collaboratively to help those individuals stabilize. This may help providers take steps to proactively intervene early, particularly with individuals who present with multiple risk factors, helping to alleviate the feeling of always operating in “crisis mode.” Additionally, metrics should be evaluated across demographics and regions to examine and address disparities in accessing services that address SDOH and assist with crisis prevention, mitigation and recovery, particularly among disadvantaged and rural communities.

Provider fidelity reviews and performance improvement processes can also reinforce important features of evidence-based practices that influence crisis prevention, mitigation, and recovery so they are operationalized — such as 24/7 service availability, team-based services that are integrated with behavioral health treatment, low caseloads, face-to-face contacts in the community, and ability to

titrate services based on changing needs. Providers may additionally require guidance that allows for specific adaptations to address co-occurring SUDs; the needs of homeless individuals, children, and families; and the particular risk factors of persons with a history of criminal justice system involvement.

Finally, SBHAs must work closely with state Medicaid agencies and managed care organizations to equip providers to offer these services consistent with best practices and compliant with standards, with additional attention to their role in crisis prevention and intervention.

### *Funding Upstream Services and Supports*

SBHAs, in close coordination with state Medicaid agencies, must ensure adequate funding and coverage to support these services as established in policy and regulation, with additional attention to their role in behavioral health crisis. SBHAs should also work with state Medicaid agencies to evaluate the ability of current state plan or waiver services related to supportive housing, case management, and employment to provide prevention, mitigation, and recovery supports. SBHAs and Medicaid agencies must be clear about the spectrum of services needed in each of these types of services, which ones Medicaid will pay for, and which ones SBHAs or other sources should pay for. SBHAs and Medicaid agencies should proactively address braided funding approaches so that the services needed are reimbursed, regardless of payer.

SBHAs must also work with state Medicaid agencies so that managed care contracts articulate the need to pay for services related to preventing, mitigating, and recovering from behavioral health crisis. Additionally, provider rates for supportive housing, case management, and employment services must factor in services for crisis prevention, mitigation, and recovery, including additional staffing, increased face-to-face or virtual supports, and collateral contact time. Given the significant role that peer support services play in mitigating crisis and promoting recovery, SBHAs should work with Medicaid agencies to evaluate reimbursement rates so that peer support staff are adequately compensated. Geographic considerations, such as transportation time or the need to support technology for crisis and non-crisis program staff to communicate with service recipients, particularly in rural areas, should be accounted for as well. SBHAs should make sure that funding is available for these services to actively plan and coordinate with crisis providers about issues like 24/7 availability to connect, data- and information-sharing, linkages to services, and warm handoffs. Providers should have adequate funding to allow for equitable access to these services through provision of bilingual staff, virtual remote interpretation services, and telehealth capabilities.

### *Workforce Training and Development*

SBHAs should support supportive housing, case management, and employment programs so that staff can effectively assess for crisis risk factors, and plan for and intervene as needed to prevent, mitigate, and resolve crises. In addition to training providers on the types of program guidance, tools, and protocols that support this goal, SBHAs can offer training and technical assistance to supportive housing, case management, and employment provider agencies and staff operating both within and outside of the behavioral health system to equip them with basic skills for recognizing and responding to behavioral health crises. This education can be accomplished by creating a common curriculum, like Louisiana created for its PSH service providers<sup>48</sup>, or a centralized online training platform to enhance quality and access to training supports on a regular basis. For example, Washington is creating an online training platform for peer support staff responsible for responding to crisis.<sup>49</sup>

Training topics can include:

- Recognizing the signs and symptoms of mental illness and substance use/intoxication
- Psychiatric medications and side effects

- Crisis risk assessment and planning
- De-escalation
- Proactive engagement
- Motivational interviewing
- Trauma-informed care
- Harm reduction
- Cultural sensitivity

Staff working within supportive housing, case management, and employment programs also need training on the local crisis system and services, as well as protocols to follow during crisis situations and instruction in how to access those services when needed. Staff working in crisis services, including call centers, mobile crisis teams, and crisis stabilization programs, need working knowledge of the housing and employment programs and resources available within their community and how to access them. Some of this training can be provided internally within provider agencies, whereas some lends itself well to cross-training between provider types. This type of cross-training can be encouraged and supported by SBHAs, and providers can directly initiate it in their communities as well.

SBHAs can also offer programs and providers training and guidance in other areas, including sample policies and procedures that identify clear processes for specific activities, such as:

- Accessing program or provider agency on-call supports in the event of a crisis, as well as how and when to access crisis services, including clear protocols on when to call 988 or 911
- Handling crises that pose a safety risk, including reporting of critical incidents, processes for programmatic debrief, and protocols for engagement after a safety incident
- Information-sharing and care coordination with other providers during crisis
- Modification of crisis plans and care coordination meetings with treatment providers during crisis
- Post-crisis support, including with transitions back into housing, employment, and other services and supports

Many SBHAs are currently identifying levers to incentivize recruitment and retention efforts to address the behavioral health workforce shortage, which has been exacerbated by the COVID-19 pandemic.<sup>50</sup> To ensure more equitable access to quality upstream and crisis services, SBHAs and providers should invest in recruiting and retaining a diverse, culturally competent workforce that represents the communities being served in order to bridge the cultural gaps that can deter service engagement. Potential strategies include using financial incentives and scholarships, recruiting from local institutes of higher education, including historically Black colleges and universities, training providers in the National CLAS Standards, and evaluating barriers to retention among current providers of color.<sup>51,52</sup>

### *Collaborative Partnerships*

As SBHAs plan for and build out their crisis services continuums to help ensure the success of 988, they can encourage and support cross-sector collaboration in several ways to reinforce effective coordination between crisis and upstream services. SBHAs can encourage — and providers can directly initiate — the establishment of MOUs that, for example, define roles and responsibilities of partnering entities during and after crises; facilitate communication, warm handoffs, and referrals; and outline processes for the sharing of resources (e.g., training) and information such as data on frequent users of crisis services who are commonly served between entities.

Current investments in creating more responsive behavioral health crisis systems, including enhanced federal matching for Medicaid Home and Community Based Services provided under the American Rescue Plan Act (ARPA), can be leveraged to forge cross-system partnerships to address SDOH and increase access to housing and employment supports.<sup>53</sup> The importance of SBHAs and providers partnering with trusted community (e.g., religious) leaders and offering supportive services that improve SDOH such as housing and employment has also been cited as an effective way to engage more people of color into crisis services.<sup>54</sup> As SBHAs plan for 988 implementation, states should regularly convene key stakeholders inclusive of these community leaders, as well as the systems and providers responsible for making housing, case management, and employment services available, as connection to upstream services such as these will be necessary to reduce the potential additional burden on crisis services.

SBHAs should also take steps to ensure that crisis providers not only assess immediate crisis, but also evaluate needs related to SDOH like housing and employment. This approach is particularly important for mobile crisis and crisis stabilization programs in order to ensure coordination with available programs and services that address these needs to further promote community stability. SBHAs could also require post-crisis follow-up within a certain time period (e.g., 48 hours) after an individual comes in contact with crisis services and could support infrastructure that ensures connections with existing upstream service providers.<sup>55</sup> SBHAs can also enhance peer support services across the crisis continuum to work with upstream service providers to support an individual's community stabilization and reintegration post-crisis.

Further, SBHAs can incentivize and set expectations for partnerships between behavioral health providers and other systems and services, including HUD-funded homeless Continuums of Care which provide access to housing resources for homeless individuals and families, as well as mainstream housing providers (such as public housing authorities) that serve people with disabilities including behavioral health conditions. ARPA provided an additional \$1.5 billion in Mental Health Block Grant dollars to be utilized over the next several years, money which SAMHSA has encouraged states to use to develop partnerships among critical stakeholders of the crisis services continuum.<sup>56</sup> Given the limited funding and availability of IPS-SE within states, consideration should be given to forging partnerships with employers and with employment resources outside of the behavioral health system as well, such as with Vocational Rehabilitation and Department of Labor programs and services (e.g., Career OneStop, American Job Centers, Workforce centers, WorkSource).

## **Conclusion**

Nationally there are unprecedented investments being made into the behavioral health crisis system; however, connection to upstream services plays a significant role in making sure the crisis system is not overwhelmed. As state crisis planning moves forward, systems should also focus on providing access to upstream services like supportive housing, case management, and employment services, including the coordination of these with crisis systems and services. Given the particularly detrimental impact of crisis on individuals who have inadequate access to high quality, responsive care, strategies to expand upstream connections should address disparities in access. SBHAs play a vital role in strengthening access to crisis services as well as addressing SDOH that have a role in crisis prevention, mitigation, and recovery. SBHAs and providers can support the strategies discussed in this paper to advance policy, funding, and practice in order to integrate and coordinate the two and produce better outcomes for individuals experiencing or at risk of experiencing a behavioral health crisis.

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# RESPONDING TO AND PREVENTING CRISES

## CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum

**NASMHPD**

Paper No. 9 in the *From Crisis to Care* Series

# **Responding to and Preventing Crises: CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum**

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### **Abstract:**

Models of care are emerging throughout the United States that emphasize access to crisis services, jail diversion, and clinical accessibility to make it easier for end users with mental illness, substance use disorders, and other behavioral health concerns to get into the front door of care from any avenue. One model that has been particularly strong as a compliment to the CrisisNow model for community-based crisis prevention and postvention has been the Certified Community Behavioral Health Clinic model (CCBHC), which has been sponsored through federal efforts and related funding by both the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicaid and Medicare (CMS). This paper highlights these approaches and takes one health system, the Sheppard Pratt Health System in Maryland, which operates a CCBHC funded by an expansion grant (CCBHC-E) at two sites and describes how it links crisis response efforts to an array of services that comprehensively meet the population needs. Throughout this paper, information can be gleaned to help state leaders who are aiming to establish their own crisis service systems in the context of other accessible services when needed through a variety of models.

### **Highlights:**

- CCBHCs are an emerging model with a unique payment structure that can provide flexible services to meet the clinical needs of a community from crisis and beyond.
- Shepard Pratt provides an example of one clinical entity that has a comprehensive range of services at all levels of care, including crisis services that are linked to a broader continuum and accessible in Maryland.
- Urgent care centers and clinical services embedded in retail stores are emerging with a new focus on behavioral health services. They will likely become a bigger enterprise over time to meet the needs of populations especially in light of COVID-19's emotional toll on society.

### **Key Recommendations:**

- 1) The CCBHC model with prospective payments should be available as a standard option in Medicaid to all states to support the implementation of 988 and meet the ongoing need for services that both respond to and prevent crisis.
- 2) States should examine their crisis service continuum including examining emerging availability of behavioral health access points in non-traditional settings, such as retail pharmacies and other commercial venues, to understand where there may be additional synergies for access to crisis care and other supports.
- 3) State policy makers and mental health advocates should look to strong models of service delivery that can provide examples for local communities upon which to build a more complete continuum from crisis services to ongoing recovery supports.

**F**ocusing solely on developing high quality crisis call lines, mobile crisis teams, and crisis stabilization units will not adequately meet the need for crisis services. In order to be effective, the traditional core crisis services must be embedded in and supported by a comprehensive system of behavioral healthcare that provides ongoing prompt access that works to prevent many crises from occurring initially and provides effective care preventing relapse after an effective crisis response.

*Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care* called for prioritizing and funding “the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services...”;<sup>1</sup> and suggests that the comprehensive continuum would include “outpatient practices that...reduce bed demand by reducing the likelihood that a crisis will develop or by diverting individuals in crisis to appropriate settings outside of hospitals.”<sup>2</sup> There are potentially many pathways to achieve this aim, and the transition to 988 for crisis services has pointed to the importance of its interconnectedness to other types of services. This paper discusses three main promising practices: the Certified Community Behavioral Health Clinic (CCBHC) Model; an example of one system’s comprehensive approach to crisis prevention and response, Sheppard Pratt in Maryland that operates a CCBHC funded by an expansion grant (CCBHC-E) at two sites and many other services in an integrated continuum of care linked to crisis services; and examples of urgent care services attached to retail stores that are developing so that individuals with behavioral health challenges can get the care they need, when they need it as another element in the crisis care continuum.

## **The CCBHC Model**

The CCBHC Model is a comprehensive model for mental health services that requires prompt access to a comprehensive continuum of services treating mental illness and substance use disorders that are integrated with general medical care. In this way, it presents unique opportunities for linkage to 988 call centers who can make referrals for those in need of the CCBHC services in a particular region. The CCBHC model is supported by payments calculated to cover the actual costs of providing care from organizations that are held accountable by extensive certification and data reporting requirements. It has generated much discussion and excitement. One aspect of its recent growth is within its ability to offer services more broadly than a traditional fee-for-service model. The CCBHC model provides a funding mechanism that supports the implementation of both the core traditional crisis services of crisis phone lines, mobile crisis response, and crisis stabilization services, and the range of other services that avoid initial crises and prevent relapse to additional crises.

Section 223 of the Protecting Access to Medicare Act of 2014 authorized state demonstration programs to improve community mental health services through the establishment of

organizations to be known as CCBHCs.<sup>3</sup> The Act requires to meet CCBHC criteria promulgated by the Substance Abuse and Mental Health Administration (SAMHSA) and provides Medicaid reimbursement for mental health services to CCBHCs through provider-specific, cost-based reimbursement, referred to as a prospective payment system (PPS), based on guidance promulgated by the Centers for Medicare and Medicaid (CMS).<sup>4</sup> Together, the SAMHSA CCBHC Certification Criteria<sup>5</sup> and the CMS PPS Guidance,<sup>6</sup> define the CCBHC model. **Figure 1** aims to provide further clarity of terminology applying to CCBHC availabilities. It should be noted that SAMHSA has established a time-limited grant program to assist organizations in developing the services and interventions outlined in the SAMHSA Certification Criteria. But these “CCBHC Expansion Grants” do not incorporate the provider-specific, cost-based reimbursement component of the CCBHC Model. Therefore, the following discussion refers to the state demonstration program authorized under Section 223 of the Protecting Access to Medicare Act of 2014.

**Figure 1: Terminology Related to CCBHCs**

**CCBHC Model:** a combination of the CCBHC certification standards developed by SAMHSA plus a payment methodology based on the total cost of all care that falls under the certification criteria. Each individual CCBHC’s rate is specifically calculated for the costs at that individual CCBHC. The CCBHC model has been implemented both by the federal demonstration project in 10 states and also by individual states utilizing other pre-existing Medicaid program authorities including but not limited to the Medicaid rehab option.

**CCBHC Demonstration Program:** the SAMHSA certification criteria in combination with the CMS PPS cost report-based payment methodology implemented in the original eight states and then expanded to also include Michigan and Kentucky. Each individual state must certify that each CCBHC meets the certification criteria. The number of CCBHCs they can operate under the demonstration model in each state is limited to the number of CCBHC’s initially proposed by the state and included at the start of the demonstration.

**CCBHC Expansion Grant program:** a combination of the CCBHC certification standards developed by SAMHSA plus a SAMHSA funding grant to pay for CCBHC requirements that are not covered under the pre-existing payment methodologies that were available in that state. Original grants were up to \$2 million for two years. The newest round of grants will be 1\$ million a year for up to four years. The amount of the grant does not necessarily cover the total agency cost of care for meeting CCBHC standards. Expansion grant CCBHC’s must attest to SAMHSA that they meet the certification requirements but are not required to obtain state endorsement of their CCBHC status.

**Variations and Combinations:** Several CCBHC demonstration states have subsequently implemented state plan amendments allowing them to add additional CCBHC model organizations receiving a cost-based PPS payment outside of the federal demonstration project.

Several CCBHCs operating as part of the federal demonstration have also received SAMHSA expansion grants in addition to their demonstration site PPS payments.

There has been a great deal of activity regarding the CCBHC demonstration grants and state Medicaid programs’ efforts to move into offering CCBHC programs. In December 2016, eight states were chosen by the Department of Health and Human Services (HHS) to participate in

the CCBHC demonstration out of 24 states that had received SAMHSA planning grants: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania.<sup>7</sup> These demonstration states designated a total of 66 CCBHCs, which began providing services the same year. While the CCBHC demonstration was initially established for a two-year period, it has been extended by law numerous times, most recently through September 30, 2023.<sup>8</sup> Two states, Kentucky and Michigan, were added to the demonstration in 2020. Minnesota, Missouri, Nevada, and Oklahoma have each also amended their Medicaid State Plans to allow them to expand the CCBHC Model to organizations not included in the Demonstration.

Texas implemented the CCBHC model statewide via a Medicaid waiver and Kansas has a statewide CCBHC implementation underway using a Medicaid State Plan Amendment approved by CMS. On June 24, 2022, Congress passed the Bipartisan Safe Communities Act, which expanded the CCBHC program to allow any state or territory the opportunity to apply to participate in the demonstration and allocating additional planning grant monies for states to develop proposals to participate.<sup>9</sup> Starting in July 2024, and every two years thereafter, 10 additional states will be selected to join the demonstration. The eight original demonstration sites will be extended until September 2025, and the two newer demo states (Kentucky and Michigan) are extended to six years after their program launch.

The Protecting Access to Medicare Act of 2014 also authorized SAMHSA to provide grants directly to community behavioral health provider organizations in order to assist them in adopting CCBHC services and practices in accordance with the SAMHSA Criteria.<sup>10</sup> However, organizations receiving these direct grants do not have access to the funding mechanism that is available to organizations participating in the CCBHC Demonstration, and so do not have the tools necessary to implement several of the practices that have been important to crisis prevention and diversion in the Demonstration states.

The legislation authorizing the Demonstration stipulated that in selecting the states to participate, SAMHSA should give preference to states based on their CCBHCs' ability to **improve the availability of, access to, participation in, and quality of, the most complete scope of services, without increasing net federal spending.**<sup>11</sup>

The SAMHSA Criteria defined the scope of CCBHC services to include:<sup>12</sup>

- An array of crisis response services, including 24-hour mobile crisis teams,
- Screening, assessment, and diagnosis,
- Person-centered and family-centered treatment planning,
- Outpatient mental health and substance use services,
- Outpatient primary care screening and monitoring,
- Targeted case management,




- Psychiatric rehabilitation services,
- Peer supports, peer counseling, and family caregiver supports, and
- Intensive, community-based mental health care for members of the armed forces and veterans.

The SAMHSA Criteria also established requirements related to staffing, the availability and accessibility of services, care coordination, quality and other reporting, and organizational authority, governance and accreditation.<sup>13</sup>

The CMS PPS Guidance outlined an organization-specific, cost-based approach to establishing reimbursement rates designed to enable CCBHCs to achieve the goals of the Demonstration and comply with the SAMHSA Criteria. In order to establish organization-specific rates, each organization completes a cost report that documents its current actual costs as well as proposed new costs required to comply with the SAMHSA Criteria.


States have two options under the CCBHC Demonstration: a daily reimbursement rate, referred to as PPS-1 or a monthly reimbursement rate, referred to as PPS-2.<sup>14</sup> PPS-1 and PPS-2 have distinguishing characteristics, as well as unique advantages and disadvantages; but in both cases, reimbursement is triggered by visits.

A visit is a day (PPS-1) or month (PPS-2) in which there is at least one face-to-face encounter, or one eligible telehealth encounter, between a qualified practitioner and an eligible consumer involving the provision of a qualifying CCBHC service. Only services provided face-to-face, or via telehealth, can count as visits and are, therefore, reimbursable. But costs associated with providing important services and adopting important practices that do not involve a face-to-face interaction with a consumer are, nevertheless, included in the organization's PPS reimbursement rate; a factor critical to adopting several practices key to crisis prevention and diversion (Figure 2).



***Figure 2: Flexible Activities and Coverage through the Prospective Payment System***

Many CCBHC-required responsibilities and important practices do not involve face-to-face interactions with a consumer and so do not count as reimbursable visits. For example, many of the required care coordination activities, such as tracking admissions and discharges, efforts to follow-up after discharge, care coordination with an individual's primary care physician, as well as other service and support providers, often do not involve face-to-face interactions with a consumer. Similarly, outreach activities to engage individuals in need of community behavioral health services who, nevertheless, do not seek services or seek them from inappropriate sources/settings, often include considerable effort before an individual is engaged in ongoing face-to-face services. Such outreach efforts may target high users of emergency rooms and hospital care, or individuals who frequently come in contact with local law enforcement and the courts. The costs associated with each of these important components can be built into the PPS rate.



Each CCBHC's reimbursement rate is determined by dividing the total allowable costs for providing CCBHC services, and for complying with the SAMHSA criteria, by the total number of visits the CCBHC expects to provide in a year, yielding a reimbursement rate per visit.<sup>15</sup>

## **Improving Participation: Access and Engagement**

The fundamental goal is for people to be able to access and use care when they need it. Making care easier to access makes it easier to use, and outreach and engagement promotes use.

The SAMHSA Criteria promote improving access by requiring CCBHCs to:

- Provide outpatient clinical services during times that ensure accessibility to meet the needs of the consumer population to be served, including some nights and weekend hours,<sup>16</sup>
- Provide services at locations that ensure accessibility to meet the needs of the consumer population to be served,<sup>17</sup> and
- Provide transportation or transportation vouchers for consumers to the extent possible within the state Medicaid program.<sup>18</sup>

These requirements help remove potential barriers to access: limited hours of operation, hard to get to locations, and lack of transportation to services. But the SAMHSA Criteria require CCBHCs to be much more proactive in improving participation, and the CMS PPS Guidelines establish a reimbursement approach that supports practices that enable CCBHCs to meet this challenge.

## **Components of the CCBHC Model**

### *24-Hour Mobile Crisis Response Teams*

As noted in an earlier paper, *Crisis Services: Meeting Needs, Saving Lives*, the SAMHSA CCBHC Certification Criteria require that CCBHCs provide 24/7/365 crisis services in the form of mobile crisis teams in order to engage individuals in crisis.<sup>19</sup> The PPS reimbursement model allows 24-hour mobile crisis to be treated as a capacity that a CCBHC must maintain rather than as an individual service. The costs associated with maintaining the team, including a 24-hour access line, can be built into the organization's PPS rate such that a portion of the cost of maintaining the team is recouped every time the CCBHC receives reimbursement for a billable outpatient visit. If mobile crisis is reimbursed as an individual service, then reimbursement is dependent on the eligibility of the individual in crisis for a given funding source. Treating mobile crisis as a capacity that the organization must maintain has the advantage that an individual's eligibility for services from a particular funding source is never an issue during a crisis, or an obstacle to receiving services.

### *Timely Access to Outpatient Services*

A warm handoff and timely access to ongoing services is critical following the stabilization of a crisis.<sup>20</sup> The SAMHSA Criteria require that when an individual is seeking or being referred for

services with “an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up”; and when an individual is seeking or being referred for services, with “an urgent need, clinical services are provided and the initial evaluation completed within one business day.”<sup>21</sup> Urgent psychiatric services can provide timely access to ambulatory psychiatric assessment and short-term treatment for patients experiencing a mental health crisis or risk of rapid deterioration requiring hospitalization. Studies of urgent care reported improvements in symptom severity, distress, psychosocial functioning, mental health–related quality of life, subjective well-being, and satisfaction with care, as well as decreased wait times for post-emergency department (ED) ambulatory care, and averted ED visits and admissions.<sup>22</sup>

The SAMHSA Criteria also includes that individuals with routine needs be provided services within 10 business days.<sup>23</sup> In order to comply with these timely access requirements, CCBHCs in the Demonstration found it necessary to hire additional staff.

There is, of course, a national shortage of behavioral health care workers: the current behavioral health care workforce is only able to meet approximately 25% of the need for services, with gaps higher in rural areas.<sup>24</sup> As a result, community behavioral health providers often find themselves competing unsuccessfully with other systems of care in attracting and retaining staff due to low and/or fixed reimbursement rates that deflate their salary structures. However, states have the ability to approve any salary increases that are included as anticipated costs in the cost report. If CCBHCs can document that their salary structures are not competitive, PPS cost-based, provider-specific reimbursement allows CCBHCs to revise their salary structures to attract and retain the additional staff needed to meet the timely access requirements, as well as to provide the required comprehensive array of CCBHC services. For example, as a result of the CCBHC demonstration, CCBHCs in Nevada have been able to recruit and retain all types of behavioral health professionals by offering more competitive wages (The National Council report on *Transforming State Behavioral Health Systems* highlights this issue).<sup>25</sup> Areas that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as providers to treat certain types of substance use disorders, including providers qualified to use medications for opioid use disorders (MOUD).<sup>26</sup>

### *Open Access*

When an individual calls 988 in need of services, the goal is to not have them have to wait to access them. Moreover, a wait list for routine care when patients wait weeks to months for an initial visit is in many ways a series of crises waiting to happen.<sup>27</sup> Patients and caregivers often describe a struggle to find more immediate care during or after a crisis, particularly when seeking help for the first time.<sup>28,29</sup> For individuals with SUDs, immediate access to SUD treatment is of critical importance, as typically a short window of opportunity exists when a person in need is ready and willing to engage in care.<sup>30</sup> For people who are experiencing a mental health crisis or who have just been discharged from psychiatric hospitalization, quick

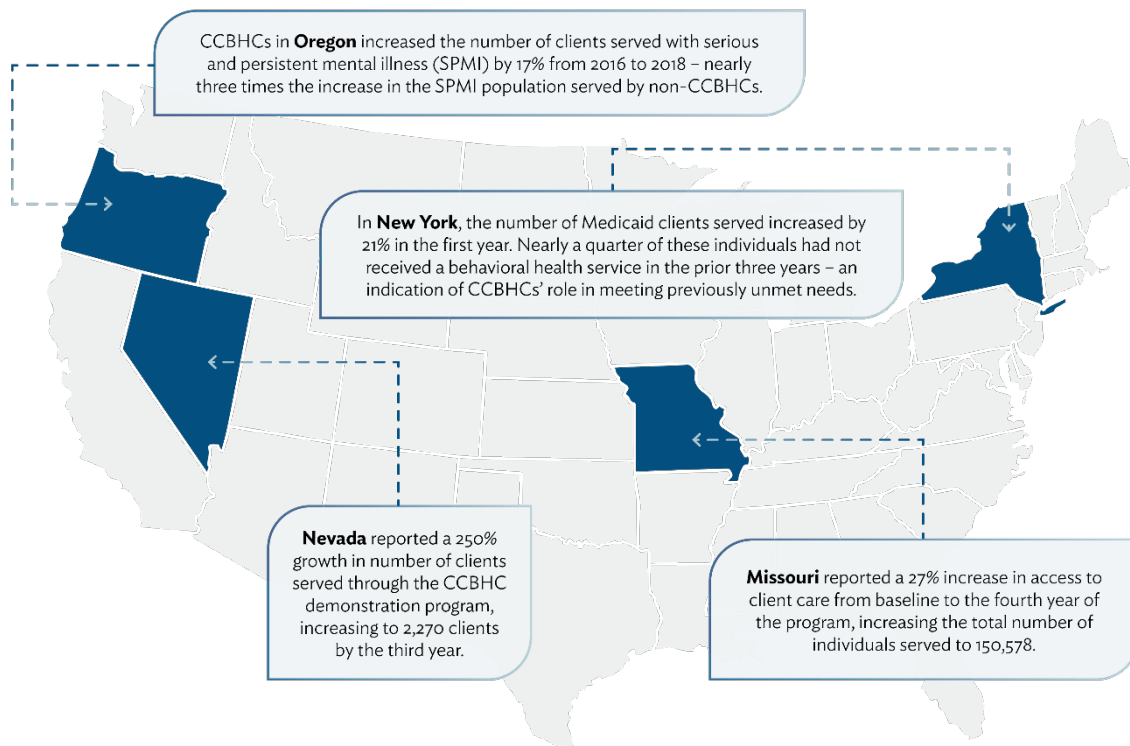
access to an assessment for outpatient care, including psychopharmacology, may make the difference in preventing escalating crises.<sup>31</sup> Despite the need, individuals and provider organizations report waits of multiple weeks for an initial intake appointment and even longer for a psychopharmacological evaluation. Studies conclude that the longer the duration between a crisis and access to services, the less likely it is that a patient will keep an appointment.<sup>32</sup> Although there are multiple reasons for no-shows, patients often report that they sought acute services at an emergency room (either because the delay in care exacerbated the crisis and made a higher level of care necessary or because it was the option of last resort), found services elsewhere, or no longer felt they were in crisis.<sup>33</sup> In the case of patients with SUDs, they may resume or continue their substance use to avoid withdrawal symptoms. Perceived societal stigma may also be a barrier for some families and patients who may delay seeking care until the situation is dire, further lengthening the time between crisis and initiation of services. The absence of a timely and simple pathway to care keeps individuals from receiving the behavioral health services they need.

One strategy to enhance more immediate access to care is in technological solutions to help create pathways that can be easier to navigate. Open access is a scheduling system in which individuals receive an outpatient appointment on the same day they contact the organization. The SAMHSA CCBHC Certification Criteria do not require CCBHCs to adopt open access. Nevertheless, approximately half of CCBHCs in the Demonstration states adopted open access under the Demonstration. State officials have described CCBHCs' adoption of open access models as "earth-shattering" in the mental health field.<sup>34</sup>

The cost-based, provider-specific PPS reimbursement mechanism enabled CCBHCs to hire additional staff CCBHCs to accommodate open access as well as demand for clinic and medication management appointments. As a result, New York's CCBHCs eliminated wait lists; and the number of Medicaid-eligible individuals served increased by 21% in the first year of operation (Figure 3).<sup>35</sup> New York also reported a 24% increase in providing children and adolescent services, noting that this was possible, in part, because the PPS allowed CCBHCs to hire more child psychiatrists.<sup>36</sup> Many CCBHCs in New York and other states have implemented open access scheduling in combination with expanding psychiatric workforce as a two-pronged strategy to increasing access.

New Jersey reported that all CCBHCs offer at least some open access hours, and that open access helped facilitate a 14% increase in the number of individuals served between the first and third demonstration years.<sup>37</sup> Missouri reported a 27% increase in access to client care from baseline to the fourth year of the program, primarily because of adopting open access.<sup>38</sup> Oregon and Nevada also experienced significant growth in the number of individuals receiving services through the organizations certified as CCBHCs under the CCBHC Demonstration Project.

**Figure 3: CCBHC Demonstration Project Outcomes**



Leaders within states note that even when offered same day appointments, some individuals, and families in particular, were unable to come in immediately. Nevertheless, Missouri reported that in the third year of the demonstration, 81% of all new clients and 83% of all new Medicaid clients had an initial evaluation within 10 business days, and New York improved on its already strong performance on this measure, decreasing time to initial evaluation from 7.3 days on average in the first demonstration year, to 4.9 in the third year of the demonstration. These are both noteworthy findings given research that indicates the average wait time for mental health and substance use services across the United States is 48 days.<sup>39</sup>

CCBHCs have taken advantage of the flexibility offered by the SAMHSA CCBHC Criteria by developing innovative approaches to improving access. See, for example, **Figure 4**, describing Oklahoma's Grand Lake Mental Health Center's innovative use of technology to improve both access during a crisis and to provide ongoing services to prevent crises.

### *Outreach and Engagement*

Many people with behavioral health needs do not seek treatment from behavioral health providers. Instead, they seek care from primary care physicians who may not be equipped to provide the appropriate treatment, or repeatedly burden hospital emergency rooms. Others may not recognize their need for care and find themselves repeatedly interacting with law enforcement as a result of their untreated illness.


Engagement in treatment for a person having a behavioral health crisis is critical to fully address the concerns of the individual as well as to prevent future crises. For example, establishing outreach visits from a local community mental health provider to psychiatric patients in an emergency department showed a significant increase in initial appointment attendance at the local mental health clinic in the aftermath of a psychiatric crisis.<sup>40</sup>

The SAMHSA Criteria require CCBHCs to provide outreach engagement services.<sup>41</sup> Typically, payers only reimburse providers for direct services provided to individuals or families. Consequently, behavioral health providers often have no means to fund activities that involve reaching out to individuals who do not seek services, but who rely on other social sectors that are often ill-equipped to respond as a result of their untreated behavioral health issues. Although CCBHCs only receive reimbursement when they provide a direct service to an individual or family (i.e., through a visit), the PPS model allows CCBHCs to build the cost of outreach and engagement activities into the CCBHC PPS rate, so that the reimbursement received for each visit helps to cover the cost of outreach and engagement initiatives.



### ***Figure 4: Access Using Technology***

Grand Lake Mental Health Center, Inc. (GLMHC), a CCBHC serving 12 counties in largely rural Northeast and Northcentral Oklahoma, is a leader when it comes to providing mobile telehealth services for clients in need of mental health, substance use, and crisis services. Many of the individuals and families served by GLMHC are living well below the poverty level, have limited or unreliable transportation, and have often relied on hospital emergency departments and inpatient services when in crisis. In order to improve access to timely outpatient treatment, reduce Emergency Department admissions, and reduce unnecessary inpatient treatment episodes, GLMHC embarked on a bold mission of bringing mobile technology to clients “when and where” they needed it. GLMHC partnered with MyCare Software Solutions to develop an application installed on iPads that gives clients access to a calendar of their appointments, the ability to request a call-back from a member of their treatment team, access to relevant documents and a crisis call button for immediate assistance. It also allows GPS tracking that enables GLMHC to engage law enforcement if necessary. The goal is to increase access to services, not only in crisis situations but in all scenarios, including regular outpatient mental health and substance use services so that individuals never escalate to the point of needing traditional crisis intervention services. Individuals who access one of GLMHC’s three Urgent Recovery Centers receive an iPad, as do individuals with high PHQ-9 scores at their first screening. To date, approximately 6,000 of the 11,000 individuals served by GLMHC have been issued an iPad, giving them access 24/7 to relapse prevention, crisis intervention and general mental health services at the touch of a button.



Under the CCBHC Demonstration, states have implemented a number of outreach and engagement initiatives aimed to divert individuals from other systems of care, such as police community response, and thereby result in savings in other systems of care that offset the CCBHC costs.

Prior to its participation in the CCBHC Demonstration, Missouri, for example, was funding outreach and engagement teams that targeted emergency rooms at some of its CMHCs, using state general revenue exclusively. The teams were designed to divert high users of emergency room services to ongoing care at the CMHCs. Missouri expanded this initiative as part of the Demonstration by requiring all CCBHCs to develop emergency room outreach teams. An evaluation of this initiative by the Missouri Institute for Mental Health of the University of Missouri-St. Louis found a 74% reduction in both emergency room usage and hospitalization at six months by those engaged by the outreach teams.<sup>42</sup> The report also found that for individual who were homeless, unemployed, or had interactions with law enforcement prior to engagement with the outreach team, at six months following engagement there was a 67% reduction in homeless, a 61% reduction in unemployment, and a 69% reduction of law enforcement involvement.<sup>43</sup>

Prior to participating in the Demonstration, Missouri had also established behavioral health homes (Community Mental Health Centers that provide care management, care coordination, preventive care, individual support and access to community resources) and had built into its behavioral health homes adequate staff to outreach to individuals with behavioral health diagnoses who were high users of Medicaid services, but who were not engaged with community mental health services.<sup>44</sup> Under the CCBHC Demonstration, Missouri embedded these activities within the CCBHC program, essentially establishing health homes as a foundation on which CCBHCs were required to build. In 2021 Missouri reported that, “From 2012 through 2018, more than \$377 million in savings have been attributed to the Missouri Community Mental Health Center (CMHC) Healthcare Homes as a result of diverting individuals from unnecessary trips to the hospital or emergency departments. While cost data is not yet available for the full range of coordination, monitoring and follow-up activities conducted by Missouri’s CCBHCs, at a minimum, it would be expected to exceed the cost savings achieved by the health homes program.”<sup>45</sup> Other states opting to build on these types of outreach and engagement initiatives through the CCBHC model could reasonably expect to see similar savings.

#### *Follow-up After Hospitalization*

Monitoring follow-up after psychiatric hospitalization within seven and 30 days of discharge are routinely used healthcare effectiveness measures. These are defined as the percentage of discharged patients who had an outpatient visit, an intensive outpatient service, or partial hospitalization with a mental health provider within seven or within 30 days of discharge.<sup>46</sup> One study analyzing the impact of follow-up on the day of the discharge proved that having a contact in the community on the day of discharge (24 h follow-up) is effective in reducing readmission rates, and so is receiving outpatient treatment at a CMHC within the first seven

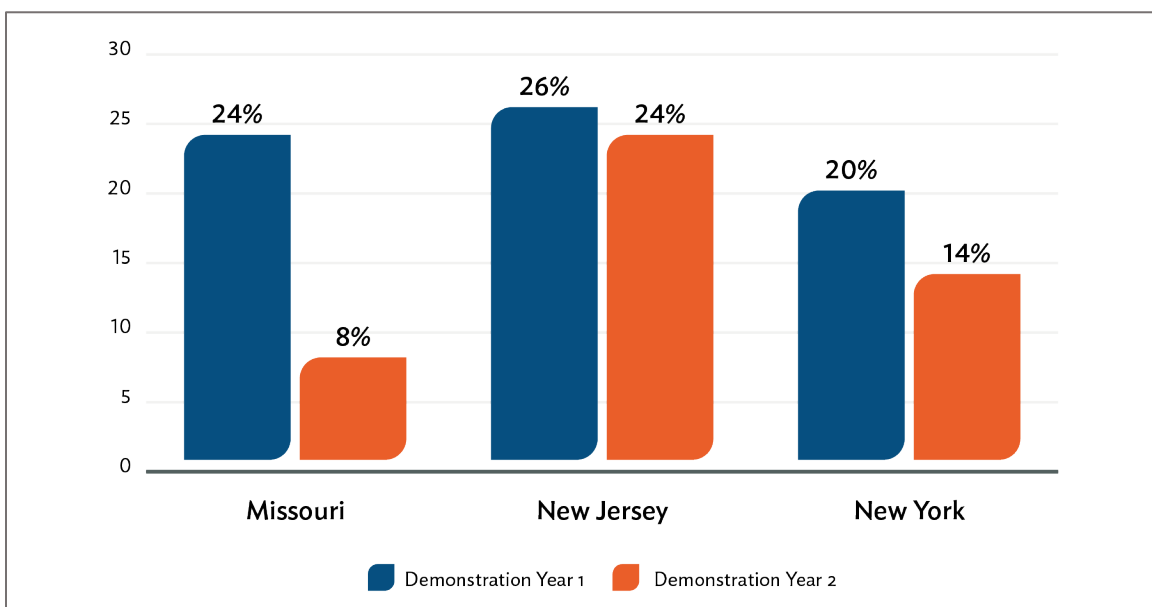
days of discharge. Five studies reported that follow-up within 30 days from discharge significantly lowered readmission rates.<sup>47</sup>

The SAMHSA Criteria call care coordination the “linchpin” of the CCBHC model,<sup>48</sup> and detail a number of care coordination expectations, including the expectation that CCBHCs “will make and document reasonable attempts to contact all CCBHC consumers who are discharged [from hospitals, emergency rooms and other crisis settings] within 24 hours of discharge.”<sup>49</sup> Actually contacting all individuals within 24 hours of discharge is an exceedingly lofty goal. CMS requires CCBHCs to document and report follow-up after an emergency room and hospitalization within 7 days and within 30 days.<sup>50</sup>

Both New York and Missouri report that CCBHCs in their states outperformed other providers on follow up metrics. The seven-day follow-up after hospitalization rate was 65% for New York’s CCBHCs compared to the state Medicaid average for this metric of 58%. Similarly, CCBHCs in New York had an average follow-up rate of 42% for individuals visiting the emergency department for alcohol or other drug dependence in the second performance year, which was double the overall state Medicaid average of 21%.<sup>51</sup> In the second year of the Demonstration, Missouri CCBHCs had a 43% follow rate within seven (7) days for adults discharged from emergency rooms compared with a 20% rate for all other Missouri Medicaid providers, and a 76% follow up rate within 30 days for adults after discharge from a hospital compared to a 33% rate for all other Missouri Medicaid providers.<sup>52</sup>

Effective follow-up likely contributed to the reduction in all-cause psychiatric hospital readmission rates that CCBHC consumers experienced in Missouri, New Jersey, and New York (Figure 5).

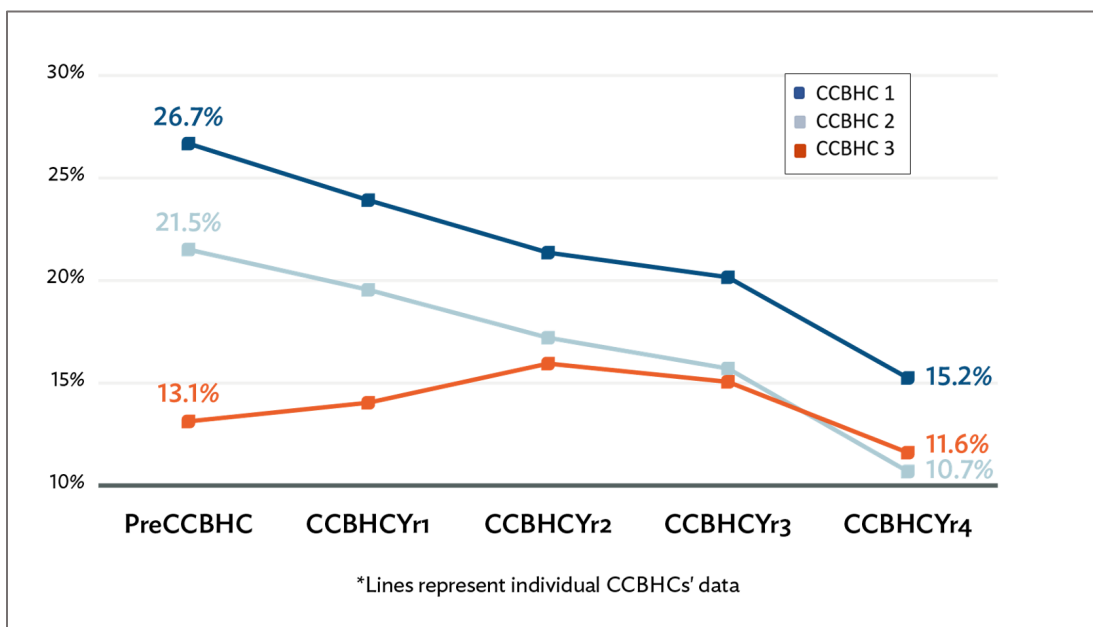
**Figure 5: All-cause Psychiatric Hospital Readmission Rates for Missouri, New Jersey and New York CCBHCs**



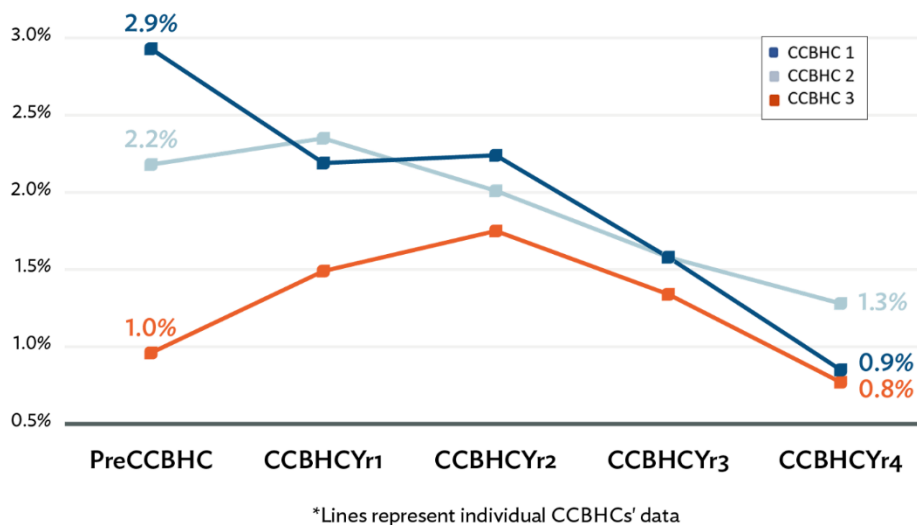


The three organizations participating in the Oklahoma CCBHC Demonstration Project each had an impact on both emergency room usage (Figure 6) and hospitalizations (Figure 7) as a result of follow-up, care coordination, and easy access.

**Figure 6: Oklahoma: Data from three individual CCBHCs and the Percentage of Clients Treated at Emergency Departments by year**



**Figure 7: Oklahoma: Data from Three Individual CCBHCs and the Percentage of Clients Admitted to Inpatient Care by year**

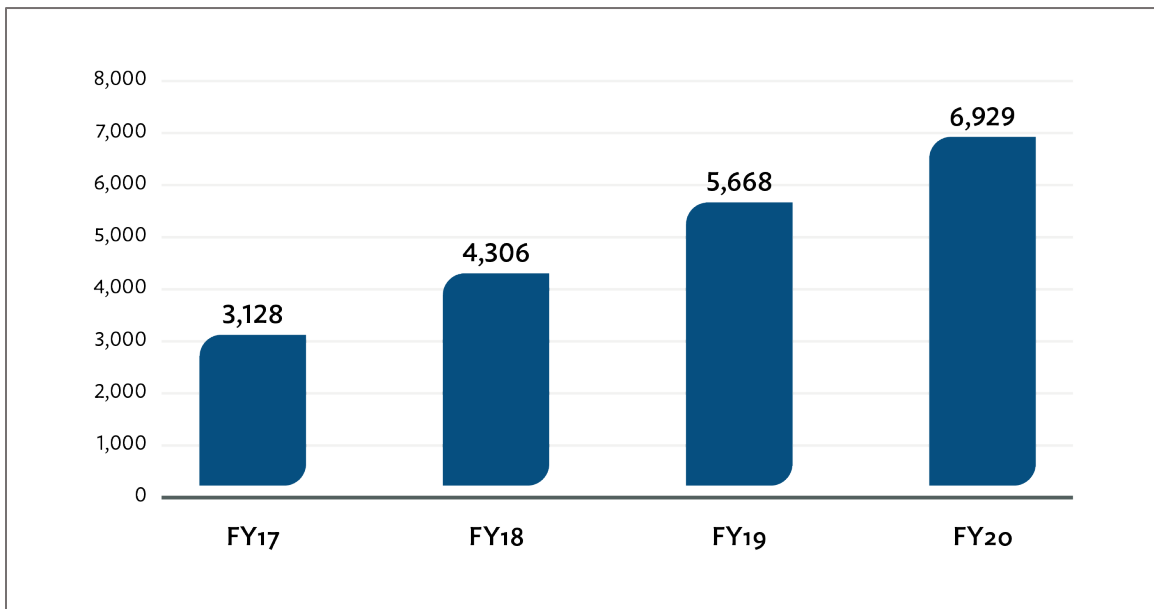


### *Evidence-based Practices: Medication Assisted Treatment*

Under the SAMHSA Criteria, states are expected to require that CCBHCs adopt a minimum set of evidence-based practices.<sup>53</sup> States have thus required the adoption of a broad range of evidence-based practices under the CCBHC Demonstration in order to best meet the needs of the people they serve. Since the SAMHSA Criteria require that CCBHCs employ medically trained behavioral health care providers who can “prescribe and manage medications independently under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders,”<sup>54</sup> states participating in the Demonstration have adopted Medication Assisted Treatment (MAT) as one of their required evidence-based practices.

MAT is associated with reduced general health care expenditures and utilization, such as inpatient hospital admissions and outpatient emergency department visits.<sup>55</sup> Nationally, many people who could benefit from MAT do not receive it, with less than 20% of individuals with an opioid use disorder receiving MAT in the past year, and less than one-third of substance use facilities offering medications to treat opioid use disorder.<sup>56</sup> By contrast, CCBHC Demonstration states saw significant growth in the number of individuals receiving MAT. Missouri reported a 122% increase in MAT from baseline to the fourth demonstration year (Figure 8).

**Figure 8: Individual's Receiving Medication Assisted Treatment from Missouri CCBHCs**



Oklahoma had 128 individuals receiving MAT prior to the Demonstration. By year four of the Demonstration, 988 individuals were receiving MAT. In New Jersey, CCBHCs nearly doubled the number of clients receiving MAT for opioid use disorder from the first to the second demonstration year.<sup>57</sup>

### *Screening and Monitoring Chronic Conditions*

Individuals with behavioral health diagnoses have significant levels of co-occurring chronic diseases and health conditions that increase their risk for hospitalization due to non-behavioral health conditions. Systematic monitoring and care management of metabolic syndrome and other chronic conditions by community mental health centers has been shown to be effective in improving quality of health indicators such as control of hypertension hemoglobin A1c and was associated with reductions in hospital and emergency room utilization.<sup>58</sup>

The SAMHSA Criteria recognize the need to see the whole person, adopt an integrated approach to health and wellness, and address the historic tendency of behavioral health systems to overlook non-behavioral health conditions by requiring that CCBHCs screen and monitor key health indicators and health risks.<sup>59</sup> How states participating in the CCBHC Demonstration have responded to this mandate depends on whether they had already adopted an integrated approach, as some states had under the Medicaid health home program, and whether they chose to expand on the SAMHSA requirements by requiring CCBHCs to directly provide primary care services.

For example, Oregon required its CCBHCs to provide 20 hours of on-site primary care per week, and Nevada carved in certain primary care services (e.g., taking client histories and establishing medical diagnoses).<sup>60</sup> CCBHCs in New York took a variety of approaches to strengthening the integration of care with some opting for a co-location model.<sup>61</sup> The flexibility of the SAMHSA CCBHC Certification Criteria and the CMS CCBHC PPS payment methodology in general, allows, and indeed, invites this type of adaptation, which is designed to strengthen integrated care. In order to continue the pre-existing Medicaid Health Home program and integrate it into the CCBHC model, Missouri, which had already adopted the Medicaid health home program, incorporated in their state CCBHC certification requirements their pre-existing Health Home requirement that qualifying organizations be recognized by the Department of Mental Health as CMHC Healthcare Homes and be accredited as health homes by CARF or the Joint Commission.

Regardless of the specific approach, the CCBHC model takes seriously the need to serve the whole person, to recognize and address the fact that the individuals they serve may have high blood pressure, high cholesterol, diabetes, metabolic syndrome, cardiovascular disease, and asthma, and that many of the people they serve smoke cigarettes or have significant weight issues. The CCBHC model can be a powerful tool for reducing the premature mortality related to serious mental illness.<sup>62</sup>

### *Peer and Family Supports*

A large body of evidence has shown that services provided by peer workers are effective and associated with a range of positive outcomes, including reduced substance use, improved social supports, reduced hospitalizations and emergency department visits and decreased criminal justice involvement.<sup>63</sup> The SAMHSA Criteria require that CCBHCs employ specialists and family

support providers,<sup>64</sup> and Minnesota, Missouri, New Jersey, Nevada and Oregon were all able to significantly expand the number of peer workers, and in some cases, family support specialists employed at their CCBHCs.

Prior to participating the CCBHC Demonstration, peer specialists in Minnesota were only allowed to work with individuals with mental health conditions within a psychiatric rehabilitation setting. Under the Demonstration, certified peer specialists employed by CCBHCs serve the full range of people coming for care regardless of mental illness severity. Minnesota also launched family peer services and reported success regarding the use of peers to engage individuals released from jail or prison in ongoing services.<sup>65</sup>

Prior to the CCBHC demonstration, less than half of Missouri's current CCBHCs had peer support specialists and less than a third had family support specialists. As a result of giving priority to the CCBHC requirement to provide peer and family supports, as of May 2021, all CCBHCs in Missouri employed peer specialists and family support providers, with the number of peer specialists increasing more than 330% and the number of family support specialist increasing more than 90%.<sup>66</sup>

### *Recovery Supports and In-Home Services*

Services that have a recovery orientation are welcoming, empowering, and promote self-determination and hope, which are particularly necessary in crisis systems. The SAMHSA Criteria require that CCBHCs provide recovery-oriented services<sup>67</sup> and that to the extent possible within a state's Medicaid program, CCBHCs provide in-home services.<sup>68</sup> The CCBHC national evaluation reported that 78% of the 92% of CCBHCs that provided services outside the clinic provided in-home services.<sup>69</sup>

The states participating in the CCBHC Demonstration Project have shown that implementation of the CCBHC model with fidelity to the SAMHSA Criteria and the provider-specific, cost-based reimbursement rates of Prospective Payment can significantly improve the availability, accessibility and quality of comprehensive community behavioral health care, while generating offsetting emergency room and hospital costs, and helping to prevent, appropriately intervene in, and stabilize crises.

### **Urgent Care Centers Linked to Other Community Based Enterprises**

Although CCBHCs offer tremendous opportunities to maximize immediate access to care regardless of payor, they may not be available in a particular region, and individuals may want alternative options for where care can be received. Access when needed to the right care is a critical element of a robust continuum of psychiatric care.<sup>70</sup> Yet waiting times for clinical access to therapists and especially psychiatrists can take months. Wait times for care can be major detractors for people who feel their mental health issues cannot be put off, and they can lead to problematic outcomes. Although limited resources are often cited as a reason for delays in openings, one study found that waiting times across a variety of clinical services were reduced

by applying analyses of where bottlenecks occur that could be resolved with careful clinical management and involvement in frontline personnel.<sup>71</sup> In addition to addressing infrastructure and operations, and creating new payment models through CCBHCs, another area of growth for population health includes the marketplace of urgent care centers, emerging in the landscape of services for people with mental health needs. With the increase in emotional challenges related to COVID-19, many retailers are moving into the market space of providing mental health services. New sites for urgent care, such as CVS Minute Clinics, Walgreens, Albertsons, and Rite Aid are among those where retailers are beginning to offer mental health assessments, referrals and counseling, covered by insurance or available for cash payments for initial assessments and 30-minute therapy and counseling sessions in person or virtually.<sup>72</sup> What this will mean overtime is unknown, but these services aim to help address the needs of broad populations, beyond those with serious mental illness. There have been examinations of promising practices across retail sites such as for substance use disorder care. One study described that medication disposal kiosks in a retail pharmacy chain, combined with naloxone dispensing and patient education as one means of prevention to address the opioid crisis.<sup>73</sup> Although some caution is required in this scaling out of potential evidence-based interventions, there may need to be adaptations to models that can lean on evidence while continuing to collect data to determine program effectiveness in new settings.<sup>74</sup>

One other model of urgent care access involves bridge clinics or transition clinics, for immediate after care following an intervention such as one at a crisis stabilization unit or emergency department or even recently discharged from an inpatient setting. Many systems have crafted “open clinic slots” for after a person is seen in crisis and needs more immediate access to prescribers or other types of therapists. This then allows for a handoff to a provider who may otherwise have a waitlist for continuing care. The University of California at San Francisco, for example, established a Bridge Clinic to allow for brief crisis intervention interim care, pharmacotherapy consultation and treatment, teaching with child and adolescent psychiatrists on a consultation/liason service and collaboration between treatment entities to help smooth out a patient’s transitions in care.<sup>75</sup>

Each of these approaches are innovative models that are designed to expand the scale of access, and many are increasingly relying upon telehealth to do so. Research on how they connect individuals to longer term care when needed, meet the needs of diverse populations, and improve mental health outcomes as well as their cost effectiveness is needed. Still with increasing demand for care, they are likely to continue to grow.

### **Sheppard Pratt in Maryland: One Model Linking Crisis Care to Comprehensive Care**

In addition to innovative models like CCBHCs and urgent care access, Maryland’s Sheppard Pratt system has evolved as an example of how many services--from crisis care to continuing care-- can be woven together to provide a seamless care delivery system across multiple regions within the state.

**Figure 9: Sheppard Pratt in Baltimore in the 19<sup>th</sup> Century**



When Sheppard Pratt’s psychiatric hospital was created in the 19<sup>th</sup> century (Figure 9), crises were broadly defined to include unusual behaviors in addition to dangerous ones. The hospital’s founding benefactor, Moses Sheppard, was innovative for his time and redefined crisis services by changing the method and place of intervention from containment in jails to treatment in “asylums.”<sup>76,\*</sup> As Sheppard Pratt embraced evidence-based practices in the 2000s such as Illness Management and Recovery, its community-based crisis interventions shifted from focusing solely on

preventing crises to also teaching people how to manage crises. Today, with 988 available to link individuals from crisis to care, the Sheppard Pratt system serves as an example for policy makers looking at models that can include a comprehensive array of hospital and community services, as well as those integrated in general hospitals to facilitate more rapid and effective discharge to outpatient programs.

**Figure 10: Sheppard Pratt’s Baltimore Hospital Campus Today**

Sheppard Pratt serves 70,000 individuals of all ages each year at 380 sites across 16 Maryland counties (Figure 10). Programs include:

- 2 mobile crisis teams
- 5 residential crisis programs
- 2 psychiatric urgent care programs
- 1 CCBHC funded by an expansion grant (CCBHC-E) at two sites
- 13 outpatient mental health clinics
- 2 hospitals
- 4 partial hospitalization programs
- 12 special education schools
- 11 psychosocial rehabilitation, supported housing, and supported employment programs
- 5 assertive community treatment teams
- 17 Medicaid health home programs
- 1 outpatient opioid treatment program
- Many other programs that provide treatment and rehabilitation and address social determinants of health.



\* The name of the “Sheppard Asylum” was later changed to “Sheppard and Enoch Pratt Hospital” when 19<sup>th</sup> century philanthropist Enoch Pratt made a significant contribution.

This paper focuses on three specific crisis-related Sheppard Pratt programs: mobile crisis, psychiatric urgent care, and residential crisis. Each employs innovative components, and the integration among them within the Sheppard Pratt system of care provides additional distinction that can be useful for other states looking to expand the array of services available in their locales. Also noteworthy are Sheppard Pratt's partnerships with state and local governments that help create system change to develop and enhance crisis services.

### *Mobile Crisis*

Sheppard Pratt's mobile crisis services (MCS) start at initial points of contact with individuals in crisis, bringing the institution back to its roots by diverting people from jails and hospitals when a hospital is not needed. Recognizing differences in local and individual needs, Sheppard Pratt provides MCS 24-hours per day, seven days per week in Frederick County, Maryland with teams of two mobile crisis counselors who respond with and without police accompaniment. In a smaller county, Sheppard Pratt provides mobile crisis services 84-hours per week with one counselor who is accompanied by law enforcement for all initial calls.

In addition to providing MCS 24/7, the Frederick program also operate an innovative pilot for 80 hours/week called the "Crisis Car," which teams a Sheppard Pratt mobile crisis counselor with a non-uniformed City police officer and a county paramedic or EMT. This multi-disciplinary first-responder team travels together in an unmarked van responding to crises, as well as providing follow-up, post-crisis support. Of course, pairing mobile crisis counselors with law enforcement has been happening throughout the country for decades. More recently, some programs have paired mobile crisis counselors with paramedics/EMTs, seeking to reduce the potential of escalation that can arise from fears of law enforcement.<sup>77,78</sup> The disadvantage of this model is that by excluding law enforcement, the teams are unable to respond to a significant number of situations that are dangerous or require involuntary hospital evaluations. The Frederick pilot retains the advantages of including law enforcement while mitigating the disadvantages by having the vehicle unmarked and staffed with non-uniformed police officers who receive additional training.

As another innovation, one law enforcement agency shares 911 call data with Sheppard Pratt to identify frequent callers so that mobile crisis counselors can develop proactive plans with these individuals. Initially, the police department had legal concerns about sharing that information, but then agreed that the data is not protected health information and could be shared with a mobile crisis provider.

Sheppard Pratt invested significant time over many years nurturing trust with law enforcement agencies in both jurisdictions. Trust is crucial for inter-agency crisis response because there is less time to plan services and process conflict. The value of personal relationships is as important to the success of agency collaboration as it is to the effectiveness of individual clinical care. Trust has been especially critical in the infrequent times that the services resulted in negative outcomes. The agencies have been able to debrief critical incidents without defensiveness or blame. Similar to Sheppard Pratt's clinical approach of teaching individuals

how to manage crises as opposed to focusing solely on preventing crises, Sheppard Pratt measures effectiveness of agency collaboration, in part, by how well the partners work together to manage and learn from negative outcomes.

### *Rapid Access to Outpatient Clinic Services*

Sheppard Pratt operates 13 outpatient mental health clinics throughout Maryland, five of which are dually licensed to provide outpatient substance use disorder treatment. Several innovations poise these clinics to respond more effectively to crises.

- *Same Day Access to Therapist:* As with many other clinics in the country, Sheppard Pratt's clinics are moving to offering same-day access with a therapist, including virtual appointments. One successful innovation is the use of a QR code to allow the client to gain easy and quick access to a virtual room staffed by a receptionist.
- *Two-day Access to Psychiatric Provider and Short-term Stabilization:* Another innovation is a contract with Howard County General Hospital in which Sheppard Pratt assures that referrals from the hospital can meet with a psychiatrist or nurse practitioner within two business days of referral and receive two follow-up medication visits with the psychiatric provider and seven sessions with a therapist. The hospital pays an amount toward the direct cost of the psychiatric provider for the held timeslots, and Sheppard Pratt bills insurance, if any, to cover a portion of the other direct and indirect costs of the program, including therapist time. Hospital staff are able to access a real-time, web-based scheduling system 24 hours/day so that patients leave the hospital with the outpatient appointment arranged. An unpublished pre/post intervention analysis by Maryland's Health Information Exchange indicated that participants experienced a 38% reduction in hospital care costs, comparing 12 months before and after program initiation. An internal analysis by the hospital indicated a 43% reduction in costs. The hospital has chosen to renew the contract every term since the pilot began.
- *Bi-directional Health Information Exchange (HIE):* Sheppard Pratt is piloting an innovation with Maryland's HIE in Frederick County for individuals served by its clinic and psychiatric rehabilitation program. For a number of years, the HIE has been sending email alerts to outpatient providers when their clients are admitted to any Maryland hospital. With the Sheppard Pratt pilot, the HIE also alerts the hospital that the patient is served by Sheppard Pratt. This bi-directional information is especially helpful when serving individuals who do not acknowledge they have a mental illness or identify their provider. In addition, the innovation recognizes that many programs such as outpatient clinics and ACT teams do not always know in real time when a client accesses an ED. The diversion and rapid discharge protocols that Sheppard Pratt has created in collaboration with general hospitals can be triggered only if both providers know that the hospital patient is also served by Sheppard Pratt.



### *Sheppard Pratt's Psychiatric Urgent Care*

Sheppard Pratt operates psychiatric urgent care (PUC) clinics at its two hospitals campuses. This service helps provide urgent assessments to those in crisis, offering timely evaluations and triage to voluntary patients helping establish appropriate levels of care. While these programs are not unique, they do employ several innovations. First, given the co-location on Sheppard Pratt hospital campuses also offering intensive inpatient level care, most individuals who are determined to need acute psychiatric stabilization are admitted seamlessly bypassing the resource intensive and cumbersome emergency department route. Additionally, those who need high-level care but not necessarily hospitalization, are connected to partial hospitalization resources that are also offered at both campuses. For those needing outpatient level of care, urgent care staff are able to schedule follow-up outpatient appointments, as opposed to handing out a referral list for the patients to call and negotiate during a difficult crisis state. Sheppard Pratt is able to provide these important linkages through its array of facility-based and community outpatient programs that are connected by a system-wide centralized call center and scheduling system. Finally, virtual telepsychiatry visits are available, which is especially beneficial for individuals and families who live significant distances from the hospitals. It is also helpful for people who are ambivalent about receiving care and are reluctant to arrive at a hospital or an emergency room setting.

### *Residential Crisis Services (RCS)*

Sheppard Pratt operates 79 residential crisis services (RCS) beds in four Maryland jurisdictions. These programs range from four to 16 beds in single-family homes, have 24/7 on-site staffing with a staff-to-client ratio of 1:4, and have an average stay of 14 days. Such programs meet the SAMHSA definition of effective "Short-term Crisis Residential Stabilization Services."<sup>79</sup> Sheppard Pratt has enhanced some of its RCS programs with several innovations.

- *24/7 Availability of Psychiatrist/Nurse Practitioner:* Sheppard Pratt chose to add 24/7 Psychiatrist/Nurse Practitioner availability to all of its programs even though the State does not currently reimburse for this.
- *Pilot for Voluntary Drop-off, Detox, and Medication for Addiction Treatment (MAT):* Sheppard Pratt is implementing a pilot with local grant funds that adds voluntary drop-off, peer specialists, ambulatory detox, and initiation of MAT. Sheppard Pratt is exploring with the Maryland Department of Health the possibility of braiding Medicaid funding to cover these enhancements for this pilot and other replicated programs.
- *Targeted Hospital Diversion:* Sheppard Pratt developed a pilot in collaboration with all six general hospitals in Montgomery County, Maryland. This 16-bed RCS program streamlines referrals from those hospitals to expedite patient discharge from their EDs and inpatient units. The program embeds Sheppard Pratt staff in the hospitals to provide consultation to hospital discharge coordinators, join discharge planning meetings, promptly assess referred patients for appropriateness of RCS, and transport patients to the RCS program. The pilot is a strong public-private partnership: the

hospitals provided funds to Sheppard Pratt toward start-up costs; the State approved the pilot to receive fee-for-service reimbursement to sustain the program; and Sheppard Pratt purchased and renovated the facility and assumes the on-going financial risk inherent in a fee-for-service financing model. The State supported the pilot because of the innovation and the significant financial investment from the hospitals and Sheppard Pratt.

A fair criticism of the RCS model is that unlike some other types of crisis stabilization centers, this program does not prevent individuals from accessing EDs as individuals may pass through an ED before entering an RCS. On the other hand, with models that deflect people from EDs, it can be difficult if not impossible to determine exactly how much use is avoided. Another advantage of this model relates to siting programs, which is an important practical factor in developing crisis services. These programs, as with most other types of solely residential mental health programs, are legally protected by the federal Fair Housing Act. This is especially important in the face of an increase in “Not in My Backyard” disability discrimination. Especially relevant to RCS programs is the position of the U.S. Department of Justice, supported by court decisions, that homeless shelters and short-term residential treatment programs are considered to be “dwellings” and therefore are protected under FHA, even though the lengths of stay may need to be brief – indeed, as short as 14 days as is the case with RCS.<sup>†</sup>

The pilot is being replicated in Baltimore in partnership with another general hospital that is making a similarly significant financial contribution toward start-up costs. In addition, Sheppard Pratt is administering a similar RCS program that streamlines referrals from state hospitals and embeds RCS staff in those hospitals.

### *Sheppard Pratt in Context*

Today, with 988 available as a way to access crisis supports, and the CrisisNow model being discussed nationally, Sheppard Pratt, like other systems will continue to innovate to help meet the demands and pivot toward strategies that help people resolve crises and receive the care that they need. The review above is aimed to help system leaders see one healthcare entity’s evolution over time to support individuals in crisis that go beyond walls in hospitals and barriers in communities.

<sup>†</sup> See Statement of Interest of the United States of America, filed by U.S. Department of Justice in *Defiore v. City Rescue Mission of New Castle*, No. 2:2012-cv-01590 (W.D. Pa. 2013).

## **Conclusion**

There are tremendous waves of change to help address the need of psychiatric patients “beyond beds” and through a continuum of care that offers varying levels of clinical and ancillary supports across settings with crisis services often functioning as the front door to care, now accessible through an easy to remember three-digit number of 988. Some of the more immediate developments include focusing on mobile crisis interventions and jail diversion, but also on infrastructure and linkages to help connect people in crisis to care without delay. These goals are critical as all too often individuals fall in the gaps, and barriers to seamless services create major impediments to treatment retention overall. Maryland’s Sheppard Pratt system is just one example of a system that bridges across various crisis services to meet the demands for current times. In addition, CCBHCs are viewed as incredibly promising, giving a financial structure that will allow for flexibility based on the needs of populations served, with funding mechanisms that allow the CCBHCs to be available to serve anyone who appears for care. Urgent care centers in communities including in retail stores, bridge clinics, and other delivery models aim to provide rapid access that is taken to scale across populations. This paper reviewed some of the exciting developments of our time for these types of system interventions. It is hoped that with these developments, some of the knottiest problems of persons living with mental illnesses and substance use disorders can be more immediately resolved.

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# LENDING HANDS

Improving Partnerships and Coordinated Practices  
between Behavioral Health, Police, and other First Responders

September 2022

Paper No. 10 in the *From Crisis to Care* Series

# Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders

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*Tenth in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs Focused on Building from 988 and Beyond for Better Mental Health Outcomes*



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**Abstract:**

For community and out-of-hospital crisis response to be effective for people with mental illnesses, substance use disorders, intellectual and developmental disabilities and other behavioral health related conditions, there is a need for partnerships, comprehensive protocols, and a range of response options to meet the needs of the particular crisis. Law enforcement, emergency medical staff, and behavioral health crisis responders are key stakeholders that could meet these needs. Yet, officer use of force in these situations remains a significant concern, while safety for responders and others are required, necessitating considerations of what responses for particular situations are needed. Additionally, individuals need to have accessible crisis responses, equitably distributed across all neighborhoods despite varying geographical rural/urban settings and socioeconomic living conditions. Medical issues pertaining to treatments during crisis responses such as urgent stabilization and initial treatment engagement, as well as legal issues pertaining to law enforcement response, use of force considerations, emergency holds and transport of individuals with behavioral health needs, the Emergency Medical Treatment and Labor Act (EMTALA), and the Americans with Disabilities Act (ADA) must be contemplated in partnership response development. This paper outlines many of the underlying factors and provides information and suggestions to improve practices to help move systems in the direction of meeting these needs.

**Highlights:**

- Law enforcement and its partners still play a role in crisis response and it is necessary for police-partners to receive the necessary tools and training to improve practices while still developing least restrictive responses to crisis.
- Mobile crisis responses have evolved to include numerous models of interdisciplinary response that will require increased coordination.
- The legal regulation of crisis response, evolving case law, Constitutional requirements, and federal statutory guidance such as that pertaining to the ADA will help dictate proper crisis response practices.
- Factors such as medical clearance protocols, less restrictive transportation options, and no wrong door protocols are needed to divert people in crisis from criminal justice system and help overcome barriers to accessing care following a mobile crisis response.
- Out-of-hospital treatment can provide rapid access to care interventions and reduce the need of costly hospitalizations post-crisis response for some individuals.
- To proactively address workforce shortages, it is critical to nurture the current and future workforce who may be exposed to all types of traumatic situations in responding to crises.

**Recommendations for Policy Makers, Practitioners and Thought Leaders:**

1. Sufficient funding at the federal level for multi-disciplinary crisis responses that can be sustained and grown over time should be prioritized across populations.

2. With the growing need for national standards for behavioral health crisis response, there should be ongoing consideration of the evolution of coordinated 988 and EMS standards in the implementation of 988 and related responses.
3. Out-of-hospital treatment interventions should be explored for specific protocols and resultant quality analyses and their development should involve multi-disciplinary perspectives.
4. Policies for multidisciplinary responses should be built into the crisis delivery system, including those that address staff safety, public safety, and management and treatment of high risk encounters that involve volatile individuals who may have means to harm themselves or others during the encounter, while taking into account Constitutional rights, the ADA, case law and federal statutes that may play a role in shaping practices.
5. Mechanisms for transport of individuals in behavioral health crisis should be considered in a way that reduces reliance upon law enforcement while still upholding principles of safety.
6. Technology should be leveraged for the out-of-hospital community mobile response to maximize access to proper assessment and triage, with the establishment of related protocols regarding needed parameters for technology utilization.
7. Research regarding mobile crisis response, types of responders, and outcomes should be prioritized to help further best practices across communities.
8. Data collection across sites for mobile crisis responses in its various forms should be collected with routine governmental reporting for public awareness and quality improvement across communities and such data should be examined with an equity lens.

The responses needed to manage crisis calls are complex and can be fraught with risk. Yet, these types of events happen daily in communities around the world (see Text Box). Although many people with serious mental illnesses and substance use disorders do not end up in these types of dire situations, some do, and when they do, the alignment and availability of proper responses and resources are critical to alleviate such crises, including the proper legal authority to intervene if needed. Individuals in crisis may have serious conditions and even their own trauma histories, requiring responses to be sensitive and skilled on many levels. Coordinated training for all partners in the response continuum is critical, especially as it relates to actions that can yield safer outcomes for all.

### ***Crisis Calls: What May Arise on Any Given Day***

Crisis calls are made to call centers 24/7/365. For policymakers working at a distance from the actual calls, it can be helpful to consider and walk through strategies to address plausible scenarios that might lead to the need to deploy a crisis response of some type. In the following examples, there may be real concerns about safety to the responders and to the individual who is the “subject” of the call or others. Each scenario is based on actual narratives that have been described in clinical contexts with the author:

*“Hello! Someone please help me. My son Taylor has a hammer and is banging holes in our walls! He pulled everything out of the pantry and cans are everywhere and dishes are broken. He keeps thinking that there are electronic wiretaps in our house and he was hammering our wall to see if he could stop the sounds coming through. He is yelling at my husband who was knocked to the floor. He is telling him to stay away and is convinced we are trying to hurt him! Please help! He has schizophrenia and stopped taking his medications 3 months ago after he left the hospital!”*

*“I’m calling for help! My father has been depressed lately and has been talking about killing himself after he lost his job. He went to the basement and took a gun- he’s been drinking too. He left the house and headed toward the woods. I’m scared!! Please come help!”*

*“Help! My sister is crying hysterically and is saying she does not want to live! She and her friends were up all night partying, but she is not well. I think she is on a lot of drugs right now. She sometimes has flashbacks to a bad boyfriend she just left. And now she has a knife and is cutting herself! I can’t get her to put down the knife!!”*

*“This is local community mental health calling. One of our clients is barricaded in her apartment. We’ve been trying to do well-person visits and have her case manager visit her but over the last week she has refused to let anyone in the apartment. We have reason to believe she is not eating or drinking as she believes her food is poisoned and that we are trying to harm her. She said something about harming her cat. She will not let us into her apartment to check on her. We need her brought to the crisis services unit for an assessment, but we cannot convince her to come with us!”*

Today, there is an incredible movement in developing crisis response techniques, especially surrounding the launch of 988, the three-digit number that became available in July 2022 that simplifies access to the National Suicide Prevention Lifeline and will also serve as a national behavioral health crisis number. Part of the evolving dialogue around 988 response centers is about developing strategies that consider which entity or entities should be available to address the caller’s needs to yield the best outcomes. In this national discourse, issues of

equity, justice and least restrictive responses have been highlighted. Indeed, the scenarios above were written to be neutral with regard to the caller’s demographic information, to serve as a reminder that proper responses should be available regardless of the individual’s background, particularly their race/ethnicity, neighborhood, or socioeconomic status. And yet, if those details were added to the scenarios in the accompanying text box, there may be an immediate shift in the manner in which the crisis response is provided. Therein lies the need for clear policy to achieve just and equitable responses for all.

When developing practices that will yield appropriate and improved outcomes, it is necessary to be aware that in a small percentage of cases, a response that escalates a situation can result in major catastrophic harm, including the death of the person in distress, responders or bystanders. When there is imminent risk of harm, officers on the scene may have to the authority to protect or self-protect, which means using force including lethal force. With that comes scrutiny and criticism, especially given data that individuals with mental illness are disproportionately impacted by officer involved shootings.<sup>1</sup> And as far as disparities within those negative outcomes (see Text Box), one study showed that victims of law enforcement fatal shootings were disproportionately Black, even when unarmed, with about 22% thought to be mental health related and 18% suspected “suicide by cop” incidents.<sup>2</sup>

### ***Intersection of Race, Mental Illness, and Law Enforcement***

Actions of law enforcement have been increasingly scrutinized partially due to recent and relevant tragic deaths at the hands of police, including the murder of George Floyd. As a result the “defund police” movement advocated for sweeping change. As noted studies have shown that with regard to behavioral health crises, Black persons with mental illness are more likely to be victims of police officer shootings.<sup>3</sup> Disproportionate police contact with Black and Hispanic communities and neighborhoods of poverty has long been realized. More recently, studies have begun to examine the impact of non-fatal encounters with police, with one review of the existing research showing that individuals with a prior police interaction have poor mental health outcomes compared to those without such interactions.<sup>4</sup> Thus, the gamut of issues that may involve police need to take into account a range of collateral consequences of such interactions, and their disparate impacts for persons of color and marginalized communities. This all comes at the same time as mass shootings and gun violence are also resurfacing in headlines. A report from Johns Hopkins Bloomberg School of Public Health Center for Gun Violence Solutions reported that firearm related homicide increased by 35% from 2019 to 2020 and that Black males ages 15 to 34 were 20 times more likely to be a victim of gun homicide.<sup>5</sup> Bailey and colleagues<sup>6</sup> raise the bar higher by noting that there is critical work to be done in communities where there is intense policing and that violence and injury prevention should factor in patterns of structural racism and the need for community engagement to improve overall health outcomes. In other words, there are many intersecting issues related to race, mental illness and interactions with law enforcement and concerns about injury to people, responders and others on scenes of crises. These will require ongoing attention as police remain a critical component of the public safety system, all while new multidisciplinary models of response to behavioral health crises are emerging.



In addition to concerns about the outcomes for private parties, responses that do not have proper protections can create untoward injury to professional responders. According to the Centers for Disease Control and Prevention (CDC), between 2011 and 2015, law enforcement officers suffered 606 fatal work injuries, with the leading causes being homicides, roadway vehicle incidents, suicides, pedestrian vehicular incidents and accidental shootings (by self and others).<sup>7</sup> This data shows how responders are also at risk of being harmed during crises, pointing to the need to better understand how they can also be protected while on the scene especially as behavioral health crises may be increasing and involve potentially new types of responders, whose safety is also of tantamount importance.

Thus, with the launch of 988, and the myriad community crisis response programs that are emerging, comes the need for coordination with 911 and public safety responses as a whole. Because the decision to deploy a particular response is typically made at crisis call centers or Public Safety Answering Points (PSAPs), the role of that triage or dispatch is critical. The results of community development in crisis services mean that sometimes the response will include EMS, behavioral health or law enforcement, or all three sectors will join. Communities all over the country are developing collaborative response models, and there may be some areas where additional responses will be folded in, such as peer supports, or even lay responders especially in rural areas. Yet one study examining 911 call centers by Valazquez and Clark-Moorman from Pew Charitable Trusts found that 911 call centers lack resources and training to handle behavioral health crises.<sup>8</sup> This is all while emergency medical service (EMS) data from Colorado shows that responses to behavioral health cases increased by 146% from 2011 to 2015,<sup>9</sup> suggesting that even before the pandemic the need for additional resources and the development of best practices was even more imperative. From that initial call, countless decisions will be made with regard to the nature of the emergency, whether it can be resolved by phone or if there will need to be deployment of on-the-ground responders, and what types of responders to include.

Despite the growth of behavioral health and multidisciplinary response teams, there is a lack of clear data on them to help drive practices that could help improve safety and outcomes. In addition to seeking more administrative data, rigorous research in these areas is sorely needed.

Although crisis response models are unfolding, by providing a review of the history of community response and current practices and unique considerations with regard to law and clinical advances in this paper, it is hoped that policymakers will have greater information from which to develop mobile crisis responses with best practices. This paper outlines some of historical development of crisis responders, and then provides considerations for crisis responses with heightened safety concerns where law enforcement or medical services may be needed to lend along with behavioral health responders. It then reviews aspects of crisis services such as transportation issues, medical clearance and other facets important for consideration of an improved response continuum.



## Historical Lens of Community Responses and the Path to Today’s Landscape

The stigma and fear invoked by images of “men in white coats” and the phrase’s meaning permeated popular culture with negative connotations. Yet over time, calling for help when someone is in mental health crisis shifted from those white coat images to ones of blue uniforms and armed officers.

### ***“Men in White Coats” and Problematic Representations of Access to Care***

According to the online resource the “grammarist,” the phrase “men in white coats” is an idiom that is a reference to an image of psychiatric workers or orderlies dressed in white coats “who descend upon a psychiatric patient to subdue him to take him to a mental health facility,” thought to have become popular in the mid-twentieth century.<sup>10</sup> Two historical references speak to this. For example, one in 1936 noted referenced “[running] to the nearest phone to call for the men in the white coats.”<sup>11</sup> And another from 1938 related to a sports team article in the “Quincy Patriot Ledger” stating...“It’s too bad that other people have to suffer for the wrong doings of certain people who have been evading the men in white coats.”<sup>12</sup> Even today, the expression relates to psychiatric care and coercion in care, as evidenced by a recent publication out of the U.K. by Dr. George Szumukler, *Men in White Coats: Treatment Under Coercion*.<sup>13</sup>

As police became the default responders, there was a new wave of interest in helping improve their work. The Crisis Intervention Team (CIT) model, which was created after a deadly encounter of police with an individual with mental illness in Tennessee in the late 1990s, is built on the idea that with select officers given proper training, protocols and locations to take people, police responses can be improved and yield more favorable and less deadly or injurious outcomes.<sup>14</sup> Although traditional police uniforms conjure up their own images related to authority and control,<sup>15</sup> the CIT approach incorporated the practice of having a special badge for CIT trained officers that would show that the individual police responder was more “mental health friendly.” This effort aimed to shift prior notions, but overall policing practices continue to be questioned with regard to responses to persons with mental illness. Indeed, a 2018 U.S. Government Accountability Office (GAO) report recorded several Federal law enforcement challenges in responding to individuals with mental illness and the need to enhance those responses,<sup>16</sup> further indicating how far there is still to go in achieving the goals of quality community responses with partnerships across disciplines. To that end, Rahr and Rice from the Harvard Kennedy School comment on the importance of “recommitting American police culture to democratic ideals”, emphasizing the importance of procedural justice (how people are treated during encounters with the law), building community trust such as through positive police contacts all while maintaining officer safety.<sup>17</sup>

In the evolution of response to persons with mental illness and the advent of CIT, co-responder, embedded clinicians, and other multi-disciplinary response models emerged. This created more advances in developing pathways to better ascertain how to respond to crises with re-imagined roles rather than the “default” law enforcement response. In addition, progress has been made in how to best leverage the important role well-trained police can play in certain circumstances,

and under what circumstances they could join or provide on scene or available back up to behavioral health responders of other disciplines who might be deployed first.

Although the idea of expanding crisis response beyond police goes back decades, in 2017, Abreu and colleagues introduced to the academic literature and to policymakers the concept of Intercept 0<sup>18</sup> as an expansion of Munetz and Griffin's 1996 Sequential Intercept Model<sup>19</sup> that put forward the idea of stepwise approaches to identifying individuals with mental illness who became involved in criminal processes and redirecting them into treatment. In Abreu and colleague's review of Intercept 0, they delineate the importance of community crisis response as a first step that could decrease the reliance upon law enforcement. Further, they note the two traditional roles of law enforcement, warriors (for whom the role entails public safety protections) and guardians (that support vulnerable people by assisting them with decision-making and helping them take care of their needs) (see Text Box), and emphasize the important role that this "guardian" of society can play in helping individuals with mental illness access care.<sup>20</sup> By focusing on the roles of participants in crisis response in engaging individuals and supporting local community mental health crisis responses, the emphasis can shift toward deflection to treatment at the same time the reliance on police partnerships continues and can be refined.<sup>21</sup>

### ***Roles of Police Related to Crisis Services***

**Guardian:** Under the *parens patriae* doctrine, the government's role includes acting almost as parent in caring for vulnerable people such as those with serious mental illness who may be unable to care for themselves. This is one of the doctrines that provides a rationale for civil commitment and related procedures.

**Warrior:** There is also a rationale of "police powers" that authorizes civil commitment of individuals with mental illness who are at risk of harm to themselves or others. This allows police through their governmental authority to intervene to protect others from harm and keep people safe.

Beyond police and behavioral health professional responses through mobile crisis and co-response, emergency medical services has also grown as a field and been an increasing focus of attention in the behavioral health crisis response continuum. Freedom House was an example of a community-based medical service that came about and ran in the 1960s and 1970s, run as a Black community-based enterprise with physicians in Pittsburgh<sup>22</sup> that helped foster the development of professional emergency medical technicians as health care professionals, creating a model of health care system in which Black and white enterprise work for and towards community good. Around the time of its emergence, in 1966, President Lyndon B. Johnson received a white paper entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*,<sup>23</sup> showing high death rates due to vehicle accidents and recommended standardized emergency training for rescue personnel including police and ambulance attendants. This resulted in an early emergency medical technician-ambulance (EMT-A) curriculum published in 1969,<sup>24</sup> followed by in 1971 a national standard curriculum for EMTs published by the U.S. Department of Transportation.<sup>25</sup> Then in 1973, the Emergency Medical Services Act produced federal guidelines and over \$300 million in funding to develop regional EMS systems across the United States.

Since that time, emergency medical personnel have increasingly responded to mental health problems in out-of-hospital contexts, with one national study of ambulance transports to emergency departments in the United States showing higher rates of ambulance use between 1997 and 2003 for mental health visits, with 31% of patients arriving by ambulance to an emergency department for a mental health visit.<sup>26</sup> This increased use of paramedics and other emergency medical service personnel in behavioral health crisis response has called attention to public debates about whether this is a misuse of paramedic services and whether more could be done to prevent these emergency calls for mental health issues in the first place.<sup>27</sup>

Today, what is clear is that the crisis response space is exciting, complex, and rapidly evolving, with many more stakeholders weighing in to get responses communities want. Additionally, there is an ever expanding need to provide access to mental health services to avoid behavioral health crises in the first place, especially in the context of the human experience with COVID-19. As both these approaches converge, policymakers are aiming to build a better crisis response continuum knowing whatever is built must link to 988, and involve coordination with 911 and partnering organizations including EMS, behavioral health systems and police.

### **System Considerations for 988, 911 and the multidisciplinary team response landscape: 2022 and Beyond**

In *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*,<sup>28</sup> and in *Crisis Services, Meeting Needs, Saving Lives*,<sup>29</sup> basic models for community responses for mental health crises invoking different disciplines are described. Given the growth in this area, an expanded list of examples of available models of community responses to behavioral health crises is summarized in **Table 1**.

There has been a proliferation of different models around the country in which multidisciplinary teams are invoked to respond in a community setting to address crisis calls. The launch of 988 only makes these models even more of an imperative. In a 2018 publication of a systematic review of co-responder models seen in the literature, it appeared that articles from Australia, Canada, the United States and the United Kingdom were more numerous after 2015, and evidenced 19 different “triage models” across 26 articles that met the review’s criteria.<sup>30</sup> The models included 12 ride-along approaches, five involved ride-along and control room support with remote assistance via telephone or police radio, and six in which the primary support was via a control room or telephone triage support.<sup>31</sup>

States have established community mobile services for families, youth and adults alike. For example, a non-officer-based general community health response model out of Eugene and Springfield, Oregon, the CAHOOTS model (Crisis Assistance Helping Out on the Streets)<sup>32</sup> received enormous public attention especially in the wake of the “defund police” movement and inspired a national movement to build similar services.<sup>33</sup> And, like many similar initiatives around the country, models in Massachusetts<sup>34</sup> and Connecticut<sup>35</sup> incorporate a youth-focused

mobile crisis intervention and stabilization responses including aftercare follow up services with family partners.

**Table 1: Emerging Designs of Community Based Partnership Responses with Law Enforcement, Mental Health Providers, EMS and Others (see also [Crisis Services: Meeting Needs, Saving Lives](#))**

<i>Dispatch-based behavioral health supports</i>	Behavioral health specialists work within dispatch call centers to be available to assist with calls, provide consultation and support of call center workers and engage in frontline “triage”.
<i>Police-based specialized police response</i>	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.
<i>Police-based specialized mental health co-response</i>	Typically involves behavioral health clinicians hired by police departments whose job is to accompany officers on calls where an individual might be in a behavioral health crisis or where a behavioral health specialist might be helpful.
<i>Mental health-based mental health response</i>	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; Law enforcement may or may not jointly and cooperatively appear on the scene.
<i>Health system-based response</i>	Provided by EMS, Federally Qualified Health Centers, and other health systems where medical personnel are first responders to behavioral health crises.
<i>Street outreach workers</i>	Focus on homeless populations and provide specialized responses to manage crises, refer to treatment and even initiate or provide treatment to people on the streets.
<i>Peer-based crisis responders</i>	Individuals with lived experience respond to families or individuals in distress and connect to other service providers for referrals. These may be tailored to unique populations such as veterans, native Americans, and others.
<i>Multi-disciplinary team responses</i>	Services that bring together medical personnel, behavioral health personnel and law enforcement to be on scene in a community and provide responses leveraging each discipline.
<i>Blended and innovative</i>	Services that involve unarmed officers, peer support collaborations, community response teams that utilize a combination of efforts of an of the above and additional models to enhance options for responding.

Other initiatives are unfolding that invoke various disciplines in the responses. Take Texas, for example, which has grown Multi-Disciplinary Response Teams (MDRT) with the support of Meadows Mental Health Policy Institute with funding from Pew Charitable Trusts.<sup>36</sup> These teams approach crisis response with a focus on health outcomes, relying upon best-practice responses to medical emergencies for people with chronic illnesses that invokes a paramedic, a licensed master’s prepared mental health professional and a law enforcement officer with advance crisis and mental health training.<sup>37</sup> Results of that program have shown some promising findings, with 40% of 6,679 response contacts also helping link individuals to community services.<sup>38</sup>

There is also much literature on the CIT model. For example, one study showed that use of force, arrests and injuries were infrequent in Colorado after the implementation of crisis

intervention teams.<sup>39</sup> Another study examining police reports from 2003 to 2005 showed that 45% of CIT events involved suicide crisis and 26% involved a threat to others, and that use of force, while related to the violence potential of the event, was used only in 15% of events posing serious to extreme risk of violence.<sup>40</sup>

Even with these advances, with the transition to 988 that officially began in July 2022, there is an increased demand for better responses. Thus, it is more critical than ever to examine what might be best and better practices. In one Canadian rapid review of the literature from 2010 and 2020 comparing outcomes across police, co-responder and non-police models, researchers found sobering results across 62 articles: studies were observational and lacked control groups, making findings of low-to moderate quality with potential for bias.<sup>41</sup> According to the review, there was no rigorous evidence to show that CIT models improved crisis outcomes. Co-responder models showed some improved outcomes compared to police-only responses yet evidence was mixed. The authors found that non-police models varied significantly across studies making the data too limited to generalize conclusions, though youth models and crisis resolution home treatments showed some positive results. Overall, the study highlighted the critical need for better data and ongoing research to help shape policies and practices for mobile response models.

Policies will need to be established to achieve best outcomes during multidisciplinary responses. In the CIT International guidebook,<sup>42</sup> policies are recommended related to call-taking and dispatch role in gathering mental health information, procedures to follow in the event a CIT officer is unavailable, the on-scene role of the CIT officer when safety is an issue and when it is not, additional resources available to CIT officers, procedures for voluntary and involuntary psychiatric evaluations including for children, transport for voluntary and involuntary psychiatric evaluations, and coordination with receiving centers. They also tackle issues such as removal of offensive and stigmatizing language from policies, arrest procedures for persons with mental illness when that is necessary, expected wait times and locations, reduction in the use of physical and chemical restraints, communication with the individual, their family and the role of peers, to name a few. Given the trends in crisis response mechanisms, cross-discipline type protocols and policies are increasingly needed. This is crucial as the response scene itself can become a place that could get crowded, and response approaches could vary for different responders. Even in the CIT guidebook, for example, there are specific provisions how a scene should be controlled, indicating that CIT officers as opposed to other officers would be lead officers during a mental health call.<sup>43</sup> With more responders potentially present, outcomes could be very different depending on how their policies compliment or contradict each other.

In applying these concepts, consider the fictionalized crisis scenarios depicted above and how best to approach responses to them. In each of them, there may be a need for a continuum of responses that takes into account the least restrictive type analysis balanced with safety consideration. The least restrictive alternative is a term that supports maximizing the autonomy of the individual until or unless a more coercive, legally authorized approach is warranted for safety reasons. To that end, the Vera Institute provides a typology of responses along a

continuum ranging from less to more police involvement that may signal both how much a community has invested in alternative response types and how a response might best suit the community's needs.<sup>44</sup> Pushing further, but safely, toward behavioral health responders will help move the needle on least restrictive approaches.

## **Laws and Regulations Affecting Clinical Practices in Crisis Response**

When individuals are in crisis, they may be engaging in what might otherwise be arrestable offenses. Yet, one of the goals of crisis response is to divert individuals from criminal and juvenile justice processes and reroute them to treatment whenever feasible. As noted, the original sequential intercept model addressed the role of police in being able to expand alternatives to arrest. Yet how these situations play out may also relate to laws, statutes and practices. For example, it has long been recognized that there is a great deal of discretion for how officers respond to situations involving individuals with mental illness.<sup>45</sup> Exceptions to this discretion generally involve when behavior rises to felony levels, where there is a victim, or when laws such as domestic violence laws specifically limit officer discretion and require arrest under some circumstances. With jail diversion and decriminalization, as well as build-out of crisis stabilization settings and crisis receiving units that are police-friendly, there will likely be increasing use of mental health services in lieu of police response, arrest and incarceration. This is one of the goals of programs such as CCBHCs and other services.<sup>46</sup>

Case law related to arrestable offenses is also interesting to consider. In the 1960s and 1970s, some of these issues arose in two major landmark cases that are still relevant today. In the 1962 case, *Robinson v. California*,<sup>47</sup> a police officer arrested a man who had heroin tracks in his arms, because at the time there was a statute in California that made it a misdemeanor to be addicted to narcotics. He was found guilty and sentenced to 90 days in jail. However, his case was appealed and ultimately heard by the U.S. Supreme Court, which found that it was an Eighth Amendment violation and considered cruel and unusual punishment to sentence Mr. Robinson for the status of being addicted to narcotics. Only a few years later, in 1968, the U.S. Supreme Court was asked to clarify whether it was also cruel and unusual punishment to arrest and convict someone who was publicly intoxicated by acting in a disorderly manner. In *Powell v. Texas*,<sup>48</sup> the high Court found that the conviction in Texas was able to be upheld as the conviction was based on Mr. Powell's behavior that was against the law, not based on the status of being intoxicated.

Today, recognizing the high utilization of criminal processes for individuals with substance use disorders and co-occurring conditions, states are examining laws that decriminalize possession of illegal substances. Oregon's Measure 110, for example, sets up a mechanism to help route people to treatment in lieu of arrest and incarceration when they are found in possession of substances that would previously have authorized an arrest.<sup>49</sup> In addition, by 2017 approximately 40 states and the District of Columbia had passed expanded Good Samaritan laws that provided immunity from arrest for individuals who called 911 who were witness to or experiencing an opioid-related overdose even when they were in possession of illegal substances and paraphernalia.<sup>50</sup> With these laws aiming to decriminalize behavioral health issues, and a goal of

diverting individuals from criminal and juvenile justice responses, responders on the street will require greater guidance on what to do with various behaviors that may run afoul of the law but may be directly related to mental illness or substance use disorders.

There are also several important legal cases that examine police conduct in use of force situations. This is a very complicated area of jurisprudence, but in one 1989 U.S. Supreme Court decision, *Graham v. Connor*,<sup>51</sup> the Court looked at the reasonableness of force used by an officer and determined that the test of reasonableness would include an examination of the particular circumstances and whether that there would have been probable cause to believe that there was an immediate threat to the safety of the officer or others. In another case related to community policing of individuals with mental illness similar to one of the crisis call scenarios above, *City and County of San Francisco v. Sheehan*,<sup>52</sup> the U.S. Supreme Court heard arguments regarding a situation in which Teresa Sheehan had an encounter with police. She had a mental illness and lived in a group home in San Francisco and had threatened her social worker after he tried to conduct a welfare check. He summoned police for help transporting her to a facility for a 72-hour involuntary commitment. The police officers entered her room without a warrant, and she grabbed a knife and threatened to kill them. They withdrew and called for backup. Not waiting for the backup officers to arrive, they returned to her room with weapons drawn, she again threatened them with a knife and they in turn shot her several times. Though she survived, she sued the officers and the city, alleging Fourth Amendment violations of her right to be free from warrantless search and seizure and violation of the Americans with Disabilities Act (ADA). With regard to the ADA, the question was whether law enforcement was required to provide accommodations to a person with mental illness, despite her being armed and violent, when taking her into custody. As there had been a split in lower courts on this issue, this case was viewed as a potential game changer for police conduct. However, the ADA question was unanswered by the Court, given legal technicalities of how the questions were posed to the Supreme Court justices. With regard to the Fourth Amendment issue, the Justices sided with police indicating the nature of the emergency and potential injury to the occupant negated the need for the warrant and thus held their use of force was reasonable under the circumstances described.

Other lower court decisions have found that when there is the direct threat such as seen with a person with mental illness who has a knife, use of force—even deadly—may not violate the ADA during a police encounter.<sup>53</sup> In another case, the Sixth Circuit Court of Appeals reviewed the circumstances of an alleged unlawful mental health seizure of a woman they brought to a hospital in handcuffs and in its ruling the Court noted the insufficient data to justify such a seizure after her husband had left her home with her firearm and after she had denied being suicidal when police inquired.<sup>54</sup>

Taken together, the case law is replete with examples of the complexities of police encounters as they relate to individuals with mental illness. Under the law, there is no carte blanche to use of force, but it is allowable by police in certain circumstances. In legal cases there is a balancing test of the given circumstances to understand where and when violations of individual rights occurred. Issues related to judgments of probable cause for the officer to justify their actions

and considerations of the degree of threat the individual may be posing will come into play where there is litigation against officers with regard to their conduct.

With more and more multidisciplinary teams involved in responses, some of this liability may spill over to other types of responders, yet it remains to be seen how their liabilities will be examined by courts, and whether behavioral health responders will be reviewed similar to EMS in terms of relying upon emergency medical clinical standards of care. There may also be examination under the lens of laws like the ADA or even the Emergency Medical Treatment and Labor Act (EMTALA) that requires stabilization before transfer, though EMTALA generally applies to emergency departments or facilities. It is not unreasonable, however, to imagine that when CMS funding for crisis response services is sought, some of the provisions of EMTALA could be developed over time for these out-of-hospital crisis scenarios. This remains to be seen but does support the imperative to establish best practices in the field and to take into consideration legal issues when developing policies and protocols for assessing an individual's presentation, conduct during a response, and stabilization of an individual's clinical condition.

Even with additional partners in the crisis response framework, policymakers should understand that the delicate issues that could be at play if too much emphasis is placed on decreasing police roles, especially while other services are not yet in place. Such efforts, even well-intentioned, could lead to unintended consequences, if interpreted to mean law enforcement is no longer needed for work that society has come to rely upon for ensuring public safety. Take, for example, the aftermath of House Bill 1310 in Washington, which placed additional parameters upon police to limit the use of force and to foster the use of de-escalation strategies when possible.<sup>55</sup> It was reported *in The Seattle Times* that even before the bill went into effect there were multiple instances of law enforcement taking “hands-off” stances and not responding as they would have previously when in receipt of calls regarding people in behavioral health crises.<sup>56</sup> With these stories in mind, it is important to ensure that efforts to expand alternative responses do not also alienate law enforcement, who still have a critical—even if narrower—role to play in behavioral health crises where significant safety and security issues arise.<sup>57</sup>

## **Transport of Persons with Mental Illness and Related Laws**

As part of a response to a crisis, police may be called upon to transport an individual to a site where a clinical evaluation can take place or they may execute an involuntary detention or hold. Mental health laws in each state have provisions related to transport of people with mental illness and execution of such holds, that generally include liability protections for peace officers with certain uses of restraint, as well as delineate when and how such restraints can be used.<sup>58,59</sup> State rules and law enforcement departmental policies may further the guidance around these circumstances. For example, in Michigan, the Mental Health Code indicates that a peace officer may transport an individual to an approved service program or emergency medical service, and take them into protective custody “with that kind and degree of force that is lawful for the officer to arrest that individual for a misdemeanor without a warrant. In taking the individual, a peace



officer may take reasonable steps to protect himself or herself.”<sup>60</sup> Whether an ambulance or law enforcement transports individuals can depend on many facets of a crisis response.

The use of law enforcement for some of these functions has recently been called into question. For example, a recent national survey by the Treatment Advocacy Center found that in 2017 the costs associated with transporting people with mental illness by law enforcement were significant with 21% of officer time spent transporting individuals with mental illness, and risked further criminalizing the people being served.<sup>61</sup> Moreover, transporting people with mental illness by law enforcement often involves the use of handcuffs and police vehicles, and this can create stigma, shame and humiliation for an individual who is not under arrest but is instead experiencing a behavioral health crisis. Mental Health America has noted concerns about children with mental health needs and advocated that they should not be handcuffed while being transported in the community—especially out of school—and that prior to use of any restraint, respondents should use de-escalation techniques and work with support systems to promote voluntary agreement with transport to avoid restraints all together.<sup>62</sup> Although Non-Emergency Medical Transport (NEMT) is a benefit provided by CMS when an individual beneficiary requires transportation to and from medical appointments, some advocates are considering NEMT alternatives with regard to transportation to crisis stabilization units. This may be effective, especially as they may not be considered “emergency” sites like emergency departments and thus may not invoke billing like an ambulance transport in an emergency setting. Without appropriate alternatives settled, the default response can become law enforcement transports. With workforce shortages among EMS, and the problematic nature of law enforcement as a default mode of accessing needed transport for persons in crisis, use of NEMT may become an important option to consider for those situations that would allow for this.

Discussion about transports has catalyzed some innovation. In Virginia, an Alternative Transportation Sub-Group of the Mental Health Crisis Response and Emergency Services Advisory Panel Interim Report from October 2016<sup>63</sup> reviewed processes in the state including transportation of individuals to an emergency evaluation, temporary detention transports following a medical clearance and assessment of need for such detention, post-commitment transports and discharge transports. From that work, Virginia recently rolled out a whole framework of new approaches for transporting individuals on Temporary Detention Orders.<sup>64</sup>

Oklahoma is another state that has focused on transport of persons with mental illness. In 2021, the Governor of Oklahoma signed into law a bill that requires direct transport by law enforcement to a mental health facility within 30 miles for those in mental health crisis, and require that the Department of Mental Health and Substance Abuse Services to provide transport themselves if there is no facility within 30 miles.<sup>65</sup> This has shifted many transport responsibilities to behavioral health providers from what had recently been the work of law enforcement.

Transportation activities for individuals in mental health crisis require an additional layer of scrutiny and could lead to refinement of functions, eliminating the need for particular first

responders spending time needlessly on transportation type functions that could be accomplished in different ways. Alternative strategies such as those that are destigmatizing and utilize the least amount of coercion and restraint should be maximized.

## **Clinical Considerations for Out-of Hospital Care**

Traditionally emergency medical first responders administer protocols, such as CPR, or initiate medications under the control of a medical authority at an emergency scene to save a life. With decreasing criminalization and efforts at jail diversion, there will be increasing need to be able to manage complex behaviors in community settings that could correlate to any number of conditions, including those that might be best suited for immediate psychiatric or behavioral health treatment intervention beyond de-escalation or linkage supports. There will also be a growing need to be trauma-informed and responsive to people who have trauma histories, given that the behavioral health populations have high rates of exposure to adverse childhood experiences and trauma.

Some out-of-hospital treatments have resulted in considerable controversy especially when it is thought that law enforcement is making clinical decisions, such as the use of Ketamine, which was associated with use of force situation and untimely death of Elijah McClain.<sup>66</sup> This resulted in professional organizations<sup>67</sup> and leading academicians calling attention to the risks of police involvement in medical decisions and the need to re-examine the risk-benefit ratio of Ketamine with regard to quelling agitation versus the risk of it causing respiratory suppression.<sup>68</sup>

Nonetheless, just as CPR was established as a community-based life-saving response, with careful attention to proper protocols, there will likely be evidence-based expanded activities to help get treatment to people in behavioral health crisis who need it when they need it—even in home with a mobile crisis response. Especially in children’s behavioral health, there is a great deal of discussion about initiating and continuing “stabilization services” post immediate response.<sup>69</sup> In general emergency response circles, there has been increasing exploration of what specific treatment interventions could be administered on scene to help improve outcomes overall for people’s underlying conditions. For example, some EMS systems are exploring whether to induce treatments for opioid use disorder beyond overdose prevention, such as through initiation of treatment medications like buprenorphine.<sup>70</sup> As another example, an emerging protocol called PsySTART<sup>®</sup> (Psychological Simple Treatment and Rapid Triage) is a real-time triage and case management behavioral health tool for emergency medical responders to address pediatric behavioral health crises or during traumatic events.<sup>71</sup> Other avenues for very early in-the-field interventions might some day involve addressing individuals with first episode psychosis, bipolar disorder, and other conditions. This could include the benefit of a virtual psychiatric review and recommended initiation of some treatment on the streets with those first responder multidisciplinary teams. With the exciting developments of mobile crisis response, the possibilities for early, proper engagement and initiation of treatment and linkage to ongoing care are plenty.

## Medical Clearance and No Refusal Policies

With multiple potential responders resolving crises on the scene and determining whether to transport individuals to alternative sites for further evaluation and stabilization, two additional areas of concern will need attention.

First is the question of whether the individual is medically appropriate for a site other than a hospital. There is a growing body of research regarding the concept of “medical clearance” or “medically stable for transfer” determinations. With emergency department overcrowding, many states have identified that protocols for medical clearance are creating part of the delay, as sending and receiving facilities debate back and forth about whether an individual has received adequate medical screening to be sent to a facility that has fewer medical services than the emergency department. Potentially unnecessary and costly testing of patients was identified in four out of five emergency department visits in one study.<sup>72</sup> A national effort to examine medical clearance practices found that the evidence supported history, physical examination, vital signs and mental status examinations as the minimum necessary elements in the evaluation of psychiatric patients.<sup>73</sup>

Some states have adopted protocols related to medical clearance being promoted for statewide uptake. Take Michigan, for example, where state leaders are currently pursuing acceptance across all hospitals of the MI-SMART protocol,<sup>74</sup> which was developed through a comprehensive process involving a review of the literature, an environmental scan of several states and their processes, and multiple convenings of an advisory group consisting of psychiatrists, emergency medicine physicians, nurses, administrators and others. In this protocol, a standard assessment form, the SMART form<sup>75</sup> provides a rubric of items to review as the basic medical clearance protocol, which can then flag items such as neuroimaging, other medical assessments, or lab tests needed for further review before the medical provider can determine an individual as medically stable for transfer. Similar approaches have been recommended and described in the literature.<sup>76</sup>

Second, to serve anyone at anytime, it will be important to have the ability to allow anyone to enter for immediate screening at the crisis stabilization site. Even if upon evaluation it is determined that the individual warrants a different level of care, the idea of a “no refusal policy” is critical to the successful “warm handoff” from a community mobile responder or law enforcement to a crisis evaluation point of contact. Arizona’s Crisis Response Center is a great example of a system that adopted a “no wrong door” approach. If an individual is brought to the facility by law enforcement officers, the clinical staff will help evaluate the patient to ensure their stability before they determine where the person may need to go next.<sup>77</sup> Without security on site but with well-trained staff, they accept all comers and believe this helps decriminalize individuals whose behavioral health conditions may exhibit themselves with extreme behaviors. Consistent with SAMHSA’s National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit promulgated in February 2020, the idea of the program is that they can serve anyone at anytime.<sup>78</sup> These types of policies are important to promulgate as programs roll out across the country (see Text Box).

### ***Community Partnership Considerations: Partnership Development Including Policy and Protocol***

As noted in prior publications on behalf of NASMHPD, *Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies*<sup>79</sup> and *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*,<sup>80</sup> the authors emphasize the key ingredients of successful responses rest in community partnerships. Though the partnerships are critical, without an amalgamation of training, policies and protocols that take into account the various responders involved in a community, there could still be the potential for a response that runs afoul and becomes unsafe for all. Such protocols and trainings are starting to emerge, such as through SAMHSA's numerous playbooks that lay a foundation of instruction from dispatch to responder.<sup>81</sup> But just like in the development of EMS standards, there will likely need to be ongoing development in these areas to help drive practices across disciplines as more is learned about the actualities of the various mobile responses.

### **Workforce Needs and Concerns**

The largest potential impediment within the plans for improved crisis services is the ubiquitous and multidiscipline-impacted workforce shortage. In a field where there can be high burnout and trauma given the intensity of mobile responses working in high-risk scenarios, it is critical to attend to the needs of the workers, build a quality workforce, and give them the tools they need to be successful. Addressing issues of trauma are necessary, as exemplified in communities like Miami, Florida that established a peer network and trauma responsive supports for its officers.<sup>82</sup> Furthermore, disparities in care delivery and in workforce members can create additional layers of chronic stress as structural racism compounds everyday stress and responses. Nurturing a workforce and helping them build increasingly with the concepts of posttraumatic growth baked into organizational planning may be helpful in this regard as was highlighted in one review examining pandemic-driven considerations to enhance such growth.<sup>83</sup>

### **Conclusions and Future Directions**

In the scenarios above, one could imagine their unfolding in any number of ways, from escalation and tragedy to de-escalation and return to safety with linkage to ongoing treatment. With police and others each playing critical roles in the mix of responders, policymakers would do well to consider these scenarios as they build out protocols and avenues for response across different regions and for different partners who might be called to respond. Even though they are likely only a small percentage of what 988 will receive in its call lines, they are nonetheless some of the most vexing scenarios that will require due diligence for proper responses that are equitably applied across populations. Future activities will necessitate increasing standards development for protocols. More robust data collection and research related to what happens with calls received and triaged through dispatch, what happens on the scene out-of-hospital, and what happens with transport on the way to other places, will be needed to develop better responses. The 988 call centers and linked service delivery system will undoubtedly require

increasing collaboration and systems networking with 911, other partners, and community members who have a vested interest in favorable outcomes for all.

This is a pivotal time in the field of behavioral health crisis response with much at stake. It is important that the build-out of various crisis response models, and the incorporation of law enforcement when needed, is successful. Taking stock of successes as well as near misses and examining “failures” are necessary components and must occur to continue to improve quality along the way. This paper aimed to lay out some foundational principles and background while highlighting areas for consideration to help in the development of the enhanced services of tomorrow. The current momentum for crisis service innovations and improvements can be leveraged to help policymakers and administrators move their staff and their systems to make available the right responses at the right time. For the sake of people who are at their most vulnerable during a behavioral health crisis, leveraging this momentum is critical and the time to do so is now.

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